

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155211	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/08/2015
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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT LEBANON	STREET ADDRESS, CITY, STATE, ZIP CODE 1585 PERRY WORTH RD LEBANON, IN 46052
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State licensure survey.</p> <p>This visit resulted in an Extended Survey-Immediate Jeopardy.</p> <p>Survey Dates: September 22, 23, 24, 25, 28, &amp; 29, 2015.</p> <p>Extended Survey Dates: October 6, 7, and 8, 2015.</p> <p>Facility Number: 000118 Provider Number: 155211 AIM Number: 100290470</p> <p>Census Bed Type: 30 SNF/NF: 30 Total: 30</p> <p>Census Payor Type: Medicare: 2 Medicaid: 22 Other: 6 Total: 30</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 10/8/15 by</p>	F 0000	<p>This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at Lebanon desires this Plan of Correction to be considered the facility's Allegation of Compliance effective October 27, 2015.</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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F 0223 SS=K Bldg. 00	<p>29479.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure residents were free from verbal and mental abuse when a Certified Nurse Aide (CNA) who verbally and mentally abused residents was not immediately removed from resident care, resulting in psychosocial harm to 4 of 20 residents reviewed for allegations of verbal and mental abuse (Resident #32, #26, #28, #13).</p>	F 0223	F223 Itis the policy and standard of care for this facility that it will develop andimplement written policies and procedures that prohibit mistreatment, neglect,and abuse and misappropriation of resident property. Further, this facility will develop and implement written policies andprocedures that all alleged violations involving mistreatment, neglect, orabuse, including injuries of unknown source and misappropriation of	10/27/2015

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	<p>The immediate jeopardy began on 03/06/2015 when CNA #5 threatened to smother a resident with a pillow while he slept, the staff member was not removed, and the Administrator did not thoroughly investigate and/or report the incident to State agencies according to law. The Administrator and Director of Nursing (DON) were notified of the immediate jeopardy on 10//6/2015 at 8:21 a.m. The immediate jeopardy was removed on 10/8/15, but noncompliance remained at the lower scope and severity of isolated, no actual harm, with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings include</p> <p>1. During an interview on 9/23/2015 at 11:16 a.m., Resident #32 indicated Certified Nursing Assistant (CNA) #5 had been verbally abusive toward him in the past. He indicated CNA #5 told hem she was going to smother him with a pillow while he slept. The resident indicated he could not recall the date of the incident, but indicated he notified the Director of Nursing (DON) at the time of the incident.</p> <p>Resident #32's record was reviewed on 9/23/2015 at 12:00 p.m. A Minimum Data Set (MDS) assessment, dated</p>		<p>residentproperty are reported immediately to the administrator and to other officialsin accordance with State law, (ISDH). The facility also wishes to note that the issues noted in the statementof deficiencies which occurred before 9/1/2015 were during the employment of aformer administrator for this facility.</p> <p><u>1.What corrective action will be done by thefacility?</u> Since the current Administrator has onlybeen in place since 9/1/2015, the Nurse Consultant for this facilityin-serviced her on 10/07/2015 on the facility policy for mistreatment, neglect,and abuse and misappropriation of resident property, as well as Hickory Creek HealthcareFoundation's specific policy regarding <b>Accident/Incident/Reportable/S tate Officials</b>policy and procedure and the Indiana State Department of Health – Division ofLong Term Care <b>Incident Reporting Policy</b> with an effective date of 07/15/15.This includes the procedure for assuring timeliness in submission of reports tothe state agency in cases of reportable events which fall under the IncidentReporting Policy; in other words, immediate reporting of such allegations. All incidents reported by the surveyorsdirectly to facility staff have been reported through the incident reportingsystem and investigations have been in</p>		

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	<p>6/19/2015, indicated Resident #32 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 out of 15.</p> <p>During an interview on 9/23/2015 at 12:02 p.m., the DON indicated the previous Administrator had been informed of CNA #5's threat to smother Resident #32 in his sleep.</p> <p>During an interview on 10/6/15 at 9:50 a.m., the Social Service Director (SSD) indicated she was aware Resident #32 made an allegation of CNA #5 threatening to smother him with a pillow. The SSD indicated she was not able to recall the exact date of the incident, but indicated it could have been in February or March, 2015. The SSD indicated the former Administrator and DON were aware of the incident and conducted an investigation.</p> <p>During an interview on 10/6/15 at 10:00 a.m., the DON indicated the previous Administrator interviewed Resident #32 regarding CNA #5 threat to smother Resident #32 with a pillow. The DON indicated the former Administrator informed her the resident "re-canted" his story and indicated he and CNA #5 were "joking" with each other. The DON indicated she removed CNA #5 from</p>		<p>progress and/or completed. As a result of these allegations / investigations, one certified nursing assistant has been terminated from the facility. All residents identified specifically by the surveyors will be addressed individually. Each of these residents will be visited by the Social Services Designee, Director of Nursing, or other designated member of the IDT for evaluation of their current status, including assessment for any signs of distress, discomfort, or concern regarding their care and treatment. These visits will be documented in each resident's medical record. Any identified concerns will be reported to the Administrator immediately for follow up as indicated, with the physician or psychologist; in addition a report will be made to ISDH if new allegations of abuse or neglect are reported, as per policy. Re-training of all staff in all departments began on 10/6/2015, regarding the facility's Abuse Prohibition / Know Your Role policy which indicates "residents must not be subjected to abuse", the various types of abuse; mistreatment, neglect, or abuse, either verbal, mental, sexual or physical, corporal punishment, or involuntary seclusion, or misappropriation of resident property. Further, the re-training stressed the process for reporting any type of allegation or occurrence that suggests any</p>				

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	<p>providing care to Resident #32 after the allegation but the CNA was allowed to provide care to other residents. The DON indicated CNA assignment sheets indicated the residents who received care by each CNA for each shift.</p> <p>CNA assignment sheets were requested on 10/6/15 at 10: 00 a.m., and provided on 10/7/15 at 10:00 a.m. The assignment sheets indicated the last date CNA #5 provided care to Resident #32 was 3/6/15. Assignment sheets were not available for 3/10/15, but the CNA's time sheet indicated she worked during the evening shift on that date. A CNA assignment sheet, dated 3/15/15, indicated CNA #5 was assigned, but removed from care, to Resident #32.</p> <p>CNA's time card was reviewed on 10/6/15 at 3:50 p.m. and indicated the CNA's last day worked was 9/19/2015.</p> <p>2. During an interview on 9/24/2015 at 9:24 a.m., Resident #13 indicated Certified Nursing Assistant (CNA) #5 was "moody." The resident indicated CNA #5 told her she should "move elsewhere" if she didn't like how she provided care and indicated the CNA's comment made her feel like a "lost cause."</p> <p>During an interview on 9/29/2015 at</p>		<p>type of mistreatment, neglect, or abuse, either verbal, mental,sexual or physical, corporal punishment, or involuntary seclusion, or misappropriation of resident property. The re-training indicated the various scenarios in which an incident towards a resident may occur – whether resident and resident, resident and staff, visitor and resident, or visitor and staff. The staff has been told that a violation of the Abuse Prohibition protocol will not be tolerated. If an allegation is made, they will be suspended pending investigation and that they will be held accountable for immediate reporting of allegations, and failure to do so will result in disciplinary action, up to, and including termination of employment. All staff will be in-serviced no later than 11:59 PM, 10/7/2015 and if a staff member is unavailable and has not received the training due to vacation or other types of absences, they will not be allowed to work their next scheduled shift until they have received this same in-servicing. If agency staff is scheduled to work, they will receive the same training by the Director of Nursing before beginning their tour of duty. In addition, all staff will be asked to complete the "Affirmation of "No" Observation/Knowledge of Abuse" form and to sign an Affidavit confirming the</p>	

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	<p>11:10 a.m., Resident #13 indicated CNA #5 transferred her to her bed via a Hoyer lift (mechanical lift). Resident #13 indicated she had an incontinent bowel movement during the transfer and indicated CNA #5 "sarcastically" said, "You just [s---] all over the floor." The resident indicated CNA #5 told her she could have controlled her elimination and indicated the CNA's comments made her feel "horrible, disappointed, and bad" about herself.</p> <p>During an interview on 9/28/2015 at 4:15 p.m., the Director of Nursing (DON) indicated the Activity Director (AD) recorded the minutes for the Resident Council Meeting on 9/15/15 and indicated Resident #13 reported the allegation during the Resident Council meeting.</p> <p>During an interview on 9/28/2015 at 4:22 p.m., the Activity Director indicated she had not recognized the allegations as abuse and had not immediately informed the Administrator.</p> <p>During an interview on 9/29/15 at 4:17 p.m., the Administrator indicated the facility became aware of the allegation of verbal abuse during the Hoyer transfer when it was discussed in the Resident Council meeting on 9/15/15. The</p>		<p>truthfulness of their responses on the Affirmation form. If there are any indications of concerns regarding abuse or neglect from any of the staff member statements, they will be reported to the Administrator, who will send the report to the state and will initiate the investigation as required by facility and state policy. The Administrator and Director of Nursing, along with members of the management team will continue to quiz staff on the facility's policy regarding their obligation to report alleged mistreatment, neglect, or abuse, either verbal, mental, sexual or physical, corporal punishment, or voluntary seclusion, or misappropriation of resident property to verify staff members continue to understand the reporting requirements. This will be done on a regular basis for at least the next 30 days.</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>All residents in this home have the potential to be affected, but no other resident has been identified as being affected by this practice. The IDT and Administrator have interviewed all cognitively intact residents regarding their treatment and no other allegations of abuse or neglect have been received at this time. If any future allegations of abuse</p>				

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	<p>Administrator indicated the Activity Director should have immediately informed her of the abuse allegations. The Administrator indicated the DON reviewed and signed the Resident Council minutes on 9/18/15 and should have immediately notified her after awareness of the allegation.</p> <p>During an interview on 10/6/15 at 8:35 a.m., Resident #13 indicated she was not able to recall the exact date CNA #5 yelled at her during the Hoyer transfer. The resident indicated it was "sometime within a few weeks" prior to the Resident Council meeting on 9/15/15.</p> <p>During an interview on 10/6/2015 at 10:00 a.m., the DON indicated CNA #5 was not assigned to care for Resident #13 after she became aware of the allegation of verbal abuse. The DON indicated CNA #5 was allowed to provide care to other residents until she was suspended on 9/20/15.</p> <p>During an interview on 10/6/15 at 5:00 p.m., the Administrator indicated the Resident Council meeting on 9/15/15 was conducted at 2:30 p.m.</p> <p>Resident #13's record was reviewed on 9/28/15 at 10:50 a.m. A Minimum Data Set (MDS) assessment, dated 8/20/15,</p>		<p>are made, as per facility policy and practice, the Administrator will be notified immediately and any resident(s) involved will be examined and/or interviewed to make sure that they are secure and are having their needs met appropriately. The Administrator will notify the state agency of the allegation and an investigation will be initiated at that time. If any staff member is identified as being involved in the allegation, he/she will be suspended immediately pending the outcome of the investigation. Once the investigation is completed, the Administrator and management staff will follow up as needed with training or monitoring activities as deemed necessary by the investigation findings.</p> <p><u>1. What measures will be put into place to ensure this practice does not recur?</u></p> <p>The facility will continue Guardian Angel rounds which are done at least 5 times a week by the interdisciplinary management staff. These rounds are documented and the wording is being revised to contain questions that are the same as used by the survey agency for resident interviews:</p> <p>"Has staff, a resident or anyone else here abused you – this includes verbal, physical or sexual abuse? (If "Yes" ask who the abuser was, what happened, when it occurred, where it</p>		

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	<p>indicated Resident #13 was cognitively intact with a Brief Interview for Mental Status score of 15 out of 15.</p> <p>Resident Council minutes, dated 9/15/15, were reviewed on 9/28/15 at 4:20 p.m. The minutes indicated, "...[CNA #5 named] was lifting a resident (identified by the DON as Resident #13) by Hoyer when residents (sic) bowels released. States [CNA #5 named] told her she should have been able to hold it until she got in bed...."</p> <p>Schedules were reviewed for dates and times CNA #5 worked after the Activity Director and DON were aware of the abuse allegation. The schedules indicated CNA #5 worked during evening shifts on September 15, 16, 18, and 19, 2015.</p> <p>CNA assignment sheets were requested on 10/6/15 at 10:00 a.m. The documents were provided on 10/7/15 at 10:00 a.m. and indicated CNA #5 was assigned to offer snacks, provide showers, and put residents to bed on 9/15/15 (Tuesday) and 9/16/15 (Wednesday). The CNA assignment sheet indicated Resident #13 received evening showers on Mondays and Thursdays. CNA assignment sheets were not available for 9/18/15 and 9/19/15. A nurses' note, dated 9/19/15 at</p>		<p>happened, and how often.)"          "Did you tell staff?"          "Have you seen any resident here being abused?"          "Did you tell staff?"          The results of these rounds and interviews will be brought to the next scheduled morning management meeting for review; however, if there are any indications or allegations of resident abuse or neglect, the Administrator will be notified immediately and the facility will follow through as indicated in question #2. The Nurse Consultant has also reviewed with the Activity Director the process of informing the Administrator immediately of any resident concerns received during the Resident Council meetings. In addition to the Resident Council Minutes, the specifics of any resident concerns received during the Council meeting regarding care or treatment will be documented on a Resident/Family Concern form and given to the Administrator immediately. The Administrator will follow the process as outlined in question #2. The Administrator will ask the Resident Council President if they would agree to Resident Council meetings weekly for the next 30 days, then twice a month for the following 30 days and allow the Administrator or another facility management representative to attend, with</p>		

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	<p>9 p.m., indicated Resident #13 refused a shower on that date.</p> <p>3. During an interview on 9/24/15 at 10:09 a.m., Resident #28 indicated Certified Nurse Aide (CNA) #5 verbally abused Resident #26 on Saturday, 09/19/2015, during the evening meal. Resident #28 stated, "[CNA #5 named] jumped all over [Resident #26 named]" and "cursed." Resident #28 indicated CNA #5 yelled, "You had me get this [s--] and now you are not going to eat it? What do you want me to do with the [s--]?" Resident #28 indicated she reported the abuse to the Social Service Director (SSD) on 09/20/2015.</p> <p>During an interview on 9/24/15 at 10:25 a.m., Resident #26 indicated a CNA yelled at her during dinner over the weekend. She indicated she would not name the CNA because she did not want to get anyone in trouble.</p> <p>During an interview on 9/28/15 at 10:09 a.m. and again on 10/6/15 at 9:45 a.m., CNA #6 indicated she heard CNA #5 talking "loudly" and inappropriately" to cognitively impaired residents "sometime in the past 6 months." The CNA indicated she realized CNA #5 was verbally abusive, but did not immediately report it to the Administrator.</p>		<p>thepurpose of quickly identifying any concerns the council may have. With residentcouncil permission, the Administrator or another facility managementrepresentative would like to discuss the options available to the residents' <b><i>onhow and to whom they may report concerns, incidents and grievances without thefear of retribution and the manner in which facility staff will providefeedback regarding any concerns that have been expressed.</i></b> Results of the Resident Councilmeetings including any statement of concerns or allegations of abuse/neglect,along with the results of facility investigations, will be brought to the QAA Committeeat the monthly meeting for further review and recommendations. A return tomonthly Resident Council meetings or frequency as determined by the ResidentCouncil President will be encouraged after the initial 60 day period. The facility will continue to address allresident concerns as they are received, and designated members of theinterdisciplinary team will conduct an investigation regardless of whether ornot the concern or issue relates to abuse or neglect. If, however, theinvestigation of any concern is linked to possible abuse or neglect, theinterdisciplinary team member(s) will notify the</p>	

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	<p>During an interview on 9/29/15 at 11:07 a.m., Resident #2 indicated she heard CNA #5 "yelling" at Resident #26 in the dining room on 9/19/2015 and indicated the CNA was "chewing her out." She indicated it lasted a "little while before it settled down." She indicated she wasn't sure what the yelling was about but stated, "It wasn't right." The resident indicated she did not tell staff about the incident.</p> <p>During an interview on 10/6/15 at 9:50 a.m., the SSD indicated she was informed by Resident #28 on 9/20/15 of allegations CNA #5 yelled and cursed at Resident #26 during the evening meal in the dining room on 9/19/15. The SSD indicated she notified the DON on 9/20/15 of the allegation.</p> <p>Resident #26's record was reviewed on 9/28/15 at 10:40 a.m. A Minimum Data Set (MDS) assessment, dated 6/26/15, indicated Resident #26 had moderate cognitive impairment with a Brief Interview for Mental Status score of 10 out of 15.</p> <p>Resident #28's record was reviewed on 9/28/15 at 10:33 a.m. A Minimum Data Set (MDS) assessment, dated 7/16/15, indicated Resident #28 was cognitively</p>		<p>Administrator immediately and she will follow through as in question #2. The facility has a very extensive Resident Admission Agreement &amp; Admission Handbook that is discussed at the time of admission with the resident / legal representative and any family member of interest. The purpose of the document is to provide assistance to the resident/ family in a variety of areas. The Resident Admission Agreement &amp; Admission Handbook communicates in multiple places that residents and families have opportunity to communicate concerns without fear of reprisal. Some areas of this document which address these rights, (but not limited to just these sections), are Page 13 – Resident Grievances, Resident Rights under Federal Law – Pages 17-19; specifically #3, #6, #14, #15 and #28. In addition, the facility has a policy and procedure titled Grievances; Policy # SS-14 and ADM-G002. Resident / Family Member's may always approach staff in regards to the manner in which to file a grievance / concern, or to ask for assistance. The Social Service Designee and Administrator may also be a resource for assistance.</p> <p>- <u>1. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator, Director of</p>				

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	<p>intact with a Brief Interview for Mental Status score of 15 out of 15.</p> <p>Resident #2's record was reviewed on 9/28/15 at 10:45 a.m. A Minimum Data Set (MDS) assessment, dated 8/26/15, indicated Resident #2 was cognitively intact with a Brief Interview for Mental Status score of 15 out of 15.</p> <p>4. Resident #28 indicated residents were lined up in their wheel chairs in the hall after the evening meal on 09/19/2015. The resident indicated when she moved Resident #26's wheelchair so she could get to the entrance of her room, CNA #5 yelled and cursed at her. Resident #28 indicated she told the SSD about the incident on 9/20/2015.</p> <p>During an interview on 10/6/15 at 10:00 a.m., the DON indicated CNA #5 was suspended from work on 9/20/15, immediately after she became aware of the allegation of CNA #5 yelling at Resident #28 when she attempted to move Resident #26's wheelchair.</p> <p>Resident #28's record was reviewed on 9/28/15 at 10:33 a.m. A Minimum Data Set (MDS) assessment, dated 7/16/15, indicated Resident #28 was cognitively intact with a Brief Interview for Mental Status score of 15 out of 15.</p>		<p>Nursing, and/or Social Service Designee will bring the results of resident concerns, including allegations of abuse and neglect and subsequent investigations to the monthly QAA committee meeting for further review and recommendations for process improvement. If any recommendations are made, the Director of Nursing or other designated IDT member will follow through and report the results of those recommendations at the next scheduled QAA meeting. This will continue on an ongoing basis. Date of Compliance: October 27, 2015</p> <p><b>Hickory Creek at Lebanon Addendum #2 to Survey of 10/8/15</b></p> <p><b>Tag F223, F225, and F226:</b></p> <p><i>The POC addendum did not indicate how the facility determined if cognitively impaired were affected by the deficient practice (interviews with families, visitors, staff, etc. to determine if there was awareness of abuse to residents). Please include this information. If concerns of abuse were identified, indicate what the facility did to correct the deficient practice.</i></p> <p><i>The POC addendum did not indicate a number of residents, family members, visitors, staff, etc. who will be</i></p>				

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	<p>A policy, dated 12/1999 and revised on 2/2015, titled "Resident Mistreatment, Neglect, Abuse &amp; Misappropriation of Property," was provided as a current policy by the Administrator on 9/25/15 at 2:45 p.m. The policy indicated, "...Residents will be free from mistreatment, neglect, abuse, misappropriation of resident funds and property, verbal, mental, sexual or physical abuse, corporal punishment, or involuntary seclusion... Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish. Verbal Abuse: Defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples would include, but are not limited to, the following: threats of harm, saying things to frighten a resident, such as telling a</p>		<p><i>interviewed during GuardianAngel rounds to determine awareness or occurrence of abuse. Please add the minimum number of residents and others who will be interviewed during each guardian angel round to the POC.</i></p> <p><i>Please include who will be responsible for reviewing the monitoring for abuse continues to ensure the deficient practice does not recur. The POC should indicate a plan for immediate response if an allegation of abuse is reported during any of the monitoring systems (Guardian Angel rounds, Resident Council meetings, grievances, etc.)</i></p> <p>Through interviews and observations that were done during and immediately after the extended survey with residents, including those that are cognitively impaired and family members, the facility determined to the best of their ability that no other residents, including any that were cognitively impaired, were affected by the deficient practice.</p> <p>As written in Addendum #1 that was previously submitted:</p> <p>"There were no other residents residing in the facility that were identified as being affected by the practice, including those residents who are cognitively impaired. At this time, the</p>	

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	<p>resident that he/she will never be able to see his/her family again... Mental Abuse: Includes, but is not limited to, humiliation, harassment, threats of punishment, or deprivation..." All reported incidents of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported to the Administrator immediately, investigated and reported per state and federal law...Written results of investigations (including criminal, abuse, neglect, injuries of unknown etiology and misappropriation of resident property) are reported by the administrator to other officials in accordance with local, state, and federal law (including the state survey and certification agency, APS, etc.) within five (5) working days of the incidents...."</p> <p>The immediate jeopardy that began on 3/06/15 was removed on 10/8/15 when the facility in-serviced all staff regarding abuse and abuse reporting requirements. The noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy because of need for continued monitoring for abuse prevention and reporting.</p>		<p>cognitively impaired residents who reside in the facility are able to answer at least simple questions with the exception of one resident who is totally dependent and non-responsive. His father visits daily and communicates with staff regarding concerns or needs.</p> <p>To identify possible abuse situations for residents who are cognitively impaired regardless of their ability to communicate verbally to others, the interdisciplinary team and Administrator visits with them at least 5 days a week as part of the Guardian Angel rounds, which is a program wherein every resident is personally visited by a member of the interdisciplinary team.</p> <p>For residents who exhibit fluctuations in their cognitive performance, the Angel observes the residents' appearance, including any new bruises, abrasions and/or lacerations, skin tears, burns or other new or unknown injuries. The Angel also observes the resident's behavior that is unusual for that resident and any change in body language or other nonverbal indicators, such as pained or distorted facial expressions, crying, rocking, clenched fists, restlessness, decrease in appetite, withdrawal, anger, distress, etc. These indicators have been added to the Guardian Angel Round report as a point of reference for the Angel when</p>	

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	3.1-27(a)(1) 3.1-27(b)		<p>he/she is visiting cognitively impaired residents. In addition, using the BIMS score as a guide, the names of the residents who are considered cognitively impaired are listed for each Angel's group to make sure that no cognitively impaired resident is overlooked.</p> <p>If there are any indications of a change in the resident's demeanor, appearance, behavior, or anything else noticed that is unusual, the Guardian Angel notifies the Administrator immediately so that an assessment of the resident can be made and an investigation begun, as indicated by the results of the assessment. This monitoring system will continue on an ongoing basis and will not be discontinued."</p> <p><u>Every</u> resident, including <u>all</u> cognitively impaired residents, who are in the facility are observed and/or interviewed through the Guardian Angel program at least 5 days a week. An interview/observation form was developed to document the interaction/observation of cognitively impaired persons or representatives as an addition to the Guardian Angel interviews. This form was developed as part of the first addendum request since there was not a designated place to document the cognitively impaired interviews/observations before that, but that form was not sent with the addendum response</p>	

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			<p>– it is included as an attachmentwith this second addendum response and is already in use.</p> <p>The facility has madesure to contact the family members and/or legal representatives of identifiedcognitively impaired residents by 11/11/15 to inquire if there are any concernsregarding care or treatment. These contacts are documented in the residents'medical records, as well as the family/legal representatives' response to thosecontacts. The interdisciplinary team will also inquire of any concernsregarding care or treatment from the family/legal representative of thecognitively impaired residents during the residents' care plan conferenceswhich are scheduled at least quarterly. As with the Guardian Angel rounds,Resident Council minutes, resident grievances or concerns, family or legalrepresentative concerns, expressions of concerns from visitors, or any concernsexpressed or allegations of abuse or mistreatment from any source now or in thefuture, the Administrator will be notified immediately and an investigationwill be initiated, once the resident is known to be safe and secure within thefacility.</p> <p>The Administrator isresponsible for reviewing and monitoring the</p>	

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F 0225 SS=L Bldg. 00	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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</p>		<p>care and treatment of all residents, including review of the results of all allegations of concern or abuse with the QA Committee at least monthly. The Director of Operations and the facility's Nurse Consultant will review the Resident Council minutes, grievance records, and all reportable incidents on at least a monthly basis, as well.</p>		

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	<p>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 ensure allegations of verbal and mental abuse were thoroughly investigated resulting in psychosocial harm to 4 of 20 residents reviewed for allegations of verbal and mental abuse (Resident #13, #26, #28, #32).</p> <p>The immediate jeopardy began on 03/06/2015 when CNA #5 threatened to smother a resident with a pillow while he slept, the staff member was not removed, and the Administrator did not thoroughly investigate and/or report the incident to State agencies according to law. The Administrator and Director of Nursing (DON) were notified of the immediate jeopardy on 10//6/2015 at 8:21 a.m. The immediate jeopardy was removed on 10/8/15, but noncompliance remained at the lower scope and severity of isolated, no actual harm, with potential for more than minimal harm that was not</p>	F 0225	<p>F225 It is the policy and standard of care for this facility that it willdevelop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse and misappropriation of resident property. Further, this facility will develop andimplement written policies and procedures that all alleged violations involvingmistreatment, neglect, or abuse, including injuries of unknown source andmisappropriation of resident property are reported immediately to theadministrator and to other officials in accordance with State law, (ISDH). The facility also wishes to note that theissues noted in the statement of deficiencies which occurred before 9/1/2015were during the employment of a former administrator for this facility.</p> <p><u>1.What corrective action will be done by thefacility?</u> Since the current Administrator has onlybeen in place since 9/1/2015, the Nurse Consultant for this</p>	10/27/2015

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	<p>immediate jeopardy.</p> <p>Findings include</p> <p>1. During an interview on 9/23/2015 at 11:16 a.m., Resident #32 indicated Certified Nursing Assistant (CNA) #5 had been verbally abusive toward him in the past. He indicated CNA #5 told hem she was going to smother him with a pillow while he slept. The resident indicated he could not recall the date of the incident, but indicated he notified the Director of Nursing (DON) at the time of the incident.</p> <p>Resident #32's record was reviewed on 9/23/2015 at 12:00 p.m. A Minimum Data Set (MDS) assessment, dated 6/19/2015, indicated Resident #32 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 out of 15.</p> <p>During an interview on 9/23/2015 at 12:02 p.m., the DON indicated the previous Administrator had been informed of CNA #5's threat to smother Resident #32 in his sleep.</p> <p>During an interview on 9/23/2015 at 2:29 p.m., the Administrator indicated she could not provide evidence the allegation had been reported to the required entities</p>		<p>facility in-servicedher on 10/07/2015 on the facility policy for mistreatment, neglect, and abuseand misappropriation of resident property, as well as Hickory Creek HealthcareFoundation's specific policy regarding <b>Accident/Incident/Reportable/S tate Officials</b> policy and procedure and the Indiana State Department of Health – Division ofLong Term Care <b>Incident Reporting Policy</b> with an effective date of 07/15/15.This includes the procedure for assuring timeliness in submission of reports tothe state agency in cases of reportable events which fall under the IncidentReporting Policy; in other words, immediate reporting of such allegations. All incidents reported by the surveyorsdirectly to facility staff have been reported through the incident reportingsystem and investigations have been in progress and/or completed. As a resultof these allegations / investigations, one certified nursing assistant has beenterminated from the facility. All residents identified specifically by thesurveyors will be addressed individually. Each of these residents will bevisited by the Social Services Designee, Director of Nursing, or otherdesignated member of the IDT for evaluation of their current status, includingassessment for any signs of distress, discomfort,</p>				

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	<p>or an investigation of the allegation had been conducted for Resident #32's allegation of abuse by CNA #5. She indicated the allegation should have been reported and investigated.</p> <p>During an interview on 9/23/2015 at 2:57 p.m., the DON indicated the former facility Administrator had been the abuse point of contact and had not reported or thoroughly investigated Resident #32's allegation of abuse against CNA #5.</p> <p>During an interview on 10/6/15 at 8:45 a.m., the Administrator indicated staff was supposed to follow the abuse policy "to the max." The Administrator stated, "The person who was aware (of abuse) could be "as guilty" as the person who did the abuse" if the allegation of abuse was not reported immediately.</p> <p>During an interview on 10/6/15 at 9:50 a.m., the Social Service Director (SSD) indicated she was aware Resident #32 made an allegation of CNA #5 threatening to smother him with a pillow. The SSD indicated she was not able to recall the exact date of the incident, but indicated it could have been in February or March, 2015. The SSD indicated the former Administrator and DON were aware of the incident and conducted an investigation.</p>		<p>or concern regarding theircare and treatment. These visits will be documented in each resident's medicalrecord. Any identified concerns will be reported to the Administratorimmediately for follow up as indicated, with the physician or psychologist; inaddition a report will be made to ISDH if new allegations of abuse or neglectare reported, as per policy. Re-training of all staff in all departmentsbegan on 10/6/2015, regarding the facility'sAbuse Prohibition / Know Your Role policy which indicates "residents must notbe subjected to abuse", the various types of abuse; mistreatment, neglect, orabuse, either verbal, mental, sexual or physical, corporal punishment, orinvoluntary seclusion, or misappropriation of resident property. Further, there-training stressed the process for reporting any type of allegation oroccurrence that suggests any type of mistreatment, neglect, or abuse, eitherverbal, mental, sexual or physical, corporal punishment, or involuntaryseclusion, or misappropriation of resident property. The re-training indicatedthe various scenarios in which an incident towards a resident may occur –whether resident and resident, resident and staff, visitor and resident, orvisitor and staff. The staff has been told that a violation of the AbuseProhibition protocol will not</p>	

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	<p>During an interview on 10/6/15 at 10:00 a.m., the Administrator indicated Resident #32 was discharged to his family's home on 10/5/15.</p> <p>During an interview on 10/6/15 at 10:00 a.m., the DON indicated the previous Administrator interviewed Resident #32 regarding CNA #5 threat to smother Resident #32 with a pillow. The DON indicated the former Administrator informed her the resident "re-canted" his story and indicated he and CNA #5 were "joking" with each other. The DON indicated she removed CNA #5 from providing care to Resident #32 after the allegation but the CNA was allowed to provide care to other residents. The DON indicated CNA assignment sheets indicated the residents who received care by each CNA for each shift.</p> <p>Incident reports were reviewed on 10/6/15 and indicated the facility did not report the allegation of CNA #5 threatening to smother Resident #32 with a pillow until 9/23/15 at 11:30 a.m. The incident report indicated, "...9/23/2015 Description added--9/23/2015 During Annual Recertification Survey on this date [Resident #32 named] reported to the Surveyor during an interview; In November the CNA [CNA #5 named]</p>		<p>be tolerated. If an allegation is made, they will be suspended pending investigation and that they will be held accountable for immediate reporting of allegations, and failure to do so will result in disciplinary action, up to, and including termination of employment. All staff will be in-serviced no later than 11:59 PM, 10/7/2015 and if a staff member is unavailable and has not received the training due to vacation or other types of absences, they will not be allowed to work their next scheduled shift until they have received this same in-servicing. If agency staff is scheduled to work, they will receive the same training by the Director of Nursing before beginning their tour of duty.</p> <p>In addition, all staff will be asked to complete the "Affirmation of "No" Observation/Knowledge of Abuse" form and to sign an Affidavit confirming the truthfulness of their responses on the Affirmation form. If there are any indications of concerns regarding abuse or neglect from any of the staff member statements, they will be reported to the Administrator, who will send the report to the state and will initiate the investigation as required by facility and state policy. The Administrator and Director of Nursing, along with members of the management team will continue to quiz staff on the facility's policy regarding their</p>		

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	<p>told him she was going to smother him with a pillow...Follow up added -- 9/29/2015: The resident stated he thought the aide was hoping he would take her statement as a joke, but he felt it was a 'serious matter.' The resident stated the CNA's assignment was changed and she no longer provides care to him...."</p> <p>CNA assignment sheets were requested on 10/6/15 at 10: 00 a.m., and provided on 10/7/15 at 10:00 a.m. The assignment sheets indicated the last date CNA #5 provided care to Resident #32 was 3/6/15. Assignment sheets were not available for 3/10/15, but the CNA's time sheet indicated she worked during the evening shift on that date. A CNA assignment sheet, dated 3/15/15, indicated CNA #5 was assigned, but removed from care, to Resident #32.</p> <p>CNA's time card was reviewed on 10/6/15 at 3:50 p.m. and indicated the CNA's last day worked was 9/19/2015.</p> <p>2. During an interview on 9/24/2015 at 9:24 a.m., Resident #13 indicated Certified Nursing Assistant (CNA) #5 was "moody." The resident indicated CNA #5 told her she should "move elsewhere" if she didn't like how she provided care and indicated the CNA's comment made her feel like a "lost cause."</p>		<p>obligation to report alleged mistreatment,neglect, or abuse, either verbal, mental, sexual or physical, corporalpunishment, or voluntary seclusion, or misappropriation of resident property toverify staff members continue to understand the reporting requirements. Thiswill be done on a regular basis for at least the next 30 days.</p> <p><u>2.How will the facility identify otherresidents having the potential to be affected by the same practice and what correctiveaction will be taken?</u></p> <p>All residents in this home have thepotential to be affected, but no other resident has been identified as beingaffected by this practice. The IDT and Administrator have interviewed allcognitively intact residents regarding their treatment and no other allegationsof abuse or neglect have been received at this time. If any future allegations of abuse are made,as per facility policy and practice, the Administrator will be notifiedimmediately and any resident(s) involved will be examined and/or interviewed tomake sure that they are secure and are having their needs metappropriately. The Administrator willnotify the state agency of the allegation and an investigation will beinitiated at that time. If any staff member is identified as being involved inthe allegation, he/she will be suspended immediately pending</p>	

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	<p>During an interview on 9/29/2015 at 11:10 a.m., Resident #13 indicated CNA #5 transferred her to her bed via a Hoyer lift (mechanical lift). Resident #13 indicated she had an incontinent bowel movement during the transfer and indicated CNA #5 "sarcastically" said, "You just [s---] all over the floor." The resident indicated CNA #5 told her she could have controlled her elimination and indicated the CNA's comments made her feel "horrible, disappointed, and bad" about herself.</p> <p>During an interview on 9/28/2015 at 4:15 p.m., the Director of Nursing (DON) indicated the Activity Director (AD) recorded the minutes for the Resident Council Meeting on 9/15/15 and indicated Resident #13 reported the allegation during the Resident Council meeting.</p> <p>During an interview on 9/28/2015 at 4:22 p.m., the Activity Director indicated she had not recognized the allegations as abuse and had not immediately informed the Administrator.</p> <p>During an interview on 9/29/15 at 4:17 p.m., the Administrator indicated the facility became aware of the allegation of verbal abuse during the Hoyer transfer</p>		<p>the outcome of the investigation. Once the investigation is completed, the Administrator and management staff will follow up as needed with training or monitoring activities as deemed necessary by the investigation findings.</p> <p><u>1. What measures will be put into place to ensure this practice does not recur?</u></p> <p>The facility will continue Guardian Angel rounds which are done at least 5 times a week by the interdisciplinary management staff. These rounds are documented and the wording is being revised to contain questions that are the same as used by the survey agency for resident interviews:</p> <p>· "Has staff, a resident or anyone else here abused you – this includes verbal, physical or sexual abuse? (If "Yes" ask who the abuser was, what happened, when it occurred, where it happened, and how often.)"</p> <p>· "Did you tell staff?"</p> <p>· "Have you seen any resident here being abused?"</p> <p>· "Did you tell staff?"</p> <p>The results of these rounds and interviews will be brought to the next scheduled morning management meeting for review; however, if there are any indications or allegations of resident abuse or neglect, the Administrator will be notified immediately and the facility will follow through as indicated in</p>		

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	<p>when it was discussed in the Resident Council meeting on 9/15/15. The Administrator indicated the Activity Director should have immediately informed her of the abuse allegations. The Administrator indicated the DON reviewed and signed the Resident Council minutes on 9/18/15 and should have immediately notified her after awareness of the allegation.</p> <p>During an interview on 10/6/15 at 8:35 a.m., Resident #13 indicated she was not able to recall the exact date CNA #5 yelled at her during the Hoyer transfer. The resident indicated it was "sometime within a few weeks" prior to the Resident Council meeting on 9/15/15.</p> <p>During an interview on 10/6/2015 at 10:00 a.m., the DON indicated CNA #5 was not assigned to care for Resident #13 after she became aware of the allegation of verbal abuse. The DON indicated CNA #5 was allowed to provide care to other residents until she was suspended on 9/20/15.</p> <p>During an interview on 10/6/15 at 11:27 a.m., the Administrator indicated the allegation of CNA #5 being verbally and mentally abusive to Resident #13 had not been reported to the State agency and indicated she planned to submit the</p>		<p>question #2. The Nurse Consultant has also reviewed with the Activity Director the process of informing the Administrator immediately of any resident concerns received during the Resident Council meetings. In addition to the Resident Council Minutes, the specifics of any resident concerns received during the Council meeting regarding care or treatment will be documented on a Resident/Family Concern form and given to the Administrator immediately. The Administrator will follow the process as outlined in question #2. The Administrator will ask the Resident Council President if they would agree to Resident Council meetings weekly for the next 30 days, then twice a month for the following 30 days and allow the Administrator or another facility management representative to attend, with the purpose of quickly identifying any concerns the council may have. With resident council permission, the Administrator or another facility management representative would like to discuss the options available to the residents' <b><i>on how and to whom they may report concerns, incidents and grievances without the fear of retribution and the manner in which facility staff will provide feedback regarding any concerns that have been</i></b></p>	

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	<p>report that day.</p> <p>During an interview on 10/6/15 at 5:00 p.m., the Administrator indicated the Resident Council meeting on 9/15/15 was conducted at 2:30 p.m.</p> <p>Resident #13's record was reviewed on 9/28/15 at 10:50 a.m. A Minimum Data Set (MDS) assessment, dated 8/20/15, indicated Resident #13 was cognitively intact with a Brief Interview for Mental Status score of 15 out of 15.</p> <p>Resident Council minutes, dated 9/15/15, were reviewed on 9/28/15 at 4:20 p.m. The minutes indicated, "...[CNA #5 named] was lifting a resident (identified by the DON as Resident #13) by Hoyer when residents (sic) bowels released. States [CNA #5 named] told her she should have been able to hold it until she got in bed...."</p> <p>Reportable incidents were provided by the Administrator on 10/6/15 at 10:15 a.m. The incidents did not indicate the allegation of verbal abuse during the Hoyer transfer was reported timely to the State agency and did not indicate an investigation of the allegation was conducted.</p> <p>Schedules were reviewed for dates and</p>		<p><b>expressed.</b> Results of the Resident Council meetings including any statement of concerns or allegations of abuse/neglect, along with the results of facility investigations, will be brought to the QAACommittee at the monthly meeting for further review and recommendations. A return to monthly Resident Council meetings or frequency as determined by the Resident Council President will be encouraged after the initial 60 day period. The facility will continue to address all resident concerns as they are received, and designated members of the interdisciplinary team will conduct an investigation regardless of whether or not the concern or issue relates to abuse or neglect. If, however, the investigation of any concern is linked to possible abuse or neglect, the interdisciplinary team member(s) will notify the Administrator immediately and she will follow through as in question #2. The facility has a very extensive Resident Admission Agreement &amp; Admission Handbook that is discussed at the time of admission with the resident / legal representative and any family member of interest. The purpose of the document is to provide assistance to the resident/ family in a variety of areas. The Resident Admission Agreement &amp; Admission Handbook communicates in</p>		

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	<p>times CNA #5 worked after the Activity Director and DON were aware of the abuse allegation. The schedules indicated CNA #5 worked during evening shifts on September 15, 16, 18, and 19, 2015.</p> <p>CNA assignment sheets were requested on 10/6/15 at 10:00 a.m. The documents were provided on 10/7/15 at 10:00 a.m. and indicated CNA #5 was assigned to offer snacks, provide showers, and put residents to bed on 9/15/15 (Tuesday) and 9/16/15 (Wednesday). The CNA assignment sheet indicated Resident #13 received evening showers on Mondays and Thursdays. CNA assignment sheets were not available for 9/18/5 and 9/19/15. A nurses' note, dated 9/19/15 at 9 p.m., indicated Resident #13 refused a shower on that date.</p> <p>3. During an interview on 9/24/15 at 10:09 a.m., Resident #28 indicated Certified Nurse Aide (CNA) #5 verbally abused Resident #26 on Saturday, 09/19/2015, during the evening meal. Resident #28 stated, "[CNA #5 named] jumped all over [Resident #26 named]" and "cursed." Resident #28 indicated CNA #5 yelled, "You had me get this [s--] and now you are not going to eat it? What do you want me to do with the [s--]?" Resident #28 indicated she reported</p>		<p>multiple places that residents and families have opportunity to communicate concerns without fear of reprisal. Some areas of this document which address these rights, (but not limited to just these sections), are Page 13 – Resident Grievances, Resident Rights under Federal Law – Pages 17-19; specifically #3, #6, #14, #15 and #28. In addition, the facility has a policy and procedure titled Grievances; Policy # SS-14 and ADM-G002. Resident / Family Member's may always approach staff in regards to the manner in which to file a grievance / concern, or to ask for assistance. The Social Service Designee and Administrator may also be a resource for assistance. _</p> <p><u>1. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator, Director of Nursing, and/or Social Service Designee will bring the results of resident concerns, including allegations of abuse and neglect and subsequent investigations to the monthly QAA committee meeting for further review and recommendations for process improvement. If any recommendations are made, the Director of Nursing or other designated IDT member will follow through and report the results of those recommendations at the next scheduled QAA</p>		

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	<p>the abuse to the Social Service Director (SSD) on 09/20/2015.</p> <p>During an interview on 9/24/15 at 10:25 a.m., Resident #26 indicated a CNA yelled at her during dinner over the weekend. She indicated she would not name the CNA because she did not want to get anyone in trouble.</p> <p>During an interview on 9/25/15 at 1:55 p.m., the SSD indicated she immediately notified the DON on 09/20/2015 of awareness of allegations of abuse occurring in the dining room and in the hallway on 09/19/15. She indicated she should have notified the Administrator, but didn't call her because it was the weekend.</p> <p>During an interview on 9/25/15 at 2:01 p.m., the Administrator indicated the DON left a voice message on 9/20/15 and indicated the DON informed her of the allegation of abuse occurring in the hallway on 09/19/2015 and indicated the DON suspended CNA #5 from work on 09/20/2015.</p> <p>During an interview on 9/28/15 at 10:09 a.m. and again on 10/6/15 at 9:45 a.m., CNA #6 indicated she heard CNA #5 talking "loudly" and inappropriately" to cognitively impaired residents "sometime</p>		<p>meeting. This will continue on an ongoing basis. Date of Compliance: October 27, 2015</p>		

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	<p>in the past 6 months." The CNA indicated she realized CNA #5 was verbally abusive, but did not immediately report it to the Administrator.</p> <p>During an interview on 9/29/15 at 11:07 a.m., Resident #2 indicated she heard CNA #5 "yelling" at Resident #26 in the dining room on 9/19/2015 and indicated the CNA was "chewing her out." She indicated it lasted a "little while before it settled down." She indicated she wasn't sure what the yelling was about but stated, "It wasn't right." The resident indicated she did not tell staff about the incident.</p> <p>During an interview on 10/6/15 at 9:50 a.m., the SSD indicated she was informed by Resident #28 on 9/20/15 of allegations CNA #5 yelled and cursed at Resident #26 during the evening meal in the dining room on 9/19/15. The SSD indicated she notified the DON on 9/20/15 of the allegation.</p> <p>During an interview on 10/6/15 at 10:00 a.m., the DON indicated she was unable to recall being notified of the allegation of verbal and mental abuse to Resident #26 that allegedly occurred during the evening meal in the dining room on 9/19/15.</p>			

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	<p>During an interview on 10/6/15 at 10:00 a.m., the Administrator indicated she had not been made aware of the allegation of verbal and mental abuse to Resident #26 during the evening meal in the dining room on 9/19/15.</p> <p>Resident #26's record was reviewed on 9/28/15 at 10:40 a.m. A Minimum Data Set (MDS) assessment, dated 6/26/15, indicated Resident #26 had moderate cognitive impairment with a Brief Interview for Mental Status score of 10 out of 15.</p> <p>Resident #28's record was reviewed on 9/28/15 at 10:33 a.m. A Minimum Data Set (MDS) assessment, dated 7/16/15, indicated Resident #28 was cognitively intact with a Brief Interview for Mental Status score of 15 out of 15.</p> <p>Resident #2's record was reviewed on 9/28/15 at 10:45 a.m. A Minimum Data Set (MDS) assessment, dated 8/26/15, indicated Resident #2 was cognitively intact with a Brief Interview for Mental Status score of 15 out of 15.</p> <p>Reportable incidents were reviewed on 10/6/15 at 10:15 a.m. and did not indicate the allegation of CNA #5 being verbally and mentally abusive to Resident #26 had been investigated and reported timely to</p>			

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	<p>the Administrator and State agencies in accordance with the law.</p> <p>4. Resident #28 indicated residents were lined up in their wheel chairs in the hall after the evening meal on 09/19/2015. The resident indicated when she moved Resident #26's wheelchair so she could get to the entrance of her room, CNA #5 yelled and cursed at her. Resident #28 indicated she told the SSD about the incident on 9/20/2015.</p> <p>During an interview on 10/6/15 at 9:50 a.m., the SSD indicated she was informed by Resident #28 of allegations of verbal abuse to Resident #28 by CNA #5 in the hallway when she attempted to move Resident #26's wheelchair from the line outside the dining room. The SSD indicated she reported to allegation to the DON immediately after Resident #28 reported it to her and indicated she also notified the DON of the allegation of CNA #5 yelling and cursing at Resident #26 in the dining room on 9/19/15.</p> <p>During an interview on 10/6/15 at 10:00 a.m., the DON indicated CNA #5 was suspended from work on 9/20/15, immediately after she became aware of the allegation of CNA #5 yelling at Resident #28 when she attempted to move Resident #26's wheelchair.</p>			

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	<p>An incident report, dated 09/19/2019 at 7:01 p.m., was reviewed on 09/25/15 at 1:50 p.m. The report indicated, "...9/21/15 Social Service Director was Manager on Duty for the week end of 9/19/15. [Resident #28 named] approached her on Sunday 9/20/15 and informed her of an incident that had happened on 9/19/15, Saturday around 7 pm. [Resident #28 named] stated another [Resident #26 named] was sitting in her wheelchair in the hall. [Resident #28 named] asked if she would like her to push her to her room and she replied yes. [CNA #5 named] saw this happening and according to [Resident #28 named], approached her and in a "rude and hateful manner" told her to STOP. That she had the resident where she wanted her, and that she was not being helpful at all! [Resident #28 named] released the wheel chair and walked to her room...Action Taken added--9/21/15 Social Service Designee interviewed [Resident #26 named] ...The Director of Nursing then contacted [CNA #5 named] and explained the allegation that had been given to the Social Service Designee and per facility policy she was to be suspended pending a complete investigation of the allegation...."</p> <p>Resident #28's record was reviewed on</p>			
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	<p>9/28/15 at 10:33 a.m. A Minimum Data Set (MDS) assessment, dated 7/16/15, indicated Resident #28 was cognitively intact with a Brief Interview for Mental Status score of 15 out of 15.</p> <p>A policy, dated 12/1999 and revised on 2/2015, titled "Resident Mistreatment, Neglect, Abuse &amp; Misappropriation of Property," was provided as a current policy by the Administrator on 9/25/15 at 2:45 p.m. The policy indicated, "...Residents will be free from mistreatment, neglect, abuse, misappropriation of resident funds and property, verbal, mental, sexual or physical abuse, corporal punishment, or involuntary seclusion... Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish. Verbal Abuse: Defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance,</p>			

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	<p>regardless of their age, ability to comprehend, or disability. Examples would include, but are not limited to, the following: threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again... Mental Abuse: Includes, but is not limited to, humiliation, harassment, threats of punishment, or deprivation..." All reported incidents of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported to the Administrator immediately, investigated and reported per state and federal law...Written results of investigations (including criminal, abuse, neglect, injuries of unknown etiology and misappropriation of resident property) are reported by the administrator to other officials in accordance with local, state, and federal law (including the state survey and certification agency, APS, etc.) within five (5) working days of the incidents...."</p> <p>The immediate jeopardy that began on 3/06/15 was removed on 10/8/15 when the facility in-serviced all staff regarding abuse and abuse reporting requirements. The noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than</p>			

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F 0226 SS=L Bldg. 00	<p>minimal harm that is not immediate jeopardy because of need for continued monitoring for abuse prevention and reporting.</p> <p>3.1-28(d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to implement their policies and procedures to thoroughly investigate abuse allegations and prohibit further verbal and mental abuse, resulting in psychosocial harm to 4 of 20 residents reviewed for allegations of verbal and mental abuse (Resident #13, #26, #28, #32).</p> <p>The immediate jeopardy began on 03/06/2015 when CNA #5 threatened to smother a resident with a pillow while he slept, the staff member was not removed, and the Administrator did not thoroughly investigate and/or report the incident to State agencies according to law. The Administrator and Director of Nursing</p>	F 0226	F226 It is the policy and standard of care for this facility that it willdevelop and implement written policies and procedures that prohibitmistreatment, neglect, and abuse and misappropriation of resident property. Further, this facility will develop andimplement written policies and procedures that all alleged violations involvingmistreatment, neglect, or abuse, including injuries of unknown source andmisappropriation of resident property are reported immediately to theadministrator and to other officials in accordance with State law, (ISDH). The facility also wishes to note that theissues noted in the statement of deficiencies which occurred before 9/1/2015were during the	10/27/2015

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	<p>(DON) were notified of the immediate jeopardy on 10//6/2015 at 8:21 a.m. The immediate jeopardy was removed on 10/8/15, but noncompliance remained at the lower scope and severity of isolated, no actual harm, with potential for more than minimal harm that was not immediate jeopardy.</p> <p>Findings include</p> <p>1. During an interview on 9/23/2015 at 11:16 a.m., Resident #32 indicated Certified Nursing Assistant (CNA) #5 had been verbally abusive toward him in the past. He indicated CNA #5 told hem she was going to smother him with a pillow while he slept. The resident indicated he could not recall the date of the incident, but indicated he notified the Director of Nursing (DON) at the time of the incident.</p> <p>Resident #32's record was reviewed on 9/23/2015 at 12:00 p.m. A Minimum Data Set (MDS) assessment, dated 6/19/2015, indicated Resident #32 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 out of 15.</p> <p>During an interview on 9/23/2015 at 12:02 p.m., the DON indicated the previous Administrator had been</p>		<p>employment of a former administrator for this facility.</p> <p><u>1.What corrective action will be done by the facility?</u> Since the current Administrator has only been in place since 9/1/2015, the Nurse Consultant for this facility in-serviced her on 10/07/2015 on the facility policy for mistreatment, neglect, and abuse and misappropriation of resident property, as well as Hickory Creek Healthcare Foundation's specific policy regarding <b>Accident/Incident/Reportable/State Officials</b> policy and procedure and the Indiana State Department of Health – Division of Long Term Care <b>Incident Reporting Policy</b> with an effective date of 07/15/15. This includes the procedure for assuring timeliness in submission of reports to the state agency in cases of reportable events which fall under the Incident Reporting Policy; in other words, immediate reporting of such allegations. All incidents reported by the surveyors directly to facility staff have been reported through the incident reporting system and investigations have been in progress and/or completed. As a result of these allegations / investigations, one certified nursing assistant has been terminated from the facility. All residents identified specifically by the surveyors will be addressed</p>				

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	<p>informed of CNA #5's threat to smother Resident #32 in his sleep.</p> <p>During an interview on 9/23/2015 at 2:29 p.m., the Administrator indicated she could not provide evidence the allegation had been reported to the required entities or an investigation of the allegation had been conducted for Resident #32's allegation of abuse by CNA #5. She indicated the allegation should have been reported and investigated.</p> <p>During an interview on 9/23/2015 at 2:57 p.m., the DON indicated the former facility Administrator had been the abuse point of contact and had not reported or thoroughly investigated Resident #32's allegation of abuse against CNA #5.</p> <p>During an interview on 10/6/15 at 8:45 a.m., the Administrator indicated staff was supposed to follow the abuse policy "to the max." The Administrator stated, "The person who was aware (of abuse) could be "as guilty" as the person who did the abuse" if the allegation of abuse was not reported immediately.</p> <p>During an interview on 10/6/15 at 9:50 a.m., the Social Service Director (SSD) indicated she was aware Resident #32 made an allegation of CNA #5 threatening to smother him with a pillow.</p>		<p>individually. Each of these residents will be visited by the Social Services Designee, Director of Nursing, or other designated member of the IDT for evaluation of their current status, including assessment for any signs of distress, discomfort, or concern regarding their care and treatment. These visits will be documented in each resident's medical record. Any identified concerns will be reported to the Administrator immediately for follow up as indicated, with the physician or psychologist; in addition a report will be made to ISDH if new allegations of abuse or neglect are reported, as per policy. Re-training of all staff in all departments began on 10/6/2015, regarding the facility's Abuse Prohibition / Know Your Role policy which indicates "residents must not be subjected to abuse", the various types of abuse; mistreatment, neglect, or abuse, either verbal, mental, sexual or physical, corporal punishment, or involuntary seclusion, or misappropriation of resident property. Further, there-training stressed the process for reporting any type of allegation or occurrence that suggests any type of mistreatment, neglect, or abuse, either verbal, mental, sexual or physical, corporal punishment, or involuntary seclusion, or misappropriation of resident property. The re-training</p>		

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	<p>The SSD indicated she was not able to recall the exact date of the incident, but indicated it could have been in February or March, 2015. The SSD indicated the former Administrator and DON were aware of the incident and conducted an investigation.</p> <p>During an interview on 10/6/15 at 10:00 a.m., the Administrator indicated Resident #32 was discharged to his family's home on 10/5/15.</p> <p>During an interview on 10/6/15 at 10:00 a.m., the DON indicated the previous Administrator interviewed Resident #32 regarding CNA #5 threat to smother Resident #32 with a pillow. The DON indicated the former Administrator informed her the resident "re-canted" his story and indicated he and CNA #5 were "joking" with each other. The DON indicated she removed CNA #5 from providing care to Resident #32 after the allegation but the CNA was allowed to provide care to other residents. The DON indicated CNA assignment sheets indicated the residents who received care by each CNA for each shift.</p> <p>Incident reports were reviewed on 10/6/15 and indicated the facility did not report the allegation of CNA #5 threatening to smother Resident #32 with</p>		<p>indicated the various scenarios in which an incident towards a resident may occur –whether resident and resident, resident and staff, visitor and resident, or visitor and staff. The staff has been told that a violation of the Abuse Prohibition protocol will not be tolerated. If an allegation is made, they will be suspended pending investigation and that they will be held accountable for immediate reporting of allegations, and failure to do so will result in disciplinary action, up to, and including termination of employment. All staff will be in-serviced no later than 11:59 PM, 10/7/2015 and if a staff member is unavailable and has not received the training due to vacation or other types of absences, they will not be allowed to work their next scheduled shift until they have received this same in-servicing. If agency staff is scheduled to work, they will receive the same training by the Director of Nursing before beginning their tour of duty. In addition, all staff will be asked to complete the "Affirmation of No" Observation/Knowledge of Abuse" form and to sign an Affidavit confirming the truthfulness of their responses on the Affirmation form. If there are any indications of concerns regarding abuse or neglect from any of the staff member statements, they will be reported to the Administrator, who will send</p>	

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	<p>a pillow until 9/23/15 at 11:30 a.m. The incident report indicated, "...9/23/2015 Description added--9/23/2015 During Annual Recertification Survey on this date [Resident #32 named] reported to the Surveyor during an interview; In November the CNA [CNA #5 named] told him she was going to smother him with a pillow...Follow up added -- 9/29/2015: The resident stated he thought the aide was hoping he would take her statement as a joke, but he felt it was a 'serious matter.' The resident stated the CNA's assignment was changed and she no longer provides care to him...."</p> <p>CNA assignment sheets were requested on 10/6/15 at 10: 00 a.m., and provided on 10/7/15 at 10:00 a.m. The assignment sheets indicated the last date CNA #5 provided care to Resident #32 was 3/6/15. Assignment sheets were not available for 3/10/15, but the CNA's time sheet indicated she worked during the evening shift on that date. A CNA assignment sheet, dated 3/15/15, indicated CNA #5 was assigned, but removed from care, to Resident #32.</p> <p>CNA's time card was reviewed on 10/6/15 at 3:50 p.m. and indicated the CNA's last day worked was 9/19/2015.</p> <p>2. During an interview on 9/24/2015 at 9:24 a.m., Resident #13 indicated</p>		<p>the report to the state and will initiate the investigation asrequired by facility and state policy. The Administrator and Director of Nursing, along with members of the management team will continue to quiz staff on thefacility's policy regarding their obligation to report alleged mistreatment, neglect, or abuse, either verbal, mental, sexual or physical, corporalpunishment, or voluntary seclusion, or misappropriation of resident property toverify staff members continue to understand the reporting requirements. Thiswill be done on a regular basis for at least the next 30 days.</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>All residents in this home have thepotential to be affected, but no other resident has been identified as beingaffected by this practice. The IDT and Administrator have interviewed allcognitively intact residents regarding their treatment and no other allegationsof abuse or neglect have been received at this time. If any future allegations of abuse are made, as per facility policy and practice, the Administrator will be notifiedimmediately and any resident(s) involved will be examined and/or interviewed tomake sure that they are secure and are having their needs met</p>		

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	<p>Certified Nursing Assistant (CNA) #5 was "moody." The resident indicated CNA #5 told her she should "move elsewhere" if she didn't like how she provided care and indicated the CNA's comment made her feel like a "lost cause."</p> <p>During an interview on 9/29/2015 at 11:10 a.m., Resident #13 indicated CNA #5 transferred her to her bed via a Hoyer lift (mechanical lift). Resident #13 indicated she had an incontinent bowel movement during the transfer and indicated CNA #5 "sarcastically" said, "You just [s---] all over the floor." The resident indicated CNA #5 told her she could have controlled her elimination and indicated the CNA's comments made her feel "horrible, disappointed, and bad" about herself.</p> <p>During an interview on 9/28/2015 at 4:15 p.m., the Director of Nursing (DON) indicated the Activity Director (AD) recorded the minutes for the Resident Council Meeting on 9/15/15 and indicated Resident #13 reported the allegation during the Resident Council meeting.</p> <p>During an interview on 9/28/2015 at 4:22 p.m., the Activity Director indicated she had not recognized the allegations as</p>		<p>appropriately. The Administrator will notify the stateagency of the allegation and an investigation will be initiated at that time.If any staff member is identified as being involved in the allegation, he/shewill be suspended immediately pending the outcome of the investigation. Oncethe investigation is completed, the Administrator and management staff willfollow up as needed with training or monitoring activities as deemed necessaryby the investigation findings.</p> <p><u>1.What measures will be put into place to ensure this practice does not recur?</u></p> <p>The facility will continue Guardian Angelrounds which are done at least 5 times a week by the interdisciplinarymanagement staff. These rounds are documented and the wording is being revisedto contain questions that are the same as used by the survey agency forresident interviews:</p> <p>·“Has staff, a resident or anyone else here abused you – this includes verbal, physical or sexual abuse? (If “Yes” ask who the abuser was, what happened, when it occurred, where it happened, and how often.)”</p> <p>·“Did you tell staff?”</p> <p>·“Have you seen any resident here being abused?”</p> <p>·“Did you tell staff?”</p> <p>The results of these rounds and interviews will be brought to the next scheduled morning</p>		

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	<p>abuse and had not immediately informed the Administrator.</p> <p>During an interview on 9/29/15 at 4:17 p.m., the Administrator indicated the facility became aware of the allegation of verbal abuse during the Hoyer transfer when it was discussed in the Resident Council meeting on 9/15/15. The Administrator indicated the Activity Director should have immediately informed her of the abuse allegations. The Administrator indicated the DON reviewed and signed the Resident Council minutes on 9/18/15 and should have immediately notified her after awareness of the allegation.</p> <p>During an interview on 10/6/15 at 8:35 a.m., Resident #13 indicated she was not able to recall the exact date CNA #5 yelled at her during the Hoyer transfer. The resident indicated it was "sometime within a few weeks" prior to the Resident Council meeting on 9/15/15.</p> <p>During an interview on 10/6/2015 at 10:00 a.m., the DON indicated CNA #5 was not assigned to care for Resident #13 after she became aware of the allegation of verbal abuse. The DON indicated CNA #5 was allowed to provide care to other residents until she was suspended on 9/20/15.</p>		<p>management meeting for review;however, if there are any indications or allegations of resident abuse or neglect, the Administrator will be notified immediately and the facility will follow through as indicated in question #2. The Nurse Consultant has also reviewed with the Activity Director the process of informing the Administrator immediately of any resident concerns received during the Resident Council meetings. In addition to the Resident Council Minutes, the specifics of any resident concerns received during the Council meeting regarding care or treatment will be documented on a Resident/Family Concern form and given to the Administrator immediately. The Administrator will follow the process as outlined in question #2. The Administrator will ask the Resident Council President if they would agree to Resident Council meetings weekly for the next 30 days, then twice a month for the following 30 days and allow the Administrator or another facility management representative to attend, with the purpose of quickly identifying any concerns the council may have. With resident council permission, the Administrator or another facility management representative would like to discuss the options available to the residents' <b>on how</b></p>		

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	<p>During an interview on 10/6/15 at 11:27 a.m., the Administrator indicated the allegation of CNA #5 being verbally and mentally abusive to Resident #13 had not been reported to the State agency and indicated she planned to submit the report that day.</p> <p>During an interview on 10/6/15 at 5:00 p.m., the Administrator indicated the Resident Council meeting on 9/15/15 was conducted at 2:30 p.m.</p> <p>Resident #13's record was reviewed on 9/28/15 at 10:50 a.m. A Minimum Data Set (MDS) assessment, dated 8/20/15, indicated Resident #13 was cognitively intact with a Brief Interview for Mental Status score of 15 out of 15.</p> <p>Resident Council minutes, dated 9/15/15, were reviewed on 9/28/15 at 4:20 p.m. The minutes indicated, "...[CNA #5 named] was lifting a resident (identified by the DON as Resident #13) by Hoyer when residents (sic) bowels released. States [CNA #5 named] told her she should have been able to hold it until she got in bed...."</p> <p>Reportable incidents were provided by the Administrator on 10/6/15 at 10:15 a.m. The incidents did not indicate the</p>		<p><b>and to whom they may report concerns, incidents and grievances without the fear of retribution and the manner in which facility staff will provide feedback regarding any concerns that have been expressed.</b> Results of the Resident Council meetings including any statement of concerns or allegations of abuse/neglect, along with the results of facility investigations, will be brought to the QAAC committee at the monthly meeting for further review and recommendations. A return to monthly Resident Council meetings or frequency as determined by the Resident Council President will be encouraged after the initial 60 day period. The facility will continue to address all resident concerns as they are received, and designated members of the interdisciplinary team will conduct an investigation regardless of whether the concern or issue relates to abuse or neglect. If, however, the investigation of any concern is linked to possible abuse or neglect, the interdisciplinary team member(s) will notify the Administrator immediately and she will follow through as in question #2. The facility has a very extensive Resident Admission Agreement &amp; Admission Handbook that is discussed at the time of admission with the resident / legal representative and</p>				

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	<p>allegation of verbal abuse during the Hoyer transfer was reported timely to the State agency and did not indicate an investigation of the allegation was conducted.</p> <p>Schedules were reviewed for dates and times CNA #5 worked after the Activity Director and DON were aware of the abuse allegation. The schedules indicated CNA #5 worked during evening shifts on September 15, 16, 18, and 19, 2015.</p> <p>CNA assignment sheets were requested on 10/6/15 at 10:00 a.m. The documents were provided on 10/7/15 at 10:00 a.m. and indicated CNA #5 was assigned to offer snacks, provide showers, and put residents to bed on 9/15/15 (Tuesday) and 9/16/15 (Wednesday). The CNA assignment sheet indicated Resident #13 received evening showers on Mondays and Thursdays. CNA assignment sheets were not available for 9/18/5 and 9/19/15. A nurses' note, dated 9/19/15 at 9 p.m., indicated Resident #13 refused a shower on that date.</p> <p>3. During an interview on 9/24/15 at 10:09 a.m., Resident #28 indicated Certified Nurse Aide (CNA) #5 verbally abused Resident #26 on Saturday, 09/19/2015, during the evening meal.</p>		<p>any family member of interest. The purpose of the document is to provide assistance to the resident/ family in a variety of areas. The Resident Admission Agreement &amp; Admission Handbook communicates in multiple places that residents and families have opportunity to communicate concerns without fear of reprisal. Some areas of this document which address these rights, (but not limited to just these sections), are Page 13 – Resident Grievances, Resident Rights under Federal Law – Pages 17-19; specifically #3, #6, #14, #15 and #28. In addition, the facility has a policy and procedure titled Grievances; Policy # SS-14 and ADM-G002. Resident / Family Member's may always approach staff in regards to the manner in which to file a grievance / concern, or to ask for assistance. The Social Service Designee and Administrator may also be a resource for assistance. _</p> <p><u>1. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator, Director of Nursing, and/or Social Service Designee will bring the results of resident concerns, including allegations of abuse and neglect and subsequent investigations to the monthly QAA committee meeting for further review and recommendations for process</p>		

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	<p>Resident #28 stated, "[CNA #5 named] jumped all over [Resident #26 named]" and "cursed." Resident #28 indicated CNA #5 yelled, "You had me get this [s--] and now you are not going to eat it? What do you want me to do with the [s--]?" Resident #28 indicated she reported the abuse to the Social Service Director (SSD) on 09/20/2015.</p> <p>During an interview on 9/24/15 at 10:25 a.m., Resident #26 indicated a CNA yelled at her during dinner over the weekend. She indicated she would not name the CNA because she did not want to get anyone in trouble.</p> <p>During an interview on 9/25/15 at 1:55 p.m., the SSD indicated she immediately notified the DON on 09/20/2015 of awareness of allegations of abuse occurring in the dining room and in the hallway on 09/19/15. She indicated she should have notified the Administrator, but didn't call her because it was the weekend.</p> <p>During an interview on 9/25/15 at 2:01 p.m., the Administrator indicated the DON left a voice message on 9/20/15 and indicated the DON informed her of the allegation of abuse occurring in the hallway on 09/19/2015 and indicated the DON suspended CNA #5 from work on</p>		<p>improvement. If any recommendations are made, the Director of Nursing or other designated IDT member will follow through and report the results of those recommendations at the next scheduled QAA meeting. This will continue on an ongoing basis. Date of Compliance: October 27, 2015</p>	

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	<p>09/20/2015.</p> <p>During an interview on 9/28/15 at 10:09 a.m. and again on 10/6/15 at 9:45 a.m., CNA #6 indicated she heard CNA #5 talking "loudly" and inappropriately" to cognitively impaired residents "sometime in the past 6 months." The CNA indicated she realized CNA #5 was verbally abusive, but did not immediately report it to the Administrator.</p> <p>During an interview on 9/29/15 at 11:07 a.m., Resident #2 indicated she heard CNA #5 "yelling" at Resident #26 in the dining room on 9/19/2015 and indicated the CNA was "chewing her out." She indicated it lasted a "little while before it settled down." She indicated she wasn't sure what the yelling was about but stated, "It wasn't right." The resident indicated she did not tell staff about the incident.</p> <p>During an interview on 10/6/15 at 9:50 a.m., the SSD indicated she was informed by Resident #28 on 9/20/15 of allegations CNA #5 yelled and cursed at Resident #26 during the evening meal in the dining room on 9/19/15. The SSD indicated she notified the DON on 9/20/15 of the allegation.</p> <p>During an interview on 10/6/15 at 10:00</p>						

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	<p>a.m., the DON indicated she was unable to recall being notified of the allegation of verbal and mental abuse to Resident #26 that allegedly occurred during the evening meal in the dining room on 9/19/15.</p> <p>During an interview on 10/6/15 at 10:00 a.m., the Administrator indicated she had not been made aware of the allegation of verbal and mental abuse to Resident #26 during the evening meal in the dining room on 9/19/15.</p> <p>Resident #26's record was reviewed on 9/28/15 at 10:40 a.m. A Minimum Data Set (MDS) assessment, dated 6/26/15, indicated Resident #26 had moderate cognitive impairment with a Brief Interview for Mental Status score of 10 out of 15.</p> <p>Resident #28's record was reviewed on 9/28/15 at 10:33 a.m. A Minimum Data Set (MDS) assessment, dated 7/16/15, indicated Resident #28 was cognitively intact with a Brief Interview for Mental Status score of 15 out of 15.</p> <p>Resident #2's record was reviewed on 9/28/15 at 10:45 a.m. A Minimum Data Set (MDS) assessment, dated 8/26/15, indicated Resident #2 was cognitively intact with a Brief Interview for Mental</p>			

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	<p>Status score of 15 out of 15.</p> <p>Reportable incidents were reviewed on 10/6/15 at 10:15 a.m. and did not indicate the allegation of CNA #5 being verbally and mentally abusive to Resident #26 had been investigated and reported timely to the Administrator and State agencies in accordance with the law.</p> <p>4. Resident #28 indicated residents were lined up in their wheel chairs in the hall after the evening meal on 09/19/2015. The resident indicated when she moved Resident #26's wheelchair so she could get to the entrance of her room, CNA #5 yelled and cursed at her. Resident #28 indicated she told the SSD about the incident on 9/20/2015.</p> <p>During an interview on 10/6/15 at 9:50 a.m., the SSD indicated she was informed by Resident #28 of allegations of verbal abuse to Resident #28 by CNA #5 in the hallway when she attempted to move Resident #26's wheelchair from the line outside the dining room. The SSD indicated she reported to allegation to the DON immediately after Resident #28 reported it to her and indicated she also notified the DON of the allegation of CNA #5 yelling and cursing at Resident #26 in the dining room on 9/19/15.</p>			

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	<p>During an interview on 10/6/15 at 10:00 a.m., the DON indicated CNA #5 was suspended from work on 9/20/15, immediately after she became aware of the allegation of CNA #5 yelling at Resident #28 when she attempted to move Resident #26's wheelchair.</p> <p>An incident report, dated 09/19/2019 at 7:01 p.m., was reviewed on 09/25/15 at 1:50 p.m. The report indicated, "...9/21/15 Social Service Director was Manager on Duty for the week end of 9/19/15. [Resident #28 named] approached her on Sunday 9/20/15 and informed her of an incident that had happened on 9/19/15, Saturday around 7 pm. [Resident #28 named] stated another [Resident #26 named] was sitting in her wheelchair in the hall. [Resident #28 named] asked if she would like her to push her to her room and she replied yes. [CNA #5 named] saw this happening and according to [Resident #28 named], approached her and in a "rude and hateful manner" told her to STOP. That she had the resident where she wanted her, and that she was not being helpful at all! [Resident #28 named] released the wheel chair and walked to her room...Action Taken added--9/21/15 Social Service Designee interviewed [Resident #26 named] ...The Director of Nursing then contacted [CNA</p>			

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	<p>#5 named] and explained the allegation that had been given to the Social Service Designee and per facility policy she was to be suspended pending a complete investigation of the allegation...."</p> <p>Resident #28's record was reviewed on 9/28/15 at 10:33 a.m. A Minimum Data Set (MDS) assessment, dated 7/16/15, indicated Resident #28 was cognitively intact with a Brief Interview for Mental Status score of 15 out of 15.</p> <p>A policy, dated 12/1999 and revised on 2/2015, titled "Resident Mistreatment, Neglect, Abuse &amp; Misappropriation of Property," was provided as a current policy by the Administrator on 9/25/15 at 2:45 p.m. The policy indicated, "...Residents will be free from mistreatment, neglect, abuse, misappropriation of resident funds and property, verbal, mental, sexual or physical abuse, corporal punishment, or involuntary seclusion... Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well being. This presumes that instances of abuse of all</p>			

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	<p>residents, even those in a coma, cause physical harm, or pain or mental anguish. Verbal Abuse: Defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples would include, but are not limited to, the following: threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again... Mental Abuse: Includes, but is not limited to, humiliation, harassment, threats of punishment, or deprivation..." All reported incidents of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported to the Administrator immediately, investigated and reported per state and federal law...Written results of investigations (including criminal, abuse, neglect, injuries of unknown etiology and misappropriation of resident property) are reported by the administrator to other officials in accordance with local, state, and federal law (including the state survey and certification agency, APS, etc.) within five (5) working days of the incidents...."</p>			

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F 0242 SS=D Bldg. 00	<p>The immediate jeopardy that began on 3/06/15 was removed on 10/8/15 when the facility in-serviced all staff regarding abuse and abuse reporting requirements. The noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy because of need for continued monitoring for abuse prevention and reporting.</p> <p>3.1-28(a) 3.1-28(b)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on record review and interview, the facility failed to assess residents' preferences for wake up times for 2 of 3 residents reviewed for choices (Resident #9, Resident #26).</p>	F 0242	<p>F242 It is the policy of this facility that residents are allowed to make choices about aspects of their care, including residents' preferences for wake up times.</p> <p><u>1. What corrective action will be done by the facility?</u> All residents in the facility who are able to indicate their personal</p>	10/27/2015

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	<p>Findings include:</p> <p>1. During an interview on 9/23/15 at 9:23 a.m., Resident #9 indicated the staff came in and woke him up in the morning. Resident #9 indicated staff had never asked his preference for a wake up time.</p> <p>On 9/25/15 at 10:18 a.m., Resident #9's record was reviewed. The resident's record lacked evidence of an assessment for the resident's preference for a wake up time. Resident #9's care plan, dated 9/10/15, lacked evidence regarding the resident's preference for a wake up time.</p> <p>On 9/25/15 at 10:00 a.m., LPN #2 provided the night shift wake up list, and Resident #9 was on the list.</p> <p>2. During an interview on 9/23/2015 at 2:47 p.m., Resident #26 indicated she did not have a choice when staff woke her in the morning. She indicated staff woke her up at 5 a.m. and that time had not been her preference.</p> <p>Resident #26's record was reviewed on 9/25/2015 at 12:00 p.m. A Minimum Data Set assessment (MDS), dated 6/26/2015, indicated Resident #26 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 10 out of 15 and required assistance of one person with bed mobility and transfers.</p>		<p>preferences regarding their care, including those identified specifically by the surveyors, have been visited by the Social Service Designee, Director of Nursing, or other designated member of the interdisciplinary team (IDT) to obtain each one's preference for a wake up time, bed time, bathing times, and frequency of baths/showers each week. These preferences are documented in the residents' medical records and recorded on each resident's care plan and CNA assignment sheet. All nursing staff has been re-trained on the residents' rights to make their preferences known and honored regarding the care and services that they receive.</p> <p><u>1. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>All residents in the facility have the potential to be affected by this practice. The Administrator and members of the IDT have interviewed all residents in the facility who are able to indicate their preferences for care, including wake up time. If, in the future, the Administrator or member of the IDT finds a resident who has not been assessed regarding his/her preferences for care, the resident will be interviewed as quickly as possible by an IDT member, and the preferences obtained will be</p>		

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	<p>During an interview on 9/25/2015 at 1:38 p.m., the Director of Nursing (DON) indicated the staff did not assess resident preferences for wake up times. She indicated the Certified Nursing Assistants (CNA) had chosen which residents were put on the "Night Shift Get Up List".</p> <p>During an interview on 9/28/2015 at 10:45 a.m., Qualified Medication Aide (QMA) #1 indicated Resident #9 and Resident #26 were awakened by the night shift CNAs before 6 a.m.</p> <p>An undated document titled "Night Shift Get Up List", was reviewed on 9/25/2015 at 11:20 a.m., and indicated Resident #9 and Resident #26 were assigned to be awakened every morning on night shift.</p> <p>A policy titled "Resident's Rights", dated October 2004, was provided by the Administrator on 9/29/2015 at 11:56 a.m., and indicated, "...The Resident has a right to reasonable accommodation of individual needs and preferences except where the health and safety of the Resident or other Residents would be endangered...."</p> <p>3.1-3(u)(1) 3.1-3(u)(3)</p>		<p>made part of the resident's medical record, care plan, and CNA assignment sheet. If the Administrator or IDT member finds a concern or issue regarding a resident whose care is not being done according to his/her stated preferences, this concern will be documented immediately on the facility Resident Concern form. The Administrator will be notified at that time, if she is not already aware of the situation, and the immediate needs of the resident will be addressed. Once the resident is cared for, the written concern will be brought to the next scheduled morning IDT management meeting which occurs at least 5 days a week for further review and discussion. The Administrator or DON will re-train the staff involved regarding the facility policy for honoring resident preferences for care and will address the noncompliance with written counseling/disciplinary action as indicated by occurrence itself.</p> <p><u>1. What measures will be put into place to ensure this practice does not recur?</u></p> <p>The facility will continue Guardian Angel Rounds at least 5 times weekly performed by the IDT management team. These rounds are documented and the wording has been revised to contain questions regarding residents' preferences:</p>		

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			<p>·Do you choose when to get up in the morning? ·Do you choose when to go to bed at night? ·Do you choose how many times a week you bathe? ·Can you have visitors anytime during the day or night? The results of these rounds and interviews are brought to the next scheduled morning management meeting for review and discussion. The Director of Nursing or Designee will document the residents' preferences in the medical record and will update the care plan and CNA assignment sheet as necessary. Any identified concerns from the rounds or interviews will be addressed as indicated in question #2.</p> <p><u>1. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put in place?</u> The Administrator or her Designee will monitor the results of the Guardian Angel rounds as part of the morning IDT management meetings 5 days per week. The Director of Nursing or Designee will audit the CNA assignment sheets at least monthly to make sure that the preferences listed on there are accurate. The results of the rounds, interviews, and audits will be brought to the monthly QAA Committee meeting for further review and recommendations.</p>	

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			<p>This will continue on an ongoing basis. Date of Compliance: October 27, 2015</p> <p><b>F242:</b></p> <p><i>Please indicate if any cognitively impaired residents were affected by the deficient practice. Were family members interviewed to determine the cognitively impaired residents' preferences for activities, schedules, and health care? How will the facility monitor to ensure preferences are honored for the cognitively impaired resident?</i></p> <p>The facility has included the content from the first addendum, because it does contain some of the information requested in the 2nd addendum: "There were no other residents residing in the facility that were identified as being affected by the practice, including those residents who are cognitively impaired. At this time, the cognitively impaired residents who reside in the facility are able to answer simple questions and verbally make their wishes known in regards to their care. There is one resident who is totally dependent and is completely unresponsive. His father visits daily and communicates very directly to staff regarding any preferences for his son's care.</p> <p>As part of the Guardian Angel</p>	

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			<p>rounds that occur at least 5 days a week, each Angel sees residents in his/her assigned group each day. For all residents, including those who are cognitively impaired, the Angel observes the residents' appearance for things such as, eyes that are matted, mouth that is dry or in need of oral care, hair that is uncombed or not clean, and other signs that the resident may need bathing or other aspects of ADL care more frequently than what he/she is receiving. The Angel will bring the results of the observations to the interdisciplinary team that meets that same day for review and development of new schedules or interventions to better meet the residents' needs. Each resident's care and schedule for receiving it are also discussed at each care plan conference meeting. Any preferences expressed by the resident or family at that time will be added to the care plan interventions and changed on the CNA assignment sheets accordingly. This process will continue on an ongoing basis."</p> <p>The facility has made sure to contact the family members and/or legal representatives of residents identified as cognitively impaired by 11/11/15 to inquire if there are any concerns regarding care or treatment. In addition, families/legal representatives will be asked about any knowledge that they may have regarding the</p>	

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			<p>residents' preferences or customary habits regarding their care, activities, or schedules. These contacts are documented in the residents' medical records, as well as the family/legal representatives' response to those contacts.</p> <p>The interdisciplinary team will also inquire from the family/legal representative of the cognitively impaired residents of any concerns regarding care or treatment, as well as any changes in the residents' routine, care, schedules, or activities during the residents' care plan conferences which are scheduled at least quarterly. If there are any changes in routines, schedules, or care, the IDT will document those on the care plan conference form, add them to the residents' care plan, and will make sure that the CNA assignment sheets are updated.</p> <p>The Guardian Angel for each resident identified as cognitively impaired will be notified of any changes in the residents' schedule, care, or activities, so that he/she can monitor if those things are occurring as per the residents' preferences according to the interviews/observations being done through the Guardian Angel program at least 5 days a week. If any concern or issue is identified, it will be brought to the Administrator and IDT for review and discussion. The Administrator and appropriate department</p>	

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F 0371 SS=E Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure hand hygiene was performed by staff prior to serving drinks, and before and in between feeding residents during 1 of 2 dining observations in the main dining room. This deficiency had the potential to affect 27 of 27 residents who dined in the dining room (Residents #29, #20, #35, #28, #2, #30, #10, #4, and #11).</p> <p>Findings include:</p> <p>Lunch service was observed in the main dining room on 9/22/15 from 11:29 a.m. to 12:30 p.m., and the following was observed:</p> <p>1. Certified Nursing Assistant (CNA) #4 was observed to push Resident #29's wheelchair into the dining room. CNA #4 adjusted Resident #29's wheelchair locks with her bare hands. CNA #4 was not observed to wash her hands or use</p>	F 0371	<p>manager will follow up and correct the situation as needed.</p> <p>F371 It is the policy of this facility that food will be served under sanitary conditions, including staff performance of appropriate hand hygiene when serving or assisting residents with drinks and meal service.</p> <p><u>1. What corrective action will be done by the facility?</u> All staff and managers serving residents in the dining room will be in-service doing performing proper hand hygiene as they serve residents their drinks and meals by 10/27/15.</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents in the dining room have the potential to be affected by this practice. If any IDT manager or Administrator observes a lack of proper hand hygiene during meal service, he/she will stop the staff at the time of the observation and will re-train the individual involved. If the breach in technique affects the cleanliness of utensils, glasses,</p>	10/27/2015

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	<p>hand sanitizer.</p> <p>CNA #4 placed gloves on and picked up Resident's #20's empty cups from the table. CNA #4 picked up the ice pitcher, water pitcher, and tea pitcher and filled the resident's cups with ice, water, and tea. CNA #4 placed the cups back in front of Resident #20. CNA #4 picked up a coffee cup and poured coffee for Resident #35. CNA #4 touched the handle of the beverage cart and moved it down to the next set of tables. CNA #4 picked up Resident #2's and Resident #28's cups and poured coffee. CNA #4 picked up Resident #30's cup poured hot water into the cup, and opened a hot chocolate packet for Resident #30. CNA #4 removed her gloves. CNA #4 was not observed to wash her hands or use hand sanitizer. CNA #4 poured coffee for Resident #10 and handed the resident a couple of sugar substitute packets with her bare hands. CNA #4 was observed to use hand sanitizer.</p> <p>2. Certified Nursing Assistant (CNA) #3 put her bare hand on the top of the chair next to Resident #4, pulled it out, and sat down. CNA #3 picked up Resident #4's spoon and used the resident's spoon to feed Resident #4. CNA #3 touched Resident #4's arm with her right bare hand. CNA #3 was not observed to wash</p>		<p>or other items used by the resident for eating, the manager will make sure that they are given clean replacements. The staff involved will also receive written counseling/disciplinary action as indicated by the situation.</p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u> Each meal service in the dining room will have an IDT manager assigned to oversee the dining services as they occur and to monitor staff performance during the meal service. Any identified issues or concerns will be addressed as indicated in question #2.</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator or Designee will bring the results of the dining room monitoring activities to the monthly QAA Committee meeting for review and recommendations for improvement. This will continue on an ongoing basis. Date of Compliance: October 27, 2015</p>		

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	<p>her hands or use hand sanitizer after touching the chair, before feeding the resident, or after touching the resident.</p> <p>CNA #3 stood up and went over to Resident #11. CNA #3 picked up Resident #11's fork and knife, and cut the resident's meat. CNA #3 was not observed to wash her hands or use hand sanitizer before or touching the resident's silverware.</p> <p>CNA #3 walked back and sat next to Resident #4 again. CNA #3 picked up Resident #4's spoon and fed the resident. CNA #3 picked up Resident #4's lidded cup and held the cup up to the resident's mouth. CNA #3 was not observed to wash her hands or use hand sanitizer before or touching the resident's silverware or cup.</p> <p>During an interview on 9/29/15 at 9:43 a.m., Certified Nursing Assistant (CNA) #3 indicated she normally washed her hands or used hand sanitizer after assisting a resident and before assisting another resident, after she touched a resident or resident's equipment, and before and after assisting with dining service.</p> <p>On 9/28/15 at 4:46 p.m., the Director of Nursing (DON) provided the current</p>			

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F 0520 SS=E Bldg. 00	<p>handwashing policy titled, "Handwashing/Alcohol-Based Hand Rub." The policy stated, "personnel should always wash their hands (even when gloves are worn)." The policy indicated staff was to wash or sanitize their hands after gloves were removed, before and after contact with residents, and after touching a resident or resident's property.</p> <p>3.1-21(i)(2)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p>			

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	<p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on interview and record review, the facility failed to identify and implement a process for quality improvement for prohibiting, reporting, and thoroughly investigating allegations of verbal and mental abuse for 4 of 20 residents reviewed for verbal and mental abuse( Residents #13, #26, #28, and #32). This deficient practice had the potential to affect 30 of 30 residents in the facility.</p> <p>Findings include:</p> <p>1. During an interview on 9/23/2015 at 11:16 a.m., Resident #32 indicated Certified Nursing Assistant (CNA) #5 had been verbally abusive toward him in the past. He indicated CNA #5 told hem she was going to smother him with a pillow while he slept. The resident indicated he could not recall the date of the incident, but indicated he notified the Director of Nursing (DON) at the time of the incident.</p> <p>During an interview on 9/23/2015 at 12:02 p.m., the DON indicated the previous Administrator had been informed of CNA #5's threat to smother Resident #32 in his sleep was reported to</p>	F 0520	<p>F520 It is the standard of this facilitythat a quality assessment and assurance committee is maintained to identifyissues and to develop and implement plans of action to correct identifieddeficiencies, including instances of verbal or physical abuse, neglect, ormisappropriation of residents' personal items.</p> <p><u>1.What corrective action will be accomplishedfor those residents found to have been affected by the deficient practice?</u></p> <p>In addition to the plan ofcorrection and responses already outlined in F223, F225, and F226, the facilitydoes maintain a QAA monthly Committee meeting, along with a morning IDTmanagement meeting and a weekly Standards of Care meeting to discuss pertinentresident information, changes in status, and resident/family concerns or issuesidentified through interviews or observations, as well as the facilityinvestigation and response to the concerns. The Administrator and IDT managershave been re-trained by the Nurse Consultant on the content of these meetingsand the immediate response expected whenever residents, families, or staffvoice concerns about</p>	10/27/2015
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	<p>the former Administrator.</p> <p>During an interview on 9/23/2015 at 2:29 p.m., the Administrator indicated she could not provide evidence the allegation had been reported to the required entities and an investigation of the allegation had been conducted for Resident #32's allegation of abuse by CNA #5. She indicated the allegation should have been reported and investigated.</p> <p>During an interview on 10/07/2015 at 9:39 a.m., the Administrator indicated the Quality Assurance committee had not identified deficient practices in regard to abuse reporting and investigations and implementation of facility's abuse policies and procedures prior to being made aware of concerns during the survey.</p> <p>Incident reports were reviewed on 10/6/15 and indicated the facility did not report the allegation of CNA #5 threatening to smother Resident #32 with a pillow until 9/23/15 at 11:30 a.m.</p> <p>2. During an interview on 9/24/2015 at 9:24 a.m., Resident #13 indicated Certified Nursing Assistant (CNA) #5 had been verbally and mentally abusive during a Hoyer (mechanical lift) transfer and indicated the CNA's comments made</p>		<p>services and treatment. The QAA Committee met October 26,2015 andreviewed the concerns identified in the 2567, as well as the plan of correctionand processes that were being put into place as a result. At the next QA committee meetingscheduled in November 2015 the Committee will discuss the status of the processimprovement efforts, review their effectiveness, and offer recommendations for further improvement, whereindicated.</p> <p><u>1.How other resident having the potential to beaffected by the same deficient practice will be identified and what correctiveaction will be taken?</u> All residents have the potential tobe affected by this practice. If anyconcerns of abuse or mistreatment are identified or voiced by residents, staff,or families, the Administrator, DON, or IDT manager will notify theAdministrator immediately (if she is not already aware of the situation) andwill make sure that the resident is taken care of as quickly as possible. Oncethat is done, the Administrator will report the incident as required, willinitiate an investigation, and will follow through with re-training anddisciplinary action as indicated by the situation.</p> <p><u>1.What measures will be put into place or whatsystemic changes will be made to ensure that the deficient practice?</u> The Administrator or designee</p>		

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	<p>her feel like a "lost cause."</p> <p>During an interview on 9/28/2015 at 4:15 p.m., the Director of Nursing (DON) indicated the Activity Director (AD) recorded the minutes for the Resident Council Meeting on 9/15/15 and indicated Resident #13 reported the allegation during the Resident Council meeting.</p> <p>During an interview on 9/29/15 at 4:17 p.m. the Administrator indicated the facility became aware of the allegation of verbal abuse during the Hoyer transfer when it was discussed in the Resident Council meeting on 9/15/15. The Administrator indicated the Activity Director should have immediately informed her of the abuse allegations. The Administrator indicated the DON reviewed and signed the Resident Council minutes on 9/18/15 and should have immediately notified her after awareness of the allegation.</p> <p>During an interview on 10/6/15 at 11:27 a.m., the Administrator indicated the allegation of CNA #5 being verbally and mentally abusive to Resident #13 had not been reported to the State agency and indicated she planned to submit the report that day.</p>		<p>willbring to the QAA Committee on a monthly basis any concerns or issues withabuse, mistreatment, or other issues with care that have been identified by theIDT as part of their Guardian Angel rounds, resident/family interviews,observations, and other sources of feedback. Through the QA Committee the IDTwill follow through on recommendations made by the committee for process improvementthroughout the facility and will bring the results of those recommendationsback to the Committee at the next scheduled meeting for a status update andfurther discussion as necessary.</p> <p><u>1.How the corrective action will be monitoredto ensure the deficient practice will not recur and what quality program willbe put into place?</u></p> <p>At the next QA committee meeting,the Committee will discuss the concerns cited on the 2567, especially thosethat encompass deficiencies related to resident abuse. These will continue to be discussed at themonthly QAA committee meeting, along with any newly identified areas on anongoing basis as directed by the QAA committee members. The Administrator willkeep the minutes of the QAA meetings; these meeting minutes will be reviewed bythe Nurse Consultant on a monthly basis to assure</p>				

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	<p>Resident Council minutes, dated 9/15/15, were reviewed on 9/28/15 at 4:20 p.m. The minutes indicated, "...[CNA #5 named] was lifting a resident (identified by the DON as Resident #13) by Hoyer when residents (sic) bowels released. States [CNA #5 named] told her she should have been able to hold it until she got in bed..."</p> <p>3. During an interview on 9/24/15 at 10:09 a.m., Resident #28 indicated Certified Nurse Aide (CNA) #5 verbally abused Resident #26 on Saturday, 09/19/2015, during the evening meal. Resident #28 stated, "[CNA #5 named] jumped all over [Resident #26 named]" and "cursed." Resident #28 indicated CNA #5 yelled, "You had me get this [s-- -] and now you are not going to eat it? What do you want me to do with the [s-- -]?" Resident #28 indicated she reported the abuse to the Social Service Director (SSD) on 09/20/2015.</p> <p>During an interview on 10/6/15 at 9:50 a.m., the SSD indicated she was informed by Resident #28 on 9/20/15 of allegations CNA #5 yelled and cursed at Resident #26 during the evening meal in the dining room on 9/19/15. The SSD indicated she notified the DON on 9/20/15 of the allegation.</p>		<p>follow through, actual improvement in processes, and improvement in resident care and treatment. This will continue on an ongoing basis. Date of Compliance: October 27, 2015</p>	

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	<p>During an interview on 10/6/15 at 10:00 a.m., the DON indicated she was unable to recall being notified of the allegation of verbal and mental abuse to Resident #26 that allegedly occurred during the evening meal in the dining room on 9/19/15.</p> <p>During an interview on 10/6/15 at 10:00 a.m., the Administrator indicated she had not been made aware of the allegation of verbal and mental abuse to Resident #26 during the evening meal in the dining room on 9/19/15.</p> <p>Reportable incidents were reviewed on 10/6/15 at 10:15 a.m. and did not indicate the allegation of CNA #5 being verbally and mentally abusive to Resident #26 had been investigated and reported timely to the Administrator and State agencies in accordance with the law.</p> <p>4. Resident #28 indicated residents were lined up in their wheel chairs in the hall after the evening meal on 09/19/2015. The resident indicated when she moved Resident #26's wheelchair so she could get to the entrance of her room, CNA #5 yelled and cursed at her. Resident #28 indicated she told the SSD about the incident on 9/20/2015.</p> <p>During an interview on 10/6/15 at 9:50</p>			

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	<p>a.m., the SSD indicated she was informed by Resident #28 of allegations of verbal abuse to Resident #28 by CNA #5 in the hallway when she attempted to move Resident #26's wheelchair from the line outside the dining room. The SSD indicated she reported the allegation to the DON immediately after Resident #28 reported it to her and indicated she also notified the DON of the allegation of CNA #5 yelling and cursing at Resident #26 in the dining room on 9/19/15.</p> <p>During an interview on 10/6/15 at 10:00 a.m., the DON indicated CNA #5 was suspended from work on 9/20/15, immediately after she became aware of the allegation of CNA #5 yelling at Resident #28 when she attempted to move Resident #26's wheelchair.</p> <p>An incident report, dated 09/19/2019 at 7:01 p.m., was reviewed on 09/25/15 at 1:50 p.m. The report indicated an allegation of CNA #5 yelling at Resident #28 in the hallway, but did not include the allegation of the CNA yelling and cursing at Resident #26 in the dining room on 9/19/2015 during the evening meal.</p> <p>A policy titled "Quality Assessment and Assurance" identified as current by the Administrator on 10/8/15 at 1:39 a.m.</p>			

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	<p>indicated, "This facility maintains a quality assessment and assurance (QA&amp;A) committee... QA&amp;A is a management process that is ongoing, multi-level, and facility-wide. It encompasses all managerial, administrative, clinical, and environmental services, as well as the performance of outside (contracted or arranged) providers and suppliers of care and services. Its purpose is continuous evaluation of facility systems with the objectives of: keeping systems functioning satisfactorily and consistently, including maintaining current practice standards: Prevention deviation from care processes from arising to the extent possible; Discerning issues and concerns, if any, with the facility systems and determining if issues/concerns are identified; and Correcting inappropriate care processes...."</p> <p>3.1-52(b)(2)</p>			