

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2014
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NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
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F000000	<p>This visit was for the Investigation of Complaints IN00148167, IN00148353, and IN00148561.</p> <p>This visit resulted in a partially extended survey-immediate jeopardy.</p> <p>Complaint #IN00148167 - Substantiated. Federal/State deficiencies related to the allegations are cited at F225, F226, F250, F504, F514, and F520.</p> <p>Complaint #IN00148353 - Substantiated. Federal/State deficiencies related to the allegations are cited at F225, F226, F250, F504, F514, and F520.</p> <p>Complaint #IN00148561 - Substantiated. Federal/State deficiencies related to the allegations are cited at F225, F226, F250, F504, F514, and F520.</p> <p>Survey dates: May 1, 2, 3, 4, 5, and 7,</p> <p>Facility number: 000681 Provider number: 155549 AIM number: 100286100</p> <p>Survey team: Betty Retherford RN, TC (May 1, 2, 4, 5, and 7, 2014) Karen Lewis RN</p>	F000000	<p>Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report.</p> <p>Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.</p> <p>The Plan of Correction is prepared and submitted because of requirements under State and Federal law.</p> <p>Please accept this Plan of Correction as our credible allegation of compliance.</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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F000225 SS=L	<p>(May 3, 2014) Tina Smith-Staats RN (May 5, 2014)</p> <p>Census bed type: SNF: 3 NF: 34 Total: 37</p> <p>Census payor type: Medicare: 3 Medicaid: 34 Total: 37</p> <p>Sample: 11</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</p> <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>				

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	<p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the staff identified reasonable suspicion of a crime related to significant injuries found on a resident's pelvic and vaginal areas and failed to promptly notify the investigative and/or police authorities in a timely manner resulting in a delay in the resident being sent to the emergency room for a "Sexual Assault Nurse Exam" and a delay in the police investigation for 1 of 3 residents reviewed for self reported incidents. In addition, the facility failed</p>	F000225	1a. Resident B was immediately assessed, Administrator, MD and POA were notified, and a complete and thorough investigation was completed. The police was contacted for any additional follow up that may have been needed. ISDH, Ombudsman, and APS were updated. 2a. All other residents have the potential to be affected. The facility reviewed all records of injury of unknown origin during the previous 30 days in an effort to verify any other injury of unknown origin had been	05/20/2014

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	<p>to complete a thorough investigation of the injury of unknown origin. This deficient practice had the potential to effect 37 of 37 residents residing in the facility. (Resident #B)</p> <p>This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 4/23/14 when the facility staff failed to identify a reasonable suspicion of a crime resulting in a delay in police notification and failed to conduct a thorough facility investigation following the incident. The Administrator, Director of Nursing, and RN Consultant were present when informed of the immediate jeopardy on 5/2/14 at 12:45 p.m. The Immediate Jeopardy was removed on 5/5/14 at 4 p.m., but the facility remained out of compliance at the level of isolated no actual harm with potential for more than minimal harm that is not immediate jeopardy because the additional training completed needed to be monitored, the effectiveness of the facilities staff inservices needed to be evaluated, and auditing of new facility practices needed to be completed.</p> <p>Findings include:</p> <p>1. During an observation on 5/2/14 at 9:55 a.m., conducted with LPN #11,</p>		<p>identified with appropriate notification and investigation conducted, and necessary corrective action taken, if warranted. 3a. As a means to ensure ongoing compliance with ensuring staff identify reasonable suspicion of a crime related to significant injuries and promptly notify the investigative and/or police authorities in a timely manner, the following corrective actions were taken: the facility's policy for Reporting Unusual Occurrences and Elder Justice (i.e., suspicion of a crime) has been reviewed and no changes are indicated at this time. The Administrator, DON, and ADON have been re-educated on the policies with a special focus on identifying, investigating, and reporting reasonable suspicions of a crime in a timely manner. As a preventative, the facility staff has also been re-educated on the Elder Justice Act with a special focus on timely notification. An Injuries of Unknown Origin form has been implemented in an effort to confirm ongoing compliance with identification, investigation and subsequent action, if warranted. 4a. As a means of quality assurance, the Administrator or designee will review all incident reports daily on scheduled work days to ensure any unusual occurrences are identified, investigated, and reported per guidelines and the</p>	

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	<p>Resident #B was lying in her bed on her back. Privacy was provided. Permission was requested to observe bruised areas on the resident's abdomen and pelvic area. The resident gave permission. Her shirt was pulled up slightly and her pants were lowered. A irregular bruise with various colors of healing was noted on the resident's outer left groin area. Bruising remained on the resident's pelvic bone in a pyramid like shape that widened the further it went down into the lower pelvis and pubic area. This bruise also appeared to be in various stages of healing. Her labia majora remained dark in color, but did not appear to be swollen at this time.</p> <p>Review of facility reportable incident form identified as the "Follow-up Report", dated 4/28/14, included, but was not limited to the following information:</p> <p>The report indicated Resident #B was a female who was able to ambulate independently and dress and toilet herself. The report was completed related to injuries of unknown origin found on Resident #B during a routine skin assessment completed on 4/23/14 at 4:20 a.m.</p> <p>The bruises noted on the resident were described as follows:</p>		<p>Injuries of Unknown Origin form will be completed on an ongoing basis. Should a concern be identified, immediate corrective action will occur. The results of these reviews and any corrective actions taken will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, if indicated.</p> <p>1b. The allegation lodged by CNA #12 has been fully investigated and reported to ISDH. LPN #13 provided a written statement to the facility Administrator.</p> <p>2b. In an effort to identify any other allegations/concerns voiced to ensure appropriate investigation/reporting, administration reviewed with the Nurse Consultant any such record of allegation/concern received during the last 30 days.</p> <p>3b. In an effort to ensure ongoing compliance with the appropriate reporting and conducting of thorough investigation of any allegation of abuse as per facility policy, the Administrator, DON and Department Heads have been re-educated as to immediate reporting of any allegation of abuse and initiation of thorough investigation. An investigation template has been provided to outline critical steps in the investigation process, including but not limited to, obtaining statements and retaining documented proof of any investigation and follow up action. Additionally, the Administrator</p>				

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	<p>a. Bruise to pubic bone: 23.5 cm [centimeters] by 13 cm.</p> <p>b. Bruise to left lower groin/left lower abdominal quadrant: 6.1 cm by 7.5 cm.</p> <p>c. Bruise to left lower buttocks: 1.9 cm by 1.6 cm</p> <p>d. Bruise to right inner thigh: 1.5 cm by 1.5 cm.</p> <p>e. Bruise to back of left forearm: 9.8 cm by 4.5 cm.</p> <p>f. Bruise to back of right forearm: 3.5 cm by 2.1 cm</p> <p>g. Bruise to left lower abdominal quadrant next to hip area: 1 cm by 2.5 cm.</p> <p>The report indicated the resident's husband [who lived out of state] was contacted and he did not want her sent to the hospital for an evaluation. The report indicated the physician was contacted and wanted to honor the husband's wishes.</p> <p>The report indicated the resident was unable to state how the injuries occurred. The report indicated she denied falling or bumping into anything and denied any aggression by another individual. The report indicated the resident's demeanor was not different from her normal.</p> <p>The report indicated the resident had been assisted with dressing by a restorative CNA on 4/22/14 at 6 a.m. and</p>		<p>shall be responsible to review any allegation of abuse and subsequent actions taken with the assigned Regional Director/designee or Nurse Consultant/designee as they are received in an effort to confirm appropriate immediate action was taken, as well as appropriate steps initiated to conduct a thorough investigation.</p> <p>4b. As a means of quality assurance, all records of investigation of allegations of abuse shall be again reviewed with the Quality Assurance Committee on an ongoing basis and discussed during the facility's quarterly meetings as a basis to confirm continued compliance with the ongoing continued investigation of alleged abuse with appropriate investigation and corrective actions, as warranted.</p> <p>Willow Bend Living Center is requesting an Independent Informal Dispute Review for the Investigation of Complaints IN00148167, IN00148353, and IN00148561. The IIDR Rationale and supporting attachments will be loaded to the Gateway system. A few documents (with pre-existing shading) were unable to be lightened sufficiently. Thus, should paper copies be requested, please contact the facility and copies will be delivered to ISDH accordingly.</p>		

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	<p>no bruising had been noted to Resident #B at that time.</p> <p>The report indicated staff, other residents, and a lab technician were interviewed as part of the investigation. The report indicated the secured unit [where the resident lived] was checked to ensure no hazards were present. The windows and outside doors on the unit were also checked to ensure the windows were intact and the doors remained locked and alarmed with no issues noted.</p> <p>The report indicated the resident's physician and husband were updated. [no timeline provided] The husband was re-approached regarding sending the resident to the ER [emergency room] for an evaluation which he continued to refuse. "He indicated he thinks she fell or ran in to something. He doesn't think she experienced any aggression by another individual, because had she been approached, he indicated she would have made noise and someone would have heard it." The report did not indicate if the resident's husband had been made aware of the extent and location of the bruising.</p> <p>The report indicated "Due to the bruising and inability to definitively determine a cause, the [name of county] Sheriff's</p>			

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	<p>Department was contacted and arrived at the facility. [No timeline was provided] Deputy #1 reviewed the information and contacted Investigator #2. The Investigator arrived at the facility and reviewed the information. The report indicated "the Deputy and Investigator concurred the facility had completed a thorough investigation". However, as the facility could not definitely determine how the bruising occurred, they determined it appropriate to take Resident #B to the ER for further evaluation. The physician was undated and a message was left for the husband. The DoN and Administrator accompanied the resident to the ER.</p> <p>A statement related to the bruising found on Resident #B, dated 4/23/14, written by LPN #3 [the skin assessment nurse], indicated the following:</p> <p>"At 4:20 a.m., I went into [name of Resident #B] room to do her weekly skin assessment. Resident's door was shut and resident was in bed sleeping aroused easily. I asked resident if it was OK that I did her weekly skin assessment and she said, 'Yes'. Resident had PJ [pajama] bottoms on and a PJ top. I ask [sic] resident if I could lift her shirt to assess her abdomen and there were no red areas noted. Then I asked resident if I could</p>			
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	<p>assess below her waist which meant she would have to lower her PJ pants she immediately grabbed a hold of her waistband and held her hand on it. This was unusual for this resident from doing her skin assessments in the past she would lower her pants and not hold onto them. I asked resident, 'Is something wrong, are you OK?' Resident did not answer me as she shrugged her shoulders. I asked resident is it ok to lower your pants so I can assess the rest of you skin? Resident said yes and shook her head yes also. I observed a bluish purplish bruise to left lower groin area and a very large bruise on her pubic bone that extended down her labia majora and labia minora all the way down to her vaginal opening. The bruising on her pubic bone is dark purple mainly dark purple with also bluish in color and the bruising that extends downward to labia major and labia minor is dark purple. Observed purple bruising inside of the vagina. Also noted a bruise that resembles a finger print on the resident's inner right thigh and the same size bruise that resembles a finger print on the back of the resident's left upper leg/buttocks area. Resident had facial grimacing when assessing areas as if areas were tender. Asked resident 'Are you in pain, do you have discomfort?' Resident stated, 'No', and shook her head no. Resident has no</p>			

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	<p>bruising noted on 4/15/14 during her weekly skin assessment.</p> <p>"I asked resident if she would like to have a prn [as needed] pain medication due to the facial grimacing and the areas being tender. Resident stated, 'No.' I also noted a bruise on the back of the resident's left forearm noted bluish in color and a faded light brown bruise to bask side of resident's right forearm. I asked resident, 'What happened, How did you get these bruises?' Resident stated, 'I don't know, I don't know.' She shrugged her shoulders.</p> <p>"I heard [name of QMA #4] in the hallway she is the staff member working on the unit at this time so I asked her to come into the room and [name of CNA #5] was with QMA #4. She was relieving her for a break and had been on the unit this shift. Both staff members stated they had not observed any of the bruises before seeing it now for the first time. Both staff members were shocked when seeing these bruises at this time.</p> <p>"I measured all of the bruises with permission of the resident. See skin sheets for measurements.</p> <p>"I immediately contacted [name of DoN] reported all of the bruises with</p>			

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	<p>measurements and that there was also bruising at the vaginal opening. I reported the resident's unusual behavior of her holding her pants at her waist at the start of the skin assessment. DoN stated 'I am not coming in today you will need to call [name of Administrator]. DoN wanted statements from all staff members at the facility.</p> <p>"I called [name of Administrator] reported all of the bruising to her and the same above information that I reported to the DoN. I also reported it to charge Nurse [name of LPN #6] who was working this shift. She also assessed bruising and stated she had not seen before now. [Name of Administrator] had asked that resident be placed on 10 minutes checks and she would be coming into facility</p> <p>"I did call [name of Administrator] again because myself and [LPN #6] remembered when we had our inservice with the [name of county] Police Department regarding The Elder Justice Act. We were told that it's not our job to decide if it is a crime. It's our job to report a crime and the police will decide if its a crime. I asked [DoN] if [LPN #6] or myself needed to go ahead and call [name of county] Police Department. She stated 'No I am on my way in to take</p>			

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	<p>care of this.'</p> <p>"[Name of DoN] called the facility back to let us know that another resident on the unit needed to have 1:1 [one to one observations] with a staff member sitting right with him. I was that staff member who was going to be giving this other resident 1:1 [observation] which I did per DoN's request.</p> <p>"[Name of Administrator] arrived at the facility requested I write out a statement, skin sheets for all the bruises and a 'picture of the body to mark areas on there'. All of which I did and gave to [Administrator name].</p> <p>"[Name of Administrator] did go to resident's room to talk to her and is handling this situation." (This statement ended with the signature of LPN #3 and the date of 4/23/14.)</p> <p>Review of a statement, signed by the Administrator, dated 4/23/14, titled "Reportable" included, but was not limited to the following:</p> <p>"Administrator arrived at facility 5:50 a.m. I spoke with [name of Restorative CNA #7] in regards to bruising on [Resident #B] and how was her demeanor during adl [activities of daily living] care.</p>			

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	<p>Asked her to please document in a full statement. I then went to [name of unit where Resident #B resides] to interview [name of Resident #B] at approximately 6 A. After interview, with [name of resident] I called medical director [name of doctor] approx. 6:30 A and informed him of unusual bruising and location. At this time he informed me to call her husband [POA] and report injuries and did he wish to have her sent to ER for exam and he stated no. Spoke with [name of husband] approx at 6:45 A. I did explain bruising and location and my conversation with [name of resident]. He again did not want her sent out. I called [name of Nurse Practitioner for Medical Director] per his [Medical Director] request to up-date her. [Name of Nurse Practitioner] was updated at 7:34 A when she returned call. Voicemail left at 6:50 A. I called husband again left voicemail for him to call me. [Name of husband] did return a second call at 8:55 A. We talked about his wishes.... I let him know about exam from nurse consultant and ADoN. [Name of Nurse Consultant] did note discharge near rectal area and spoke with husband. [Name of husband] stated he would like to have this mucus cultured. He said yes to culture, but again no to sending her to ER....</p> <p>"Nurse Consultant and ADoN did exam</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2014
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NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
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	<p>at 7:45 A. Res. [resident] did wish to get up and dressed. She was dressed by Administrator and ADoN. All residents linens and brief were bagged and stored approp. [appropriately?]...."</p> <p>Review of a written statement, dated 4/23/14 at 8:45 a.m., signed by the RN Consultant included, but was not limited to, the following:</p> <p>"Assessed the bruised areas and remeasured with measurements placed on skin sheets. Spoke with [name of resident] regarding the areas. She indicated she didn't know what happened. Does not recall being injured in any way. Res did not shy away from the assessment. Didn't guard area. No c/o [complaints of] pain. Noted thick cream colored mucus between buttock. No odor, redness, or edema noted. No c/o related to rectal area...."</p> <p>Review of a "Timeline" sheet, dated 4/23/14, initialed by the Administrator, included, but was not limited to, the following:</p> <p>"Around 7:45 p, Res met with police and investigator. We explained to her about going to hosp [hospital] for exam and investigation.... 8:30 p We left for hosp...."</p>			

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	<p>The Administrator and DoN were interviewed on 5/1/14 at 10:30 a.m. They indicated the bruises on Resident #B were found during a routine exam by the Skin Assessment Nurse on 4/23/14 at approximately 4 a.m. They indicated the husband was asked twice about sending her to the emergency room for an evaluation and he refused. They indicated the resident was eventually sent to the emergency room after the police were contacted and insisted she had to be evaluated. They indicated she was taken to the hospital and pictures, exam, and tests were completed as part of the hospital sexual assault protocol. They indicated the exam kit had been sent to the police lab for testing by the hospital and it could be months before the results were known. They indicated the resident was treated prophylactically with Flagyl (an antibiotic often used for vaginal infections) and another oral antibiotic.</p> <p>During an interview with Resident #B's husband on 5/6/14 at 1:27 p.m., he indicated the following:</p> <p>He was called by the Administrator around 6:30 a.m. on 4/23/14. He was informed that, during a routine skin assessment, the facility had found some bruising they were concerned about due</p>			

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NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
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	<p>to the location of the bruising. The administrator asked him if he wanted the resident sent out for a "rape test". She described the location, but not the sizes, of the bruises. He was not informed of the bruises on her forearms. He asked if the resident could have run into a table, etc. He indicated the Administrator told him she would be talking to the resident and the facility would be doing their own investigation. He indicated it was left up to his discretion as to whether he wanted her sent to the ER or not. He indicated he did not want to put her through this if it wasn't necessary, so he did not tell them to send her to the hospital for an exam. He indicated it had seemed to be purely at his discretion. He indicated if he had any idea the physician and, later in the day, the Nurse Practitioner had wanted the resident to go to the hospital, he absolutely would have agreed to the ER evaluation and rape exam.</p> <p>Review of the emergency department SANE [sexual assault nurse examination] Documentation Record, provided by hospital nursing staff, RN #8, on 5/1/14 at 4:10 p.m., included, but was not limited to, the following:</p> <p>"...Patient History...On 4/23/14 at appx [approximately] 0500, a wound nurse doing her weekly skin assessment noted</p>			

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NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
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	<p>injury to [name of Resident #B] genital area. She made staff aware including the director of nursing. An internal investigation at the ECF [extended care facility] began including interviews and a social consult. [Name of Administrator] present at bedside, stated that they were told no abuse was suspected and to take no action. On further investigation by [name of Investigator #2] it was deemed further examination was necessary. [Name of Resident #B] is unable to give a health history, and can not recollect an assault. Injury noted on exam....</p> <p>...Post Sexual Assault Hygiene Activity:</p> <p>Urinated - yes checked ...Genital wash/wipe - yes checked ... Drank or rinsed mouth - yes checked ... Eaten - yes checked</p> <p>...Patient dress during assault: given to law enforcement</p> <p>...General Physical Exam</p> <p>...2. Collect outer and underclothing if indicated: Not indicated was checked and the statement "Already given to law enforcement"</p> <p>3. Conduct a physical examination. "Findings" was checked.</p>			

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NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
--	--

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	<p>4. Collect dried and moist secretions, stains, and foreign materials from the body. Scan the entire body with an alterative light source (ALS). "Findings" was checked.</p> <p>5. Collect fingernails scrapings or cuttings according to local policy...." This was checked as completed.</p> <p>The report also included a anatomical diagram indicating where findings were observed. The findings were numbered and a description and some measurements were noted. The form indicated the following findings:</p> <p>1. A discolored and tender area on the left lower pelvic area which measured 4 inches and indicated "see pictures".</p> <p>2. A discolored and tender area located on the pubic bone area that measured 6 inches by 5 inches and indicated "see pictures."</p> <p>3. A discolored and tender area located on the right inner forearm with measured 3 cm and indicated to "see photos."</p> <p>4. A discolored and tender area on the left inner forearm that measured 2.5 cm and indicated "see photos".</p>			

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NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
--	--

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	<p>5. A discolored and tender area on the right inner forearm that measured 2 cm and indicated "see photos".</p> <p>The report also included a "Genital Examination" record for females with anatomical diagrams of the vaginal opening, labia majora, labia minora, clitoral area, and perineal area. The report indicated there was tenderness and redness of the following areas: labia majora, both sides of the vaginal area, the perineal area and an area between the anus and buttocks. The exam indicated to "see photos".</p> <p>The "Genital Examination" record additional information which included, but was not limited to, the following:</p> <p>1. Examine the inner thighs, external genitalia, and perineal area. Check the box(es) if there are assault related findings: [Boxes were checked for inner thighs/perineum, labia majora, and clitoris/surrounding area]</p> <p>2. Collect dried and moist secretions, stains, and foreign materials. Scan the area with an alterative light source (ALS). [The box for 'findings' was checked.]</p>			

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NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
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	<p>...4 Examine the vagina and cervix. Check the box(es) if there are assault related findings. [The box for 'vagina' was checked,]</p> <p>...8. Examine the buttocks, anus, and rectum (if indicated by history)... Check box(es) if there are assault related findings: [The box for 'buttocks anal verge/folds/rugae' was checked.]</p> <p>9. Collect dried and moist secretions, stains, and foreign materials. [The box for 'findings' was checked.]"</p> <p>The report was signed by a hospital RN.</p> <p>Review of a employee list, provided by the Administrator on 5/1/14 at 1:00 p.m., indicated 5 males were employed by the facility. An LPN, CNA, cook, Maintenance staff, and dietary staff.</p> <p>The facility investigation packet provided by the Administrator, related to the bruising on Resident #B found on 4/23/14, was reviewed on 5/1/14 at 10:40 a.m. The packet contained many staff statements, skin assessments, and event timelines. The packet lacked any statements and/or interview information from male staff members employed by</p>			

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	<p>the facility.</p> <p>The Administrator, DoN, and RN Consultant were interviewed on 5/2/14 at 11:45 a.m. They indicated no male employees had been interviewed or required to give statements in regards to the investigation completed for the injuries of unknown origin found on Resident #B on 4/23/14.</p> <p>When queried why they had not contacted the police immediately after the injuries were found since the injuries were extensive and were located almost exclusively in sexual areas, they all indicated they had not seen her injuries as a possible assault due to her demeanor and inability to state how she had been injured. They indicated she had later been seen near males on her unit and had not "shied away". They indicated they put Resident #C on 1 to 1 observation as a precaution. They indicated the windows, doors, and alarms were checked as a preventative measure.</p> <p>The Administrator and Don indicated they had collected the residents brief, sheets, and clothing and had bagged it all together in one large trash bag on the morning of 4/23/14. When queried why the resident's clothing and linens had been bagged if they had not felt a</p>			

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--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
--	--

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	<p>possible crime had occurred, the DoN indicated it was done due to the "unknown factor". She "just did everything she could think of" because she had been a party to this type of investigation at another facility. She indicated she had not arrived at the facility until around 8:30 a.m. on 4/23/14.</p> <p>When the DoN and Administrator were queried if they had any special training on how to collect possible forensic evidence, they indicated they had not.</p> <p>When queried if they had any police or special training on how to interview a possible sexual assault victim, they all indicated they had not.</p> <p>LPN #3 was interviewed on 5/1/14 at 10:55 a.m. She indicated she was doing the skin assessment on the morning of 4/23/14 when the bruising on Resident #B was found. She indicated it was unlike anything she had ever seen before. She indicated there were bruises on both forearms. The right was possible old bruising, but the left was newer bruising that was lighter blue with darker areas of blue in them that could be finger print areas. She indicated the rest of the bruising was highly concentrated in the resident's pelvic and vaginal region. She indicated she remembered a police officer</p>			

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--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
--	--

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	<p>talking to the staff about the "Elder Justice Act" and had concerns that maybe the police should be called. She indicated she and LPN #6 discussed this concern and looked for the "Elder Justice Act" books on the unit. She indicated they were unable to find them and she called the Administrator back to see if she wanted her or LPN #6 to call the police. She indicated she was told "No, don't call" by the Administrator who indicated she was getting dressed and would be coming in to take care of it. She indicated the Administrator arrived a short while later and went in to see the resident. She indicated she went home and slept for awhile. She indicated she called the facility around 4 p.m. just to see what the police said and find out if they (the police) needed to talk to her since she was the staff member who found the bruises. She indicated she was told the police had never been called. She indicated she was very upset by this because that is what she thought the Administrator was going to do when she came in to the facility. LPN #3 indicated she told them she wanted the police called. She indicated she followed up a short while later and found out the facility had contacted the police sometime around 6 p.m.</p> <p>LPN #6 was interviewed on 5/1/14 at</p>			

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--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
--	--

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	<p>8:40 p.m. She indicated she was the Charge Nurse in the facility on the morning the bruises were discovered on Resident #B. She indicated she had not seen Resident #B that morning until she was called to the unit by LPN #3 because a QMA had been covering that unit while she was on the other unit. She indicated Resident #B's bruising was not like anything she had ever seen before. The whole vaginal area was dark. The bruising was highly contained in that area. She felt it was possible that the resident had been assaulted and she would have preferred to call the police, but they were told not to and administrative staff were coming in to handle it.</p> <p>CNA #5 was interviewed on 5/1/14 at 8:40 p.m. She indicated she had seen the bruises on Resident #B on the morning of 4/23/14 and had "never seen anything like that" in her 17 years as a CNA.</p> <p>LPN #9 was interviewed on 5/1/14 at 9:15 p.m. She indicated she had seen the bruising on Resident #B a few days after it was found when she assisted with a "soak" ordered to the area. She indicated it was not like anything she had ever seen before. It was not a routine type injury and could have been a sexual assault.</p>			

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--	---	--	---

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--	--

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	<p>CNA #10 was interviewed on 5/1/14 at 9:25 p.m. She indicated she had seen the bruised area on Resident #B on the weekend after it was found when she helped with a "soak" to the area. She indicated it was still extremely bruised and she had never seen anything like that before. She felt the resident could have "been taken advantage of".</p> <p>Restorative CNA #7 was interviewed on 5/2/14 at 2:30 p.m. She indicated she assisted Resident #B with toileting and dressing on the morning of 4/22/14 and she did not have any skin problems or bruising. She indicated she had seen the bruising on the morning of 4/23/14 after it was first found. She indicated she had never seen anything like that before in 6 years of CNA work. She felt it was possible the resident could have been sexually assaulted.</p> <p>The Assistant DoN was interviewed on 5/2/14 at 11:55 a.m. She indicated she had assisted the RN Consultant with measuring the resident's bruises on the morning of 4/23/14. She indicated she had seen lots of falls, skin tears, etc, but had not seen anything like this before. She indicated she could not rule out a "mistreatment concern". She indicated there was a gray/white discharge between the buttocks, but close to the anus.</p>			

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NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
--	--

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	<p>The Administrator was interviewed on 5/4/14 at 3:20 p.m. She indicated the police had been called between 4:45 p.m. and 5 p.m. on 4/23/14 related to the bruising found on Resident #B at 4:20 a.m. She indicated they had arrived at the building sometime between 6:15 and 6:30 p.m. This indicated a time period of over 12 hours from the time the bruising was found until the police were contacted.</p> <p>Police Investigator #2 was interviewed on 5/2/14 at 10:20 a.m. She indicated she had been very upset by the delay in contacting the police department related to the extensive bruising found on Resident #B on the morning of 4/23/14. She indicated in her 11 years investigating sex abuse cases, she had never seen bruising as extensive as Resident #B's. She indicated the bruising extended all the way from the pubic bone down into the labia. When asked if nursing staff should have felt there was "reasonable suspicion of a crime", she indicated "yes".</p> <p>When asked if the collection method for the brief, clothing, and bed linens was acceptable, she indicated "no". She indicated they had all been bagged together and then left to sit for 12 hours</p>			

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--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
--	--

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	<p>prior to the police being contacted. She indicated this would make them much more difficult to use as evidence if needed.</p> <p>She further indicated she was "7th in line" to interview the resident regarding the bruises and any possible assault due to the delay in being notified of the event. She indicated the bruising was extensive enough for reasonable suspicion of a crime and they (law enforcement) should have been called right away.</p> <p>The clinical record for Resident #B was reviewed on 5/1/14 at 9:35 a.m. Diagnoses for the resident included, but were not limited to, cerebral insufficiency, encephalopathy secondary to cerebral hypoxia, atypical psychosis with anxiety and dementia, and organic mood disorder. The clinical record indicated the resident was independently ambulatory and was able to dress and toilet herself.</p> <p>This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 4/23/14 when the facility staff failed to identify a reasonable suspicion of a crime resulting in a delay in police notification and failed to conduct a thorough facility investigation following the incident. The</p>			

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--	---	--	---

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	<p>Administrator, Director of Nursing, and RN Consultant were present when informed of the immediate jeopardy on 5/2/14 at 12:45 p.m.</p> <p>The Immediate Jeopardy was removed on 5/2/14 at 4 p.m., when through interviews with licensed staff, CNAs and other staff members they were able to identify the procedure to be followed in the event they felt a situation had occurred that involved reasonable suspicion of a crime and/or any other type of resident abuse situation, inservice data and attendance records were provided and reviewed related to the training the staff had received, and the DoN and Administrator were interviewed regarding the need to complete a thorough investigation following incidents as identified in their training above.</p> <p>Even though the facility's corrective action removed the Immediate Jeopardy, the facility remained out of compliance at a reduced scope and severity level of isolated no actual harm with potential for more than minimal harm that is not immediate jeopardy because the additional training completed will need to be monitored, the effectiveness of the facilities staff inservices with need to be evaluated, and auditing of new facility practices will need to be completed.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2014
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NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
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	<p>2. Review of a staff reported allegation of concern, dated 4/8/14, written by CNA #12 at the request of the Administrator after a verbal report was made to her, included, but was not limited to, the following:</p> <p>"[Name of LPN #13] is rude to residents. She told [name of Resident #B] that she could not lay down. That she needed to stay up for exercise group because her pants were getting too tight. She also told [name of Resident #B] not to put her PJ's [pajamas] on and if she did she would be the one putting them back on and it is not gonna be nice...."</p> <p>The investigation material indicated that the Administrator talked to 4 residents on the unit about staff treatment. The investigation material included an interview with one housekeeper who works on that unit. The investigative packet contained one interview completed by the Administrator with LPN #13. It did not contain any information about the specific allegation made by CNA #12. It discussed how a persons "tone" could be hurtful or taken out of context. It discussed the need to keep a "mother voice" at home and not at work.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/07/2014	
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	<p>The investigative packed contained no written statement from LPN #13 in regards to the allegations made by CNA #12 related to possible mistreatment to Resident #C.</p> <p>LPN #13 was interviewed on 5/7/14 at 10:45 a.m. She indicated no one had discussed any concerns with her related to her possibly being unkind or inappropriate with Resident #B.</p> <p>The Administrator was interviewed on 5/7/14 at 11:30 a.m. She indicated she had talked to LPN #13 about tone of voice and perception. She indicated she did not take any written statement from her. The Administrator indicated she had not discussed the specific allegation issues reported by CNA #12 when she talked to LPN #13. She indicated she had not reported the allegation to the ISDH.</p> <p>3. Review of the current facility policy, dated 9/11, provided by the RN Consultant on 5/2/14 at 1:45 p.m., titled "Reporting a Reasonable Suspicion of a Crime Against a Resident", included, but was not limited to, the following:</p> <p>"Policy This facility shall implement the following procedures to ensure</p>						

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	<p>compliance with section 1150(B) of the Affordable Care Act.</p> <p>...II. Coordination with Local Law Enforcement This facility shall coordinate with local law enforcement regarding reporting and determination of crime. The facility shall be responsible to contact a local law enforcement entity (county sheriff, local police or Town Marshal) and determine necessary contact information and identify the process for reporting suspicion of crimes....</p> <p>IV. Steps for Reporting The ISDH incident report form shall be made available to covered individuals and 'may' be used by the individual, however, the individual can choose to report by using another form of reporting , at their discretion. The ISDH incident report form shall be used by this facility to report unusual occurrences and/or report a suspected crime, should the incident meet the definition of both the reporter of the unusual occurrence also be a covered individual.</p> <p>In the event that caused the reasonable suspicion resulted in serious bodily injury, the report will be made immediately after forming the suspicion, but not later than two hours after forming</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2014
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F000226 SS=L	<p>the suspicion...." A sheet attached to the policy contained the Fax and phone number for the ISDH and the lo 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 observation, record review, and interview, the facility failed to ensure facility policy was implemented and the staff identified reasonable suspicion of a crime related to significant injuries found on a resident's pelvic and vaginal areas and failed to promptly notify the investigative and/or police authorities in a timely manner resulting in a delay in the resident being sent to the emergency room for a "Sexual Assault Nurse Exam" and a delay in the police investigation for 1 of 3 residents reviewed for self reported incidents. In addition, the facility failed to implement facility policy and complete and thorough investigation of the injury of unknown origin. This deficient practice had the potential to effect 37 of 37 residents residing in the facility. (Resident #B)</p> <p>This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 4/23/14 when the</p>	F000226	<p>1a. Resident B was immediately assessed, Administrator, MD and POA were notified, and a complete and thorough investigation was completed. The police was contacted for any additional follow up that may have been needed. ISDH, Ombudsman, and APS were updated. 2a. All other residents have the potential to be affected. The facility reviewed all records of injury of unknown origin during the previous 30 days in an effort to verify any other injury of unknown origin had been identified with appropriate notification and investigation conducted, and necessary corrective action taken, if warranted. 3a. As a means to ensure ongoing compliance with ensuring staff identify reasonable suspicion of a crime related to significant injuries and promptly notify the investigative and/or police authorities in a timely manner, the following corrective actions were taken: the facility's policy for</p>	05/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2014
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	<p>facility staff failed to identify a reasonable suspicion of a crime resulting in a delay in police notification and failed to conduct a thorough facility investigation following the incident. The Administrator, Director of Nursing, and RN Consultant were present when informed of the immediate jeopardy on 5/2/14 at 12:45 p.m. The Immediate Jeopardy was removed on 5/5/14 at 4 p.m., but the facility remained out of compliance at the level of isolated no actual harm with potential for more than minimal harm that is not immediate jeopardy because the additional training completed needed to be monitored, the effectiveness of the facilities staff inservices needed to be evaluated, and auditing of new facility practices needed to be completed.</p> <p>Findings include:</p> <p>During an observation on 5/2/14 at 9:55 a.m., conducted with LPN #11, Resident #B was lying in her bed on her back. Privacy was provided. Permission was requested to observe bruised areas on the resident's abdomen and pelvic area. The resident gave permission. Her shirt was pulled up slightly and her pants were lowered. A irregular bruise with various colors of healing was noted on the resident's outer left groin area. Bruising</p>		<p>Reporting Unusual Occurrences and Elder Justice (i.e., suspicion of a crime) has been reviewed and no changes are indicated at this time. The Administrator, DON, and ADON have been re-educated on the policies with a special focus on identifying, investigating, and reporting reasonable suspicions of a crime in a timely manner. As a preventative, the facility staff has also been re-educated on the Elder Justice Act with a special focus on timely notification. An Injuries of Unknown Origin form has been implemented in an effort to confirm ongoing compliance with identification, investigation and subsequent action, if warranted. 4a, As a means of quality assurance, the Administrator or designee will review all incident reports daily on scheduled work days to ensure any unusual occurrences are identified, investigated, and reported per guidelines and the Injuries of Unknown Origin form will be completed on an ongoing basis. Should a concern be identified, immediate corrective action will occur. The results of these reviews and any corrective actions taken will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, if indicated. 1b. The allegation lodged by CNA #12 has been fully investigated and reported to ISDH. LPN #13 provided a written statement to</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/07/2014
NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302		
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	<p>remained on the resident's pelvic bone in a pyramid like shape that widened the further it went down into the lower pelvis and pubic area. This bruise also appeared to be in various stages of healing. Her labia majora remained dark in color, but did not appear to be swollen at this time.</p> <p>Review of facility reportable incident form identified as the "Follow-up Report", dated 4/28/14, included, but was not limited to the following information:</p> <p>The report indicated Resident #B was a female who was able to ambulate independently and dress and toilet herself. The report was completed related to injuries of unknown origin found on Resident #B during a routine skin assessment completed on 4/23/14 at 4:20 a.m.</p> <p>The bruises noted on the resident were described as follows:</p> <p>a. Bruise to pubic bone: 23.5 cm [centimeters] by 13 cm. b. Bruise to left lower groin/left lower abdominal quadrant: 6.1 cm by 7.5 cm. c. Bruise to left lower buttocks: 1.9 cm by 1.6 cm d. Bruise to right inner thigh: 1.5 cm by 1.5 cm. e. Bruise to back of left forearm: 9.8 cm</p>		<p>thefacility Administrator. 2b. In an effort to identify any otherallegations/concerns voiced to ensure appropriate investigation/reporting, administrat ion reviewed with the Nurse Consultant any such record ofallegation/concern received during the last 30 days. 3b. In an effort to ensure ongoing compliance withthe appropriate reporting and conducting of thorough investigation of anyallegation of abuse as per facility policy, the Administrator, DON andDepartment Heads have been re-educated as to immediate reporting of anyallegation of abuse and initiation of thorough investigation. An investigationtemplate has been provided to outline critical steps in the investigationprocess, including but not limited to, obtaining statements and retainingdocumented proof of any investigation and follow up action. Additionally, theAdministrator shall be responsible to review any allegation of abuse andsubsequent actions taken with the assigned Regional Director/designee or NurseConsultant/designee as they are received in an effort to confirm appropriateimmediate action was taken, as well as appropriate steps initiated to conduct athorough investigation. 4b As a means of quality assurance, all records ofinvestigation of allegations of</p>		

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	<p>by 4.5 cm.</p> <p>f. Bruise to back of right forearm: 3.5 cm by 2.1 cm</p> <p>g. Bruise to left lower abdominal quadrant next to hip area: 1 cm by 2.5 cm.</p> <p>The report indicated the resident's husband [who lived out of state] was contacted and he did not want her sent to the hospital for an evaluation. The report indicated the physician was contacted and wanted to honor the husband's wishes.</p> <p>The report indicated the resident was unable to state how the injuries occurred. The report indicated she denied falling or bumping into anything and denied any aggression by another individual. The report indicated the resident's demeanor was not different from her normal.</p> <p>The report indicated the resident had been assisted with dressing by a restorative CNA on 4/22/14 at 6 a.m. and no bruising had been noted to Resident #B at that time.</p> <p>The report indicated staff, other residents, and a lab technician were interviewed as part of the investigation. The report indicated the secured unit [where the resident lived] was checked to ensure no hazards were present. The windows and</p>		<p>abuse shall be again reviewed with the Quality Assurance Committee on an ongoing basis and discussed during the facility's quarterly meetings as a basis to confirm continued compliance with the ongoing continued investigation of alleged abuse with appropriate investigation and corrective actions, as warranted. Willow Bend Living Center is requesting an Independent Informal Dispute Review for the Investigation of Complaints IN00148167, IN00148353, and IN00148561. The IIDR Rationale and supporting attachments will be loaded to the Gateway system. A few documents (with pre-existing shading) were unable to be lightened sufficiently. Thus, should paper copies be requested, please contact the facility and copies will be delivered to ISDH accordingly.</p>		

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	<p>outside doors on the unit were also checked to ensure the windows were intact and the doors remained locked and alarmed with no issues noted.</p> <p>The report indicated the resident's physician and husband were updated. [no timeline provided] The husband was re-approached regarding sending the resident to the ER [emergency room] for an evaluation which he continued to refuse. "He indicated he thinks she fell or ran in to something. He doesn't think she experienced any aggression by another individual, because had she been approached, he indicated she would have made noise and someone would have heard it." The report did not indicate if the resident's husband had been made aware of the extent and location of the bruising.</p> <p>The report indicated "Due to the bruising and inability to definitively determine a cause, the [name of county] Sheriff's Department was contacted and arrived at the facility. [No timeline was provided] Deputy #1 reviewed the information and contacted Investigator #2. The Investigator arrived at the facility and reviewed the information. The report indicated "the Deputy and Investigator concurred the facility had completed a thorough investigation". However, as the</p>			

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--	--

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	<p>facility could not definitely determine how the bruising occurred, they determined it appropriate to take Resident #B to the ER for further evaluation. The physician was undated and a message was left for the husband. The DoN and Administrator accompanied the resident to the ER.</p> <p>A statement related to the bruising found on Resident #B, dated 4/23/14, written by LPN #3 [the skin assessment nurse], indicated the following:</p> <p>"At 4:20 a.m., I went into [name of Resident #B] room to do her weekly skin assessment. Resident's door was shut and resident was in bed sleeping aroused easily. I asked resident if it was OK that I did her weekly skin assessment and she said, 'Yes'. Resident had PJ [pajama] bottoms on and a PJ top. I ask [sic] resident if I could lift her shirt to assess her abdomen and there were no red areas noted. Then I asked resident if I could assess below her waist which meant she would have to lower her PJ pants she immediately grabbed a hold of her waistband and held her hand on it. This was unusual for this resident from doing her skin assessments in the past she would lower her pants and not hold onto them. I asked resident, 'Is something wrong, are you OK?' Resident did not</p>			

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NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
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	<p>answer me as she shrugged her shoulders. I asked resident is it ok to lower your pants so I can assess the rest of you skin? Resident said yes and shook her head yes also. I observed a bluish purplish bruise to left lower groin area and a very large bruise on her pubic bone that extended down her labia majora and labia minora all the way down to her vaginal opening. The bruising on her pubic bone is dark purple mainly dark purple with also bluish in color and the bruising that extends downward to labia major and labia minor is dark purple. Observed purple bruising inside of the vagina. Also noted a bruise that resembles a finger print on the resident's inner right thigh and the same size bruise that resembles a finger print on the back of the resident's left upper leg/buttocks area. Resident had facial grimacing when assessing areas as if areas were tender. Asked resident 'Are you in pain, do you have discomfort?' Resident stated, 'No', and shook her head no. Resident has no bruising noted on 4/15/14 during her weekly skin assessment.</p> <p>"I asked resident if she would like to have a prn [as needed] pain medication due to the facial grimacing and the areas being tender. Resident stated, 'No.' I also noted a bruise on the back of the resident's left forearm noted bluish in</p>			

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NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302			
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	<p>color and a faded light brown bruise to bask side of resident's right forearm. I asked resident, 'What happened, How did you get these bruises?' Resident stated, 'I don't know, I don't know.' She shrugged her shoulders.</p> <p>"I heard [name of QMA #4] in the hallway she is the staff member working on the unit at this time so I asked her to come into the room and [name of CNA #5] was with QMA #4. She was relieving her for a break and had been on the unit this shift. Both staff members stated they had not observed any of the bruises before seeing it now for the first time. Both staff members were shocked when seeing these bruises at this time.</p> <p>"I measured all of the bruises with permission of the resident. See skin sheets for measurements.</p> <p>"I immediately contacted [name of DoN] reported all of the bruises with measurements and that there was also bruising at the vaginal opening. I reported the resident's unusual behavior of her holding her pants at her waist at the start of the skin assessment. DoN stated 'I am not coming in today you will need to call [name of Administrator]'. DoN wanted statements from all staff members at the facility.</p>						

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	<p>"I called [name of Administrator] reported all of the bruising to her and the same above information that I reported to the DoN. I also reported it to charge Nurse [name of LPN #6] who was working this shift. She also assessed bruising and stated she had not seen before now. [Name of Administrator] had asked that resident be placed on 10 minutes checks and she would be coming into facility</p> <p>"I did call [name of Administrator] again because myself and [LPN #6] remembered when we had our inservice with the [name of county] Police Department regarding The Elder Justice Act. We were told that it's not our job to decide if it is a crime. It's our job to report a crime and the police will decide if its a crime. I asked [DoN] if [LPN #6] or myself needed to go ahead and call [name of county] Police Department. She stated 'No I am on my way in to take care of this.'</p> <p>"[Name of DoN] called the facility back to let us know that another resident on the unit needed to have 1:1 [one to one observations] with a staff member sitting right with him. I was that staff member who was going to be giving this other resident 1:1 [observation] which I did per</p>			

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	<p>DoN's request.</p> <p>"[Name of Administrator] arrived at the facility requested I write out a statement, skin sheets for all the bruises and a 'picture of the body to mark areas on there'. All of which I did and gave to [Administrator name].</p> <p>"[Name of Administrator] did go to resident's room to talk to her and is handling this situation." (This statement ended with the signature of LPN #3 and the date of 4/23/14.)</p> <p>Review of a statement, signed by the Administrator, dated 4/23/14, titled "Reportable" included, but was not limited to the following:</p> <p>"Administrator arrived at facility 5:50 a.m. I spoke with [name of Restorative CNA #7] in regards to bruising on [Resident #B] and how was her demeanor during adl [activities of daily living] care. Asked her to please document in a full statement. I then went to [name of unit where Resident #B resides] to interview [name of Resident #B] at approximately 6 A. After interview, with [name of resident] I called medical director [name of doctor] approx. 6:30 A and informed him of unusual bruising and location. At this time he informed me to call her</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2014
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NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
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	<p>husband [POA] and report injuries and did he wish to have her sent to ER for exam and he stated no. Spoke with [name of husband] approx at 6:45 A. I did explain bruising and location and my conversation with [name of resident]. He again did not want her sent out. I called [name of Nurse Practitioner for Medical Director] per his [Medical Director] request to up-date her. [Name of Nurse Practitioner] was updated at 7:34 A when she returned call. Voicemail left at 6:50 A. I called husband again left voicemail for him to call me. [Name of husband] did return a second call at 8:55 A. We talked about his wishes.... I let him know about exam from nurse consultant and ADoN. [Name of Nurse Consultant] did note discharge near rectal area and spoke with husband. [Name of husband] stated he would like to have this mucus cultured. He said yes to culture, but again no to sending her to ER....</p> <p>"Nurse Consultant and ADoN did exam at 7:45 A. Res. [resident] did wish to get up and dressed. She was dressed by Administrator and ADoN. All residents linens and brief were bagged and stored approp. [appropriately?]...."</p> <p>Review of a written statement, dated 4/23/14 at 8:45 a.m., signed by the RN Consultant included, but was not limited</p>			

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	<p>to, the following:</p> <p>"Assessed the bruised areas and remeasured with measurements placed on skin sheets. Spoke with [name of resident] regarding the areas. She indicated she didn't know what happened. Does not recall being injured in any way. Res did not shy away from the assessment. Didn't guard area. No c/o [complaints of] pain. Noted thick cream colored mucus between buttock. No odor, redness, or edema noted. No c/o related to rectal area...."</p> <p>Review of a "Timeline" sheet, dated 4/23/14, initialed by the Administrator, included, but was not limited to, the following:</p> <p>"Around 7:45 p, Res met with police and investigator. We explained to her about going to hosp [hospital] for exam and investigation.... 8:30 p We left for hosp...."</p> <p>The Administrator and DoN were interviewed on 5/1/14 at 10:30 a.m. They indicated the bruises on Resident #B were found during a routine exam by the Skin Assessment Nurse on 4/23/24 at approximately 4 a.m. They indicated the husband was asked twice about sending her to the emergency room for an</p>			

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	<p>evaluation and he refused. They indicated the resident was eventually sent to the emergency room after the police were contacted and insisted she had to be evaluated. They indicated she was taken to the hospital and pictures, exam, and tests were completed as part of the hospital sexual assault protocol. They indicated the exam kit had been sent to the police lab for testing by the hospital and it could be months before the results were known. They indicated the resident was treated prophylactically with Flagyl (an antibiotic often used for vaginal infections) and another oral antibiotic.</p> <p>During an interview with Resident #B's husband on 5/6/14 at 1:27 p.m., he indicated the following:</p> <p>He was called by the Administrator around 6:30 a.m. on 4/23/14. He was informed that, during a routine skin assessment, the facility had found some bruising they were concerned about due to the location of the bruising. The administrator asked him if he wanted the resident sent out for a "rape test". She described the location, but not the sizes, of the bruises. He was not informed of the bruises on her forearms. He asked if the resident could have run into a table, etc. He indicated the Administrator told him she would be talking to the resident</p>			

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	<p>and the facility would be doing their own investigation. He indicated it was left up to his discretion as to whether he wanted her sent to the ER or not. He indicated he did not want to put her through this if it wasn't necessary, so he did not tell them to send her to the hospital for an exam. He indicated it had seemed to be purely at his discretion. He indicated if he had any idea the physician and, later in the day, the Nurse Practitioner had wanted the resident to go to the hospital, he absolutely would have agreed to the ER evaluation and rape exam.</p> <p>Review of the emergency department SANE [sexual assault nurse examination] Documentation Record, provided by hospital nursing staff, RN #8, on 5/1/14 at 4:10 p.m., included, but was not limited to, the following:</p> <p>"...Patient History...On 4/23/14 at appx [approximately] 0500, a wound nurse doing her weekly skin assessment noted injury to [name of Resident #B] genital area. She made staff aware including the director of nursing. An internal investigation at the ECF [extended care facility] began including interviews and a social consult. [Name of Administrator] present at bedside, stated that they were told no abuse was suspected and to take no action. On further investigation by</p>			

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	<p>[name of Investigator #2] it was deemed further examination was necessary. [Name of Resident #B] is unable to give a health history, and can not recollect an assault. Injury noted on exam....</p> <p>...Post Sexual Assault Hygiene Activity:</p> <p>Urinated - yes checked ...Genital wash/wipe - yes checked ... Drank or rinsed mouth - yes checked ... Eaten - yes checked</p> <p>...Patient dress during assault: given to law enforcement</p> <p>...General Physical Exam</p> <p>...2. Collect outer and underclothing if indicated: Not indicated was checked and the statement "Already given to law enforcement"</p> <p>3. Conduct a physical examination. "Findings" was checked.</p> <p>4. Collect dried and moist secretions, stains, and foreign materials from the body. Scan the entire body with an alterative light source (ALS). "Findings" was checked.</p> <p>5. Collect fingernails scrapings or cuttings according to local policy...."</p>			

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--	---	--	---

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	<p>This was checked as completed.</p> <p>The report also included a anatomical diagram indicating where findings were observed. The findings were numbered and a description and some measurements were noted. The form indicated the following findings:</p> <ol style="list-style-type: none"> 1. A discolored and tender area on the left lower pelvic area which measured 4 inches and indicated "see pictures". 2. A discolored and tender area located on the pubic bone area that measured 6 inches by 5 inches and indicated "see pictures." 3. A discolored and tender area located on the right inner forearm with measured 3 cm and indicated to "see photos." 4. A discolored and tender area on the left inner forearm that measured 2.5 cm and indicated "see photos". 5. A discolored and tender area on the right inner forearm that measured 2 cm and indicated "see photos". <p>The report also included a "Genital Examination" record for females with anatomical diagrams of the vaginal opening, labia majora, labia minora,</p>			

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	<p>clitoral area, and perineal area. The report indicated there was tenderness and redness of the following areas: labia majora, both sides of the vaginal area, the perineal area and an area between the anus and buttocks. The exam indicated to "see photos".</p> <p>The "Genital Examination" record additional information which included, but was not limited to, the following:</p> <ol style="list-style-type: none"> 1. Examine the inner thighs, external genitalia, and perineal area. Check the box(es) if there are assault related findings: [Boxes were checked for inner thighs/perineum, labia majora, and clitoris/surrounding area] 2. Collect dried and moist secretions, stains, and foreign materials. Scan the area with an alterative light source (ALS). [The box for 'findings' was checked.] ...4 Examine the vagina and cervix. Check the box(es) if there are assault related findings. [The box for 'vagina' was checked,] ...8. Examine the buttocks, anus, and rectum (if indicated by history)... Check box(es) if there are assault related 			

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	<p>findings: [The box for 'buttocks anal verge/folds/rugae' was checked.]</p> <p>9. Collect dried and moist secretions, stains, and foreign materials. [The box for 'findings' was checked.]"</p> <p>The report was signed by a hospital RN.</p> <p>Review of a employee list, provided by the Administrator on 5/1/14 at 1:00 p.m., indicated 5 males were employed by the facility. An LPN, CNA, cook, Maintenance staff, and dietary staff.</p> <p>The facility investigation packet provided by the Administrator, related to the bruising on Resident #B found on 4/23/14, was reviewed on 5/1/14 at 10:40 a.m. The packet contained many staff statements, skin assessments, and event timelines. The packet lacked any statements and/or interview information from male staff members employed by the facility.</p> <p>The Administrator, DoN, and RN Consultant were interviewed on 5/2/14 at 11:45 a.m. They indicated no male employees had been interviewed or required to give statements in regards to the investigation completed for the injuries of unknown origin found on</p>			

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	<p>Resident #B on 4/23/14.</p> <p>When queried why they had not contacted the police immediately after the injuries were found since the injuries were extensive and were located almost exclusively in sexual areas, they all indicated they had not seen her injuries as a possible assault due to her demeanor and inability to state how she had been injured. They indicated she had later been seen near males on her unit and had not "shied away". They indicated they put Resident #C on 1 to 1 observation as a precaution. They indicated the windows, doors, and alarms were checked as a preventative measure.</p> <p>The Administrator and Don indicated they had collected the residents brief, sheets, and clothing and had bagged it all together in one large trash bag on the morning of 4/23/14. When queried why the resident's clothing and linens had been bagged if they had not felt a possible crime had occurred, the DoN indicated it was done due to the "unknown factor". She "just did everything she could think of" because she had been a party to this type of investigation at another facility. She indicated she had not arrived at the facility until around 8:30 a.m. on 4/23/14.</p>			

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--	---	--	---

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	<p>When the DoN and Administrator were queried if they had any special training on how to collect possible forensic evidence, they indicated they had not.</p> <p>When queried if they had any police or special training on how to interview a possible sexual assault victim, they all indicated they had not.</p> <p>LPN #3 was interviewed on 5/1/14 at 10:55 a.m. She indicated she was doing the skin assessment on the morning of 4/23/14 when the bruising on Resident #B was found. She indicated it was unlike anything she had ever seen before. She indicated there were bruises on both forearms. The right was possible old bruising, but the left was newer bruising that was lighter blue with darker areas of blue in them that could be finger print areas. She indicated the rest of the bruising was highly concentrated in the resident's pelvic and vaginal region. She indicated she remembered a police officer talking to the staff about the "Elder Justice Act" and had concerns that maybe the police should be called. She indicated she and LPN #6 discussed this concern and looked for the "Elder Justice Act" books on the unit. She indicated they were unable to find them and she called the Administrator back to see if she wanted her or LPN #6 to call the</p>			

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	<p>police. She indicated she was told "No, don't call" by the Administrator who indicated she was getting dressed and would be coming in to take care of it. She indicated the Administrator arrived a short while later and went in to see the resident. She indicated she went home and slept for awhile. She indicated she called the facility around 4 p.m. just to see what the police said and find out if they (the police) needed to talk to her since she was the staff member who found the bruises. She indicated she was told the police had never been called. She indicated she was very upset by this because that is what she thought the Administrator was going to do when she came in to the facility. LPN #3 indicated she told them she wanted the police called. She indicated she followed up a short while later and found out the facility had contacted the police sometime around 6 p.m.</p> <p>LPN #6 was interviewed on 5/1/14 at 8:40 p.m. She indicated she was the Charge Nurse in the facility on the morning the bruises were discovered on Resident #B. She indicated she had not seen Resident #B that morning until she was called to the unit by LPN #3 because a QMA had been covering that unit while she was on the other unit. She indicated Resident #B's bruising was not like</p>			

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	<p>anything she had ever seen before. The whole vaginal area was dark. The bruising was highly contained in that area. She felt it was possible that the resident had been assaulted and she would have preferred to call the police, but they were told not to and administrative staff were coming in to handle it.</p> <p>CNA #5 was interviewed on 5/1/14 at 8:40 p.m. She indicated she had seen the bruises on Resident #B on the morning of 4/23/14 and had "never seen anything like that" in her 17 years as a CNA.</p> <p>LPN #9 was interviewed on 5/1/14 at 9:15 p.m. She indicated she had seen the bruising on Resident #B a few days after it was found when she assisted with a "soak" ordered to the area. She indicated it was not like anything she had ever seen before. It was not a routine type injury and could have been a sexual assault.</p> <p>CNA #10 was interviewed on 5/1/14 at 9:25 p.m. She indicated she had seen the bruised area on Resident #B on the weekend after it was found when she helped with a "soak" to the area. She indicated it was still extremely bruised and she had never seen anything like that before. She felt the resident could have "been taken advantage of".</p>			

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	<p>Restorative CNA #7 was interviewed on 5/2/14 at 2:30 p.m. She indicated she assisted Resident #B with toileting and dressing on the morning of 4/22/14 and she did not have any skin problems or bruising. She indicated she had seen the bruising on the morning of 4/23/14 after it was first found. She indicated she had never seen anything like that before in 6 years of CNA work. She felt it was possible the resident could have been sexually assaulted.</p> <p>The Assistant DoN was interviewed on 5/2/14 at 11:55 a.m. She indicated she had assisted the RN Consultant with measuring the resident's bruises on the morning of 4/23/14. She indicated she had seen lots of falls, skin tears, etc, but had not seen anything like this before. She indicated she could not rule out a "mistreatment concern". She indicated there was a gray/white discharge between the buttocks, but close to the anus.</p> <p>The Administrator was interviewed on 5/4/14 at 3:20 p.m. She indicated the police had been called between 4:45 p.m. and 5 p.m. on 4/23/14 related to the bruising found on Resident #B at 4:20 a.m. She indicated they had arrived at the building sometime between 6:15 and 6:30 p.m. This indicated a time period of</p>			

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	<p>over 12 hours from the time the bruising was found until the police were contacted.</p> <p>Police Investigator #2 was interviewed on 5/2/14 at 10:20 a.m. She indicated she had been very upset by the delay in contacting the police department related to the extensive bruising found on Resident #B on the morning of 4/23/14. She indicated in her 11 years investigating sex abuse cases, she had never seen bruising as extensive as Resident #B's. She indicated the bruising extended all the way from the pubic bone down into the labia. When asked if nursing staff should have felt there was "reasonable suspicion of a crime", she indicated "yes".</p> <p>When asked if the collection method for the brief, clothing, and bed linens was acceptable, she indicated "no". She indicated they had all been bagged together and then left to sit for 12 hours prior to the police being contacted. She indicated this would make them much more difficult to use as evidence if needed.</p> <p>She further indicated she was "7th in line" to interview the resident regarding the bruises and any possible assault due to the delay in being notified of the event.</p>			

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	<p>She indicated the bruising was extensive enough for reasonable suspicion of a crime and they (law enforcement) should have been called right away.</p> <p>The clinical record for Resident #B was reviewed on 5/1/14 at 9:35 a.m. Diagnoses for the resident included, but were not limited to, cerebral insufficiency, encephalopathy secondary to cerebral hypoxia, atypical psychosis with anxiety and dementia, and organic mood disorder. The clinical record indicated the resident was independently ambulatory and was able to dress and toilet herself.</p> <p>This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 4/23/14 when the facility staff failed to identify a reasonable suspicion of a crime resulting in a delay in police notification and failed to conduct a thorough facility investigation following the incident. The Administrator, Director of Nursing, and RN Consultant were present when informed of the immediate jeopardy on 5/2/14 at 12:45 p.m.</p> <p>The Immediate Jeopardy was removed on 5/2/14 at 4 p.m., when through interviews with licensed staff, CNAs and other staff members they were able to identify the</p>			

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NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
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	<p>procedure to be followed in the event they felt a situation had occurred that involved reasonable suspicion of a crime and/or any other type of resident abuse situation, inservice data and attendance records were provided and reviewed related to the training the staff had received, and the DoN and Administrator were interviewed regarding the need to complete a thorough investigation following incidents as identified in their training above.</p> <p>Even though the facility's corrective action removed the Immediate Jeopardy, the facility remained out of compliance at a reduced scope and severity level of isolated no actual harm with potential for more than minimal harm that is not immediate jeopardy because the additional training completed will need to be monitored, the effectiveness of the facilities staff inservices with need to be evaluated, and auditing of new facility practices will need to be completed.</p> <p>2. Review of a staff reported allegation of concern, dated 4/8/14, written by CNA #12 at the request of the Administrator after a verbal report was made to her, included, but was not limited to, the following:</p> <p>"[Name of LPN #13] is rude to residents.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2014
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	<p>She told [name of Resident #B] that she could not lay down. That she needed to stay up for exercise group because her pants were getting too tight. She also told [name of Resident #B] not to put her PJ's [pajamas] on and if she did she would be the one putting them back on and it is not gonna be nice...."</p> <p>The investigation material indicated that the Administrator talked to 4 residents on the unit about staff treatment. The investigation material included an interview with one housekeeper who works on that unit. The investigative packet contained one interview completed by the Administrator with LPN #13. It did not contain any information about the specific allegation made by CNA #12. It discussed how a persons "tone" could be hurtful or taken out of context. It discussed the need to keep a "mother voice" at home and not at work.</p> <p>The investigative packed contained no written statement from LPN #13 in regards to the allegations made by CNA #12 related to possible mistreatment to Resident #C.</p> <p>LPN #13 was interviewed on 5/7/14 at 10:45 a.m. She indicated no one had discussed any concerns with her related</p>			

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	<p>to her possibly being unkind or inappropriate with Resident #B.</p> <p>The Administrator was interviewed on 5/7/14 at 11:30 a.m. She indicated she had talked to LPN #13 about tone of voice and perception. She indicated she did not take any written statement from her. The Administrator indicated she had not discussed the specific allegation issues reported by CNA #12 when she talked to LPN #13. She indicated she had not reported the allegation to the ISDH.</p> <p>3. Review of the current facility policy, dated 9/11, provided by the RN Consultant on 5/2/14 at 1:45 p.m., titled "Reporting a Reasonable Suspicion of a Crime Against a Resident", included, but was not limited to, the following:</p> <p>"Policy This facility shall implement the following procedures to ensure compliance with section 1150(B) of the Affordable Care Act.</p> <p>...II. Coordination with Local Law Enforcement This facility shall coordinate with local law enforcement regarding reporting and determination of crime. The facility shall be responsible to contact a local law</p>			

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F000250 SS=D	<p>enforcement entity (county sheriff, local police or Town Marshal) and determine necessary contact information and identify the process for reporting suspicion of crimes....</p> <p>IV. Steps for Reporting The ISDH incident report form shall be made available to covered individuals and 'may' be used by the individual, however, the individual can choose to report by using another form of reporting , at their discretion. The ISDH incident report form shall be used by this facility to report unusual occurrences and/or report a suspected crime, should the incident meet the definition of both the reporter of the unusual occurrence also be a covered individual.</p> <p>In the event that caused the reasonable suspicion resulted in serious bodily injury, the report will be made immediately after forming the suspicion, but not later than two hours after forming the suspicion...." A sheet attached to the 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure a resident's</p>	F000250	Resident C was interviewed and indicated he did not have a plan to commit suicide. The resident	05/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2014
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NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
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	<p>psychological reports were reviewed for follow-up and failed to immediately implement a protective plan when a resident expressed suicide ideations for 1 of 1 resident reviewed with suicide ideations in a sample of 11. (Resident #C)</p> <p>Findings include:</p> <p>The clinical record for Resident #C was reviewed on 5/2/14 at 10:40 a.m. Diagnoses for the resident included, but were not limited to, Alzheimer's dementia, and psychotic disorder.</p> <p>An initial Minimum Data Set assessment, dated 2/18/14, indicated the resident had problems with cognitive impairment and was able to ambulate independently with supervision.</p> <p>A "Medical Progress Note", dated 4/3/14, completed by one of the facility's psych services provider, indicated Resident #C had been seen on that date. The note indicated the resident was on Seroquel (an antipsychotic medication) but continued to have some somatic (relating to the body) delusions "talking about being cut in half and the doctor taking his bones away".</p> <p>The note indicated "...The patient started</p>		<p>was transferred to a behavioral unit to be evaluated and treated. All other residents have the potential to be affected. Psychological reports for the previous 90 days have been reviewed and follow up completed if indicated. The residents have been reviewed and no other resident has expressed suicidal ideation. As a means to ensure ongoing compliance with ensuring a resident's psychological reports are reviewed for follow up and a protective plan immediately implemented when a resident expresses suicidal ideations, the SSD has been re-educated on reviewing the psychological reports upon receipt to ensure follow up is completed if indicated. The facility's policy for suicidal ideation has been reviewed and no changes are indicated at this time. The staff has been re-educated on the policy with a special focus on immediately notifying Administrator, DON, and Social Services to ensure a protective plan can be implemented if indicated. As a means of quality assurance, a Suicidal Ideation Monitoring form and a Psych Note Follow up form have been initiated. Social Service employee or designee will be responsible for completing the Suicidal Ideation Monitoring form daily x 2 weeks, weekly x 2 weeks, monthly x 2 months then quarterly thereafter on an ongoing basis.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/07/2014	
NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302			
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	<p>the interview talking about another resident who recently lost her husband, and he wanted to become a better acquaintance with her, but she did not seem to want that. When I asked him about his wife, he kept talking about her [the other resident] and it was difficult to redirect him to another subject, despite several attempts..."</p> <p>The facility social service and /or nursing notes lacked any information related to the resident being monitored for possibly approaching another resident for a possible acquaintance who did not seem to interested.</p> <p>The Social Services Designee was interviewed on 5/2/14 at 12:30 p.m. She indicated she had not interviewed the staff on Resident #C's unit regarding the information in the report. She indicated she had not discussed the matter with [name of Consultant BSW] regarding the information in the report.</p> <p>A "Mood and Behavior Communication Memo", dated 4/23/14 at 10:30 p.m., included, but was not limited to, the following:</p> <p>"[Name of Resident #C] came out of his room walking up to the nurses station stating he wished he could crawl in a hole</p>		<p>Social Service employee or designee will also complete the Psych Note Follow up form on a weekly basis on an ongoing basis. Should concerns be identified with these reviews, immediate re-education/corrective action will be completed. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, if indicated.</p>				

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	<p>and just die... he also said that he didn't mean to hurt or harm anyone said he wish he had a gun so he could die... he then got up and went to his room still talking about dying and that he didn't mean any harm to anyone...."</p> <p>The memo indicated he was allowed to vent his feelings, one to one time provided to resident, and given redirection. The form was completed by CNA #5.</p> <p>The clinical record lacked any nursing note entries for Resident #C dated 4/23/14.</p> <p>A social services progress note, dated 4/24/14 at 10:30 a.m., indicated the Social Services Designee had spoken to the resident regarding his statements of wanting to die "made by res the night prior". A social services progress note, dated 4/24/14 at 4:45 p.m., indicated the resident was being sent out to the "psych unit" for evaluation and possible medication adjustment.</p> <p>The Administrator was interviewed on 5/7/14 at 1:40 p.m. She indicated she had not been called on the night of 4/23/14 nor told of the resident's negative and/or suicidal statements of wanting to die.</p>			

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	<p>The DoN was interviewed on 5/7/14 at 1:50 p.m.. She indicated she had not been called on the night of 4/23/14 nor notified of the resident's negative and/or suicidal statements of wanting to die.</p> <p>Review of the current facility policy, revised August 2010, provided by the RN Consultant on 5/2/14 at 1:45 p.m., titled "Suicide Precautions", included, but was not limited to, the following:</p> <p>"Policy The facility will monitor the safety of any resident exhibiting suicidal tendencies.</p> <p>Procedures: When a resident verbalizes the intent to or demonstrates an attempt at suicide, the following procedures are recommended:</p> <p>...6. If a resident has been assessed and determined to have a cognitive impairment and/or organic disease which contributes to the resident's thought process and verbalizations of intent to do personal harm... a Suicide/behavior program will be developed in conjunction with social services and nursing to ensure this residents safety and provide appropriate behavioral interventions....</p> <p>7. If the Social Services department is</p>			

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NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
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F000504 SS=D	<p>not in the building, the Director/designee will be notified of any verbalization of intent or demonstration of attempt at suicide of any resident...."</p> <p>This federal tag relates to Complaints IN00148167, IN00148353, and IN00148561.</p> <p>3.1-34(a)</p> <p>483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. Based on record review and interview, the facility failed to ensure laboratory specimens were not collected without the order of a physician for 1 of 1 resident reviewed for collection of a mucus like discharge following an injury of unknown origin in a sample of 11. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 5/1/14 at 9:35 a.m. Diagnoses for the resident included, but were not limited to, cerebral insufficiency, encephalopathy secondary</p>	F000504	Resident B did not experience any negative outcomes related to the alleged deficient practice. The clinical record has been reviewed and the MD and POA have been updated. All other residents have the potential to be affected. The clinical records of all residents have been reviewed to ensure compliance with collection of specimens only per the order of a physician. The facility's policy for Physician's Orders has been reviewed and no changes are indicated at this time. As a means to ensure ongoing compliance with ensuring laboratory specimens are not collected without the order of a physician, the licensed nurses	05/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/07/2014
NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302		
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	<p>to cerebral hypoxia, atypical psychosis with anxiety and dementia, and organic mood disorder.</p> <p>The clinical record indicated the resident was independently ambulatory and was able to dress and toilet herself.</p> <p>Review of facility reportable incident form identified as the "Follow-up Report", dated 4/28/14, included, but was not limited to the following information:</p> <p>The report indicated Resident #B was a female who was able to ambulate independently and dress and toilet herself. The report was completed related to injuries of unknown origin found on Resident #B during a routine skin assessment completed on 4/23/14 at 4:20 a.m.</p> <p>The bruises noted on the resident were described as follows:</p> <p>a. Bruise to pubic bone: 23.5 cm [centimeters] by 13 cm. b. Bruise to left lower groin/left lower abdominal quadrant: 6.1 cm by 7.5 cm. c. Bruise to left lower buttocks: 1.9 cm by 1.6 cm d. Bruise to right inner thigh: 1.5 cm by 1.5 cm. e. Bruise to back of left forearm: 9.8 cm</p>		<p>have been re-educated on the policy with a special focus on obtaining MD orders prior to labs/cultures being completed. A Lab Monitoring form has been implemented in an effort to confirm physician's order is present for any labs drawn and/or specimens collected. As a means of quality assurance, the DON or designee will be responsible to complete the Lab Monitoring form daily on scheduled work days on an ongoing basis. Should concerns be identified, immediate corrective action will occur. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted, if indicated.</p>		

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NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302		
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	<p>by 4.5 cm.</p> <p>f. Bruise to back of right forearm: 3.5 cm by 2.1 cm</p> <p>g. Bruise to left lower abdominal quadrant next to hip area: 1 cm by 2.5 cm.</p> <p>Review of a written statement, dated 4/23/14 at 8:45 a.m., signed by the RN Consultant included, but was not limited to, the following:</p> <p>"Assessed the bruised areas and remeasured with measurements placed on skin sheets. Spoke with [name of resident] regarding the areas. She indicated she didn't know what happened. Does not recall being injured in any way. Res did not shy away from the assessment. Didn't guard area. No c/o [complaints of] pain. Noted thick cream colored mucus between buttock. No odor, redness, or edema noted. No c/o related to rectal area...."</p> <p>A physician's order, dated 4/23/14 at 10 a.m., indicated an order had been received to "Cx [culture] peri-area discharge." The nursing notes lacked any information related to the physician having been contacted for this order.</p> <p>The DoN was interviewed on 5/4/14 at 3:40 p.m. She reviewed the physician's</p>				

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NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
--	--

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	<p>order for the culture of the peri-area discharge for Resident #B. She indicated the nurse writing the order was the ADoN. She indicated the ADoN had called the physician for the order.</p> <p>During an interview with the Medical Director on 5/4/14 at 12:20 p.m., he indicated he was not called on 4/23/14 around 10 a.m. for above noted discharge. He indicated he would have been unavailable at that time as he was taking a certification exam.</p> <p>During an interview with the ADoN on 5/7/14 at 12:30 p.m., she indicated she was aware the RN Consultant had noted a discharge on Resident #B on 4/23/14. She indicated staff (she could not remember who) had told her they had collected the discharge and it needed to be sent to the lab. She indicated she was making the computer entries to notify the lab of the need to pick up the culture when she discovered there was no order written. She indicated she went ahead and wrote the order, but she had not talked with physician and/or received the order from the physician at the time the specimen had been collected. She indicated she wrote the order for the specimen to be cultured without knowing what other tests the physician might have wanted.</p>			

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NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
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F000514 SS=D	<p>This federal tag relates to Complaints IN00148167, IN00148353, and IN00148561.</p> <p>3.1-49(f)(1)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure resident records were complete and accurately documented for 2 of 4 residents reviewed for complete and accurate clinical record documentation in a sample of 11. (Resident #B and #C)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #C was reviewed on 5/2/14 at 10:40 a.m. Diagnoses for the resident included, but</p>	F000514	Residents #B and #C experienced no negative outcomes from the alleged deficient practice. The clinical records have been reviewed and late entries made to ensure the records are complete and accurate. All other residents have the potential to be affected. The clinical records have been reviewed to ensure they are complete and accurate. Late entries have been made, if indicated. The facility's policy for nursing documentation has been reviewed and no changes are indicated at this time. As a means	05/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2014
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	<p>were not limited to, Alzheimer's dementia, and psychotic disorder.</p> <p>A "Mood and Behavior Communication Memo" [used to notify Social Services of resident behaviors and is not part of the resident's clinical record], dated 4/23/14 at 10:30 p.m., included, but was not limited to, the following:</p> <p>"[Name of Resident #C] came out of his room walking up to the nurses station stating he wished he could crawl in a whole and just die... he also said that he didn't mean to hurt or harm anyone said he wish he had a gun so he could die... he then got up and went to his room still taking about dying and that he didn't mean any harm to anyone...."</p> <p>The memo indicated he was allowed to vent his feelings, one to one time provided to resident, and given redirection. The form was completed by CNA #5.</p> <p>The clinical record lacked any nursing note entries for Resident #C dated 4/23/14.</p> <p>2. The clinical record for Resident #B was reviewed on 5/1/14 at 9:35 a.m. Diagnoses for the resident included, but were not limited to, cerebral</p>		<p>to ensure ongoing compliance to ensure resident records are complete and accurately documented, the licensed nurses have been re-educated on the policy with a special focus on complete and accurate documentation (i.e., entries made at the time of observation). A 24 Hour Report/Nurses Notes Review form has been implemented to monitor compliance following aforementioned inservice training. As a means of quality assurance, the DON or designee will be responsible for completing the 24 Hour Report/Nurses Notes Review form daily on scheduled work days on an ongoing basis to ensure records are complete and accurate, with appropriate entries made at the time of observation and/or appropriate late entry. Should concerns be identified, immediate corrective action will occur. Results of these reviews and any corrective actions taken will be discussed during the facility's quarterly QA meeting and the plan adjusted accordingly, as indicated</p>	

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	<p>insufficiency, encephalopathy secondary to cerebral hypoxia, atypical psychosis with anxiety and dementia, and organic mood disorder.</p> <p>A nursing note entry written by the DoN, dated 4/23/14 at 4:30 a.m., indicated "It was reported to this nurse that while during weekly skin assessment there was bruising noted in resident's peri and rectal area. See skin sheets. MD [medical doctor] notified and POA [power of attorney]. No new orders at this time. POA declined for resident to be send out for eval [evaluation] and treat [treatment].</p> <p>The nursing notes lacked any entries from the nurse who did the skin assessment and reported her concerns to the DoN.</p> <p>LPN #3 was interviewed on 5/1/14 at 10:55 a.m., She indicated she was the skin assessment nurse who found the extensive buises on Resident #B on/or around 4:20 a.m. on 4/23/14. She indicated she asked LPN #6 (who was the charge nurse covering Resident #B's unit that night) to come and check the resident with her due to the extent and location of the bruising. She indicated LPN #6 did observe the resident with her and they were both very concerned over what</p>				

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	<p>might have happened to the resident. They had been standing at the nursing station together during one of the conversations with the DoN. She indicated the DoN told her (LPN #3) to fill out her skin assessment sheets, but not to chart anything else in the clinical record because she was coming in and would handle it.</p> <p>LPN #6 was interviewed on 5/1/14 at 8 p.m.. She indicated the information provided by LPN #3 above was accurate. She indicated she did not chart anything for that shift because the DoN had instructed them not to chart anything in the clinical record.</p> <p>The DoN was interviewed on 5/7/14 at 12:10 p.m. She indicated she had not arrived at the facility until around 8:15 on the morning of 4/23/14. She indicated she should have charted the 4/23/14 4:30 a.m. entry information as a "late entry". She indicated she did not know why the two nurses involved in finding the bruises had not charted in the clinical record. When asked if she had talked to the MD and/or POA that morning as identified in the 4:30 a.m. nursing note, she indicated she had not. She indicated that had been done by the Administrator and she charted for her since the Administrator was not a nurse and does</p>			

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	<p>not chart in the clinical record. She indicated she had no first hand knowledge of what was said during the Administrator's conversations with the MD and POA.</p> <p>The Medical Director (and personal physician of Resident #B) was interviewed on 5/4/14 at 12:20 p.m., he indicated he had been contacted around 6 to 6:30 a.m. on 4/23/14 and told about the bruising found on Resident #B that morning. He indicated he was on his way to a certification examination and told the facility the resident should go out to the emergency room, but he knew they were going to contact her husband. He indicated he also called his Nurse Practitioner (NP) so she could follow-up with the facility since he was going to be unavailable.</p> <p>The NP for the medical director was interviewed on 5/5/14 at 2:50 p.m. She indicated she did contact the facility sometime that morning around 7:30 a.m. as requested by the Medical Director. She indicated she told them the resident needed to be sent to the ER. She told them they should send some one with her to keep her comfortable. She indicated the facility wanted her to do an exam on the resident, but she refused. She stated she would not want to contaminate any</p>			

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	<p>possible observations or evidence. She indicated she called the facility back again later in the day and was surprised they still had not sent the resident to the ER, but they told her they had been in frequent contact with [name of medical director] and she felt she should then let him handle it.</p> <p>The clinical record lacked any timely entries, made by the person who had the conversations with the Medical Director and Nurse Practitioner. The clinical record lacked any information related to the Medical Director and Nurse Practitioner indicating the resident should be sent to the hospital. The clinical record lacked any information related to the facility asking the NP to do an exam on the resident and her refusing to do so related to possible contamination of evidence.</p> <p>During an interview with Resident #B's husband on 5/6/14 at 1:27 p.m., he indicated the following:</p> <p>He was called by the Administrator around 6:30 a.m. on 4/23/14. He was informed that during a routine skin assessment the facility had found some bruising they were concerned about due to the location of the bruising. The administrator asked him if he wanted the</p>			

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	<p>resident sent out for a "rape test". She described the location, but not the sizes, of the bruises. He was not informed of the bruises on her forearms. He asked if the resident could have run into a table, etc. He indicated the Administrator told him she would be talking to the resident and the facility would be doing their own investigation. He indicated it was left up to his discretion as to whether he wanted her sent to the ER or not. He indicated he did not want to put her through this if it wasn't necessary, so he did not tell them to send her to the hospital for an exam. He indicated it had seemed to be purely at his discretion. He indicated if he had any idea the physician and, later in the day, the Nurse Practitioner had wanted the resident to go to the hospital, he absolutely would have agreed to the ER evaluation and rape exam.</p> <p>The next nursing note entry for Resident #B, dated 4/23/14 at 10 a.m., indicated "Mucus noted (thick cream color not odor noted) at anal area. New order to obtain culture. Culture done and lab notified to come pick up. POA aware". This nursing note was signed by the DoN.</p> <p>A physician's order, dated 4/23/14 at 10 a.m., indicated an order had been received to "Cx [culture] peri-area</p>			

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	<p>discharge." The nursing notes lacked any information related to the physician having been contacted for this order.</p> <p>The DoN was interviewed on 5/4/14 at 3:40 p.m. She reviewed the physician's order for the culture of the peri-area discharge for Resident #B. She indicated the nurse writing the order was the ADoN. She indicated the ADoN had called the physician for the order.</p> <p>During an interview with the Medical Director on 5/4/14 at 12:20 p.m., he indicated he was not called on 4/23/14 around 10 a.m. for above noted discharge. He indicated he would have been unavailable at that time as he was taking a certification exam.</p> <p>During an interview with the ADoN on 5/7/14 at 12:30 p.m., she indicated she was aware the RN Consultant had noted a discharge on Resident #B on 4/23/14. She indicated staff (she could not remember who) had told her they had collected the discharge and it needed to be sent to the lab. She indicated she was making the computer entries to notify the lab of the need to pick up the culture when she discovered there was no order written. She indicated she went ahead and wrote the order, but she had not talked with physician and/or received the</p>			

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	<p>order from the physician at the time the specimen had been collected.</p> <p>This federal tag relates to Complaints IN00148167, IN00148353, and IN00148561.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			