

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155294	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/25/2012
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NAME OF PROVIDER OR SUPPLIER FORUM AT THE CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240
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F0000	<p>This visit was for the Investigation of Complaints IN00101647 and IN00102956.</p> <p>Complaint IN00101647 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00102956 - Substantiated. Federal/State deficiency related to the allegation is cited at F223.</p> <p>Survey dates: January 24, 25, 2012</p> <p>Facility number: 000191 Provider number: 155294 AIM number: 100267690</p> <p>Survey team: Charles Stevenson RN</p> <p>Census bed type: SNF: 64 Residential: 27 Total: 91</p> <p>Census payor type: Medicare: 38 Other: 53 Total: 91</p>	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Sample: 3</p> <p>This deficiency also reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 1/27/12 by Suzanne Williams, RN</p>			
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F0223 SS=G	<p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure residents were protected from staff abuse (Resident B, verbal and physical abuse resulting in anxiety and pain, and Resident C, physical abuse resulting in facial cuts and bruising and bodily bruising) for 2 of 2 residents reviewed for allegations of abuse in a sample of 3.</p> <p>Findings include:</p> <p>1. The record of Resident B was reviewed on 1/25/12 at 10:45 a.m.</p> <p>Diagnoses included, but were not limited to, atrial fibrillation, hypertension, congestive heart failure, and hypothyroidism.</p> <p>An admission Minimum Data Set assessment dated 1/09/12 had no communication deficits, no behavioral concerns, did not ambulate, and required staff assistance for all activities of daily living.</p>	F0223	<p>Responses to the finding does not constitute an admission or agreement by the facility of the truth of the alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.</p> <p>In response to the cited findings R/T to F223, the following:</p> <p>A) With respect to what corrective action will be accomplished for those residents found to have been affected by the deficient practice: <i>A FU care plan meeting was held on 2/2/12 with Resident B and daughter. No further allegations/concerns re; care or caregivers since initial allegation of 1/28/12. Next scheduled care plan on 2/10/12. Continues to reside in</i></p>	02/24/2012			

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	<p>A "Mini-Mental State Exam", a test to assess a resident's level of cognition, indicated Resident B scored 28 of 30 possible points, and was noted to be alert.</p> <p>A facility document headed "Investigation/ (name of Resident B) RE: Allegations of mistreatment/abuse on 1/21/12" and signed as completed by the Administrator indicated:</p> <p>"FU (follow up) interview with (Resident B) at approximately 7 pm, 1/22/12:...Per interview, resident stated she put on her call light for assistance to the bathroom. CNA (CNA #1) answered the call light, and then it got bad from there. Stated (CNA #1) was rough with her, causing her to hit her L (left) hip on the arm of the WC (wheel chair). Stated (CNA #1) was mad, and 'she took it out on me.' When asked why she felt this incident happened, resident stated she felt like she was moving too slow for (CNA #1) (during the pivot transfer) so (CNA #1) just grabbed her pants and pushed her on around and into the chair, causing her to strike her hip on the WC."</p> <p>A facility document headed "Statement" dated 1/24/12, signed as completed by LPN #2 (Nursing Unit Manager) and witnessed by the Administrator indicated:</p>		<p><i>facility.</i></p> <p><i>Resident C continues to reside in facility.</i></p> <p><i>No further concerns voiced by spouse re: care or caregivers.</i></p> <p>B) With respect to how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: <i>All resident have the potential to be affected by the same deficient practice. To reduce the risk of recurrence, all residents will be interviewed during routine care plan meetings re: any perception of mistreatment by Forum staff. All allegations will be investigated per policy.</i></p> <p>C) With respect to what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: 1) <i>All licensed and unlicensed nursing staff have been inserviced regarding Abuse/Residents Rights by DON/ADON/Social</i></p>		

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	<p>"Per interview, at approx (approximately) 2:30 p, CNAs (4) gathered at nsg (nursing) station, pulled their CNA nursing assignment sheets, discussing specific assignments. (CNA #1) upset because of her assignment, raising her voice, angry...Later... CNA came to nsg station and informed nurse that resident in (Resident B's room) wanted to speak (symbol for "with") her...went to room...as requested...Resident stated she did not want (CNA#1) back in her room. Nurse asked why and resident stated 'she hurt me'. Resident further stated that (CNA #1) had been in a 'yelling altercation' with someone in the hallway...Resident stated when (CNA #1) transferred her to the W/C she was angry...so (CNA #1) grabbed hold of back of pants, swung her around, hitting L hip on W/C arm...completes skin assessment...Resident stated her pain was at a level '5'...'it hurts a little bit'...Took employee to nursing office, informed of allegation...Told employee she was suspended pending investigation. Employee jumped up, angry, stated 'If (CNA #3) would have answered her call light this would never have happened.' Employee refused to take a copy or sign disciplinary forms..."</p> <p>A facility document headed (Name of Resident B) Follow Up Investigation,</p>		<p><i>Services. In-service dates: 1/29/12 – 2/10/12.</i></p> <p><i>2) A mandatory all-staff inservice is scheduled for 2/19/12 to review the Abuse policy with a specific focus on accountability for personal actions in relations to resident care.</i></p> <p>D) With respect to how the corrective action will be monitored to ensure the deficient practice will not recur:</p> <p><i>1) Plan of Correction will be reviewed and monitored by the inter-disciplinary team at Continuous Quality Improvement meetings held bi-monthly and quarterly.</i></p> <p><i>2) Resident will be interviewed at routinely scheduled care plan meetings re: any concerns with care. Any allegations of mistreatment will be investigated promptly per policy.</i></p> <p>E) Date of compliance with proposed actions: February 24, 2012</p>		

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	<p>dated 1/23/12 at 3:15 p.m. and signed as completed by the Social Worker indicated:</p> <p>"Writer following-up on abuse allegation regarding a CNA providing care for her this past Saturday 1/21/12...She stated the following...</p> <p>In short, this staff member was out of control. She was angry about something else and I was at the wrong place at the wrong time...she looked out of control...Having an anger like that is a terrible burden...</p> <p>Writer asked (Resident B) if she preferred not to have this accused CNA care for her again and she decided that she would prefer she not provide her care again..."</p> <p>A nurse's note dated 1/21/12 at 4:00 p.m., completed by LPN #2, Nursing Unit Manager, indicated "400 hall aides were (symbol for "at") 400 back Station looking at assignments (symbol for "and") (CNA #3) said so I'm on the 4th assignment...and walked away. She came back and said...I'm doing the 4th assignment and that's it. A few min (minutes) later she came to the desk and was loud about the fact that (CNA #3) was on the 3rd then she should have answered the light in (Resident B's room)</p>			
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	<p>but she had to do it and it was gonna come back on her. I asked her why she was so upset and yelling at everyone and she started to yell and (LPN #2) told her to stop now and she walked away..."</p> <p>Resident B was interviewed on 1/25/12 at 1:15 p.m. in private. She was alert and oriented and logical and insightful. She indicated she remembered the incident with CNA #1 of 1/21/12 clearly and didn't mind discussing it.</p> <p>She indicated she first was aware of CNA #1 when she was still in the hallway "yelling about something to somebody else." She indicated that when CNA #1 came into her room, the CNA turned to the open door and continued to yell at someone. She then closed the door, and Resident B indicated the CNA continued to yell at the closed door. She indicated she was not sure if the CNA was cursing or not as she was hard to understand. Resident B indicated CNA #1 then came to assist her with transfer to her wheel chair, and in doing this, grabbed her pants, swung her around, and dropped her, causing her left hip to land on the arm of her wheel chair. She indicated she was "totally surprised" by being treated in this "rough" manner.</p> <p>Resident B also indicated there had been a</p>			
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	<p>previous incident of rough treatment by CNA #1. She indicated she was being transferred into bed, she was sitting on the edge of the bed, and CNA #1 grabbed under her legs, lifted them, and "spun her around" and "dropped her" into bed. She could not recall the exact date of this incident, but indicated she had reported it to one of the nursing staff.</p> <p>The Administrator was interviewed on 1/25/12 at 1:30 p.m. She indicated she was aware of the earlier incident with Resident B and CNA #1. She indicated that the incident had been investigated, and a care plan conference was held with Resident B and her family present. Resident B indicated she and CNA #1 had talked, that they were in agreement, and asked the facility not to take any further action. The Administrator indicated that since Resident B made her own decisions, and no harm had occurred, the incident was resolved.</p> <p>LPN #3, the Nursing Unit Manager, was interviewed on 1/25/12 at 3:45 p.m. She indicated that the documentation provided for review was the complete and accurate representation of events related to the allegation of abuse of Resident B by CNA #1. She indicated she had nothing further to offer.</p>						

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	<p>During an interview with the Director of Nursing on 1/25/12 at 4:00 p.m., she indicated CNA #1 had been immediately suspended and escorted from the building following the incident, that she had not returned to work, and that final action on her employment status was pending.</p> <p>2. The record of Resident C was reviewed on 1/25/12 at 2:00 p.m.</p> <p>Diagnoses included, but were not limited to, vascular dementia, depression, coronary artery disease, cerebrovascular disease, and orthostatic hypotension.</p> <p>A facility "Incident Report Form" dated 12/05/11 indicated:</p> <p>"Resident Name: (resident C)</p> <p>Staff Involved: (CNA #4)</p> <p>Brief Description of Incident: On 12/5/11, at approximately 8:30 a Licensed nurse...reported to Administrator that CNA had noted injury (bruises/abrasions) to resident while ambulating to dining room for breakfast. Resident noted to have make-up on to cover bruises...Resident has significant cognitive impairment; unable to give details related to incident. Resident is totally dependent on staff for care/ADLs</p>			
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	<p>(activities of daily living).</p> <p>Type of Injury/Injuries: Bruise to left rib are noted to be 5.0 x 3.0 cm (centimeters), raised red/purple in color. Left axilla bruise 1.6 x 1.4 cm, raised red /purple in color, Right anterior rib area bruise 9.2 x 2.0 cm, deep red/purple, Right posterior rib bruise 1.6 x 1.0 cm, deep red/purple. Additional injuries: Left periorbital (surrounding the socket of the eye) area ecchymosis (bruising) measuring 4.2 x 2.0 cm, Left periorbital ecchymosis 4.2 x 4.0, Right facial abrasions (3) measuring 8.0 x 0.5 cm, 3.0 x 0.5 cm, 2.6 x 0.4 cm respectively.</p> <p>Immediate Action Taken: ...X-ray of Right ribs due to resident c/o of pain ordered...On 12/6/11, employee (CNA) came in for interview re: incident noted on 12/5/11. Admitted incident with resident involving fall. Not reported to nurse at time of incident. Admitted to covering injuries with makeup. Employee informed of policy and removed from the schedule..."</p> <p>A typed statement form CNA #4 addressed to the Administrator and dated 12/5/11 indicated: "This is my statement about the incident with (Resident C). I went to get him dressed about 5:30 in the morning. He is difficult...I was on the</p>				

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	<p>bathroom side of the bed facing the window with one knee on the bed and one hand trying to hold his hand away from me while I was washing his neck and face area when his hand got away from me and I lost balance and fell forward onto his face causing the skin tear on his temple area and possibly the marks on his face. I stopped the bleeding on his temple area...I was nervous because I had just fallen on a patient and was tired because of lack of sleep. I debated on whether I should get a nurse or not and decided against it which, was I realize was a mistake. I was more worried about what the situation looked like then the welfare of the resident...I made a judgement call that was not very good...My decision to not call the nurse was a bad decision and there should be consequences to that decision...I realize that I really had no reason not to let the nurse know, but the damage has already been done."</p> <p>During an interview with the Director of Nursing on 1/25/12 at 3:45 p.m. she indicated that CNA #4 had been suspended immediately at the time of the discovery of the incident, that she had not been allowed to return to work, and that following corporate Human Resources procedures she had been terminated.</p> <p>3. A facility policy titled "Abuse</p>			
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	<p>Prohibition and Prevention Program" dated 10/08/08 received from the Director of Nursing on 1/25/12 at 1:00 p.m. indicated "Purpose: It is the policy of this Community to: Maintain the rights of all residents to be free from abuse, neglect, and mistreatment...The Community will take appropriate steps to prevent neglect, mental, physical, or sexual abuse..."</p> <p>This federal tag relates to Complaint IN00102956.</p> <p>3.1-27(a)(1)</p>			
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