STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155789	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for the Investigation of Complaint IN00146881. Complaint IN00146881 -- Substantiated. Federal/State deficiency is cited at F282. Unrelated deficiencies are cited. Survey dates: April 7, 8 and 9, 2014. Facility number: 012523 Provider number: 155789 AIM number: 201027870 Survey team: Penny Marlatt, RN, TC Census bed type: SNF/NF: 37 Residential: 47 Total: 84 Census Payor type: Medicare: 21 Medicaid: 16 Other: 47 Total: 84 Sample: 3 Residential: 3 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on April 11, 2014 by Cheryl Fielden, RN.	F000000	This plan of correction is prepared and executed because it is required by the provision of the State and Federal law and not because RidgeWood Health Campus agrees with the allegations and citations. RidgeWood Health Campus maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. The plan of correction shall also operate as the facility's written credible allegation of compliance.	
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure the physician's orders were followed correctly for administration of breathing treatments for 1 of 3 residents reviewed for medications administered as ordered by the physician.(Resident #A) Findings include: Resident #A's clinical record was reviewed on 4-7-14 at 2:55 p.m. Her diagnoses included, but were not limited to, left lower lobe pneumonia, COPD (chronic obstructive pulmonary disease), coronary artery disease, high blood pressure and diabetes. The record indicated she had been admitted to the facility on 3-14-14 after a hospitalization for left lower lobe pneumonia with mechanical ventilation support. Review of Resident #A's physician orders indicated the admission orders included an order for Xopenex (a bronchodilator) 1.25 mg (milligram) per 3 ml (milliliter) solution to be administered every 4 hours via nebulizer machine in conjunction with Albuterol (a bronchodilator) 0.5 mg per 3 ml solution every 4 hours via nebulizer machine. Review of Resident #A's medical administration record (MAR) for March, 2014 indicated to administer the Xopenex and Atrovent in conjunction with one another every 4 hours, but listed the administration times as 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. Administration times did not	F000282	DHS/Designee immediately reviewed all current residents receiving breathing treatments for accuracy on medication administration record (MAR). Resident #1 no longer resides in campus. DHS/Designee will inservice nursing staff by May 8th, 2014 on following physician orders for breathing treatments and proper transcription of physician orders.DHS/Designee will review all new residents with breathing treatments for accuracy on MAR x 4 weeks. The results of the audit will be presented to the Quality Assurance Committee (QA) for recommendations. The need for ongoing audits will be determined by the QA committee.	05/08/2014

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	include 12:00 a.m., and 4:00 a.m. The MAR indicated these medications were administered at 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. from 3-14-14 at 4:00 p.m. until 3-25-14 at 8:00 p.m. An interview with the Director of Health Services (DHS) on 4-7-14 at 4:00 p.m., she indicated many times the physician will not order breathing treatments during the night hours in order to allow the resident to rest. She indicated she did not see any clarification orders to address this. The DHS provided a copy of a policy entitled, "Respiratory/Inhalation Treatment Guidelines" on 4-8-14 at 9:15 a.m. This policy indicated, "It is the policy of [name of corporation] to administer aerosol breathing treatments, as ordered by the physician, by a licensed nurse..." This Federal tag relates to Complaint IN00146881. 3.1-35(g)(2)			
R000000	The following residential findings were cited in accordance with 410 IAC 16.2-5.	R000000	This plan of correction is prepared and executed because it is required by the provision of the State and Federal law and not because RidgeWood Health Campus agrees with the allegations and citations. RidgeWood Health Campus maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. The plan of	

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			correction shall also operate as the facility's written credible allegation of compliance.	
R000052	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to ensure residents were free from physical abuse for 2 of 3 residents reviewed for abuse in a total sample of 3. (Resident #E and Resident #F) Findings include: 1. Resident #E's clinical record was reviewed on 4-9-14 at 9:15 a.m. His diagnoses included, but were not limited to, traumatic brain injury related to a fall, aggressive behaviors and dementia. The record indicated he was admitted to the facility on 7-25-13 from a geriatric psychiatric facility and had subsequent readmissions to the same geriatric psychiatric facility in August, 2013, January, 2014 and March, 2014 for aggressive behaviors. 2. Resident #F's clinical record was reviewed on 4-8-14 at 4:15 p.m. His diagnoses included, but were not limited to, dementia, diabetes, coronary artery disease (CAD), congestive heart failure (CHF), carotid stenosis and high blood pressure. In review of Resident #E and Resident #F's	R000052	Resident E had been transferred to St. Elizabeth hospital for evaluation and treatment on March 31st, 2014. As a result of a care conference with Resident E's family resident will be transferred from St. Elizabeth to another facility as per mutual agreement. Resident #F has not exhibited symptoms of abuse and continues with his normal activities of daily living. Staff members at the Legacy were immediately inserviced on Abuse and Neglect Procedure and responsiblity to report any allegations to Executive Director or Director of Nursing immediately. Campus administrative staff reviewed the Policy and Procedure for Abuse and Neglect and reporting guidlines. ED/Designee will inservice staff members at the Legacy by May 8th, 2014 on Abuse and Neglect Procedure and responsibility to report allegations. ED/Designee will inservice staff on signs and symptoms of caregiver burnout by	05/08/2014

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	nursing progress notes, it indicated on 2-18-14 at 10:30 a.m. in the common area near the dining room, Resident #E ran up to Resident #F with a box and attempted to place the box on Resident #F's head. Resident #F struck the box with his cane, resulting in the box striking Resident #E in the head. Resident #F then struck Resident #E in the right flank of the abdomen. Records indicated the residents were separated by staff; neither resident complained of pain, nor suffered any injury. Records indicated the physicians and family members of each resident, as well as the Executive Director (ED) and the Director of Health Services (DHS) were notified of the events. In review of Resident #E and Resident #F's nursing progress notes, records indicated on 2-20-14 at 11:45 a.m., Resident #E was witnessed getting up from the dining table, walk across the room and threw cole slaw onto Resident #F. Resident #E was then observed to return to his seat at the dining table "and began laughing about what he had done." Records indicated there was no apparent injury to Resident #F and the physicians and family members of each resident were notified. Records did not indicate the ED or DHS were notified of the event. However, records did indicate the Interdisciplinary Team (IDT) reviewed the incident on 2-21-14. Review of Resident #E and Resident #F's nursing progress notes indicated on 2-21-14 at 10:00 a.m., Resident #E was witnessed by staff to walk across the common area and kick the left side of Resident F's wheelchair. Resident #E was then witnessed by staff to laugh about the incident. Records indicated		May 8th, 2014. ED/Designee will specifically ask staff members working at the Legacy on varying shifts if there have been any questionable incidents of concern involving resident abuse x 4 weeks. Per company policy ED/Designee will report all required incidents to Indiana State Department of Health. The results of the audit will be presented to the Quality Assurance Committee for recommendations. The need for ongoing audits will be determined by the QA committee.	

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	Resident #E was removed from the area and from Resident #F. Records indicated the physicians and family members of each resident, as well as the Executive Director (ED) and the Director of Health Services (DHS) were notified of the event. Review of Resident #E and Resident #F's nursing progress notes indicated on 3-22-14 with the time indicated as evening shift of 2:00 p.m. to 10:00 p.m., Resident #E and #F "screamed and pushed each other," and Resident #E then struck the bill of Resident #F's hat in an aggressive manner. Records indicated the residents were separated by staff. Records did not indicate if there were any injuries to either resident. Records indicated the physicians and family members of each resident were notified. Records did not indicate the ED or DHS were notified of the event. In an interview with the ED on 4-9-14 at 11:00 a.m., she indicated LPN #1 had documented this event. She indicated LPN #1 did not report this event to the ED or DHS. She indicated LPN #1 had not worked at the facility since the event date. The ED indicated this event was noted by the facility upon review of the clinical record of Resident #E on 4-8-14. She indicated LPN #1 will be counseled regarding reporting of unusual occurrences as soon as the facility is able to get in contact with her. On 4-7-14 at 1:00 p.m., the ED provided a copy of a document entitled, "Resident Rights." This document indicated, All residents in long term care facilities have rights guaranteed to them under Federal and State law..." On 4-9-14 at 10:45 a.m., the ED provided a copy of a document entitled, "Abuse and			

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	Neglect Procedural Guidelines." She indicated this document was the current policy in place for abuse and abuse prohibition for the facility's long term care and assisted living areas. This document indicated, "[Name of corporation] has developed and implemented processes's, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect...PHYSICAL ABUSE - includes hitting, slapping, pinching, spitting, holding or handling roughly, etc. It also includes controlling behavior through corporal punishment. [This includes] resident to resident abuse with or without cause; staff to resident abuse with or without injury; other (visitor, relative) to resident abuse with or without injury."			
R000053	5.1-2(v)(2) 410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse. Based on interview and record review, the facility failed to ensure residents were free from verbal abuse for 2 of 3 residents reviewed for abuse. (Resident #E and Resident #F) Findings include: 1. Resident #E's clinical record was reviewed on 4-9-14 at 9:15 a.m. His diagnoses included, but were not limited to, traumatic brain injury related to a fall, aggressive behaviors and dementia. The record indicated he was admitted to the facility on 7-25-13 from a geriatric psychiatric facility and had subsequent readmissions to	R000053	Resident E had been transferred to St. Elizabeth hospital for evaluation and treatment on March 31st, 2014. As a result of a care conference with Resident E's family resident will be transferred from St. Elizabeth to another facility as per mutual agreement.(would add the same statement here as in R0052 about Resident F, so you can show he was addressed as well).Staff members at the Legacy were immediately inserviced on Abuse and Neglect Procedure and responsiblity to report any allegations to Executive Director or Director of Nursing	05/09/2014

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	the same geriatric psychiatric facility in August, 2013, January, 2014 and March, 2014 for aggressive behaviors. 2. Resident #F's clinical record was reviewed on 4-8-14 at 4:15 p.m. His diagnoses included, but were not limited to, dementia, diabetes, coronary artery disease (CAD), congestive heart failure (CHF), carotid stenosis and high blood pressure. Review of Resident #E and Resident #F's nursing progress notes, it indicated on 3-22-14 with the time indicated as evening shift of 2:00 p.m. to 10:00 p.m., Resident #E and #F "screamed and pushed each other," and Resident #E then struck the bill of Resident #F's hat in an aggressive manner. Records indicated the residents were separated by staff. Records did not indicate if there were any injuries to either resident. Records indicated the physicians and family members of each resident were notified. Records did not indicate the ED or DHS were notified of the event. In an interview with the ED on 4-9-14 at 11:00 a.m., she indicated LPN #1 had documented this event. She indicated LPN #1 did not report this event to the ED or DHS. She indicated LPN #1 had not worked at the facility since the event date. The ED indicated this event was noted by the facility upon review of the clinical record of Resident #E on 4-8-14. She indicated LPN #1 will be counseled regarding reporting of unusual occurrences as soon as the facility is able to get in contact with her. On 4-7-14 at 1:00 p.m., the ED provided a copy of a document entitled, "Resident Rights." This document indicated, All residents in long term care facilities have rights guaranteed to them under Federal and		immediately. (may want to add the date in here that the inservice was done) ED/Designee will inservice staff members at the Legacy by May 8th, 2014 on Abuse and Neglect Procedure and responsibility to report allegations. ED/Designee will inservice staff on signs and symptoms of caregiver burnout by May 8th, 2014.ED/Designee will specifically ask staff members working at the Legacy on varying shifts if there have been any questionable incidents of concern involving resident abuse x 4 weeks. Per company policy ED/Designee will report all required incidents to Indiana State Department of Health. The results of the audit will be presented to the Quality Assurance Committee for recommedations. The need for ongoing audits will be determined by the QA committee.	

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	State law..." On 4-9-14 at 10:45 a.m., the ED provided a copy of a document entitled, "Abuse and Neglect Procedural Guidelines." She indicated this document was the current policy in place for abuse and abuse prohibition for the facility's long term care and assisted living areas. This document indicated, "[Name of corporation] has developed and implemented processes's, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect...VERBAL ABUSE - may include oral, written or gestured language that includes disparaging and derogatory terms to the resident/patient or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability. [This includes] staff to resident - any episode; resident to resident verbal threats of harm." 5.1-2(w)			
R000090	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks;			

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	(B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on interview and record review, the facility failed to ensure unusual occurrences of physical or verbal abuse were reported to the Indiana State Department of Health (ISDH) within 24 hours of becoming aware of the unusual occurrences for 2 of 3 residents reviewed for abuse. (Resident #E and	R000090	Resident E had been transferred to St. Elizabeth hospital for evaluation and treatment on March 31st, 2014. As a result of a care conference with Resident E's family resident will be transferred from St. Elizabeth to another facility as per mutual agreement. Resident #F has not	05/08/2014

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	Resident #F) Findings include: 1. Resident #E's clinical record was reviewed on 4-9-14 at 9:15 a.m. His diagnoses included, but were not limited to, traumatic brain injury related to a fall, aggressive behaviors and dementia. The record indicated he was admitted to the facility on 7-25-13 from a geriatric psychiatric facility and had subsequent readmissions to the same geriatric psychiatric facility in August, 2013, January, 2014 and March, 2014 for aggressive behaviors. 2. Resident #F's clinical record was reviewed on 4-8-14 at 4:15 p.m. His diagnoses included, but were not limited to, dementia, diabetes, coronary artery disease (CAD), congestive heart failure (CHF), carotid stenosis and high blood pressure. In review of Resident #E and Resident #F's nursing progress notes, it indicated on 2-18-14 at 10:30 a.m. in the common area near the dining room, Resident #E ran up to Resident #F with a box and attempted to place the box on Resident #F's head. Resident #F struck the box with his cane, resulting in the box striking Resident #E in the head. Resident #F then struck Resident #E in the right flank of the abdomen. Records indicated the residents were separated by staff; neither resident complained of pain, nor suffered any injury. Records indicated the physicians and family members of each resident, as well as the Executive Director (ED) and the Director of Health Services (DHS) were notified of the events.		exhibited symptoms of abuse and continues with his normal activities of daily living. Staff members at the Legacy were immediately inserviced on Abuse and Neglect Procedure and responsiblity to report any allegations to Executive Director or Director of Nursing immediately. Campus administrative staff reviewed the Policy and Procedure for Abuse and Neglect and reporting guidlines. ED/Designee will inservice staff members at the Legacy by May 8th, 2014 on Abuse and Neglect Procedure and responsibility to report allegations. ED/Designee will inservice staff on signs and symptoms of caregiver burnout by May 8th, 2014. ED/Designee will specifically ask staff members working at the Legacy on varying shifts if there have been any questionable incidents of concern involving resident abuse x 4 weeks. Per company policy ED/Designee will report all required incidents to Indiana State Department of Health. The results of the audit will be presented to the Quality Assurance Committee for recommendations. The need for ongoing audits will be determined by the QA committee.	

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	In review of Resident #E and Resident #F's nursing progress notes, records indicated on 2-20-14 at 11:45 a.m., Resident #E was witnessed getting up from the dining table, walk across the room and threw cole slaw onto Resident #F. Resident #E was then observed to return to his seat at the dining table "and began laughing about what he had done." Records indicated there was no apparent injury to Resident #F and the physicians and family members of each resident were notified. Records did not indicate the ED or DHS were notified of the event. However, records did indicate the Interdisciplinary Team (IDT) reviewed the incident on 2-21-14. Review of Resident #E and Resident #F's nursing progress notes indicated on 2-21-14 at 10:00 a.m., Resident #E was witnessed by staff to walk across the common area and kick the left side of Resident F's wheelchair. Resident #E was then witnessed by staff to laugh about the incident. Records indicated Resident #E was removed from the area and from Resident #F. Records indicated the physicians and family members of each resident, as well as the Executive Director (ED) and the Director of Health Services (DHS) were notified of the event. Review of Resident #E and Resident #F's nursing progress notes indicated on 3-22-14 with the time indicated as evening shift of 2:00 p.m. to 10:00 p.m., Resident #E and #F "screamed and pushed each other," and Resident #E then struck the bill of Resident #F's hat in an aggressive manner. Records indicated the residents were separated by staff. Records did not indicate if there were any injuries to either resident. Records indicated the physicians and family members			

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NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 181 CAMPUS DR LAWRENCEBURG, IN 47025	

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	of each resident were notified. Records did not indicate the ED or DHS were notified of the event. In an interview with the ED on 4-9-14 at 11:00 a.m., she indicated LPN #1 had documented this event. She indicated LPN #1 did not report this event to the ED or DHS. She indicated LPN #1 had not worked at the facility since the event date. The ED indicated this event was noted by the facility upon review of the clinical record of Resident #E on 4-8-14. She indicated LPN #1 will be counseled regarding reporting of unusual occurrences as soon as the facility is able to get in contact with her. On 4-9-14 at 11:40 a.m., the ED provided a document which indicated the last Abuse/Abuse Prohibition training for LPN #1 was conducted on 3-12-13. In an interview with the ED on 4-9-14 at 11:00 a.m., she indicated the only Abuse/Abuse Prohibition inservices conducted by the facility in 2014 have been with employees hired in 2014. In an interview with the ED on 4-8-14 at 5:20 p.m., she indicated the incidents between Resident #E and Resident #F on 2-18-14, 2-20-14, 2-21-14 and 3-22-14 were not reported to ISDH. She indicated the primary reason these incidents were not reported to ISDH was these were viewed as behaviors between 2 residents residing on a dementia unit. She indicated she did not interpret the state reporting regulations related to unusual occurrences to include the type of behaviors these residents displayed. On 4-7-14 at 1:00 p.m., the ED provided a copy of a document entitled, "Resident Rights." This document indicated, "All residents in long term care facilities have rights guaranteed to them under Federal and			

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	State law..." On 4-9-14 at 10:45 a.m., the ED provided a copy of a document entitled, "Abuse and Neglect Procedural Guidelines." She indicated this document was the current policy in place for abuse and abuse prohibition for the facility's long term care and assisted living areas. This document indicated, "[Name of corporation] has developed and implemented processes's, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect...The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures...PHYSICAL ABUSE - includes hitting, slapping, pinching, spitting, holding or handling roughly, etc. It also includes controlling behavior through corporal punishment. [This includes] resident to resident abuse with or without cause; staff to resident abuse with or without injury; other (visitor, relative) to resident abuse with or without injury. VERBAL ABUSE - may include oral, written or gestured language that includes disparaging and derogatory terms to the resident/patient or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability. [This includes] staff to resident - any episode; resident to resident verbal threats of harm...Staff is required to report concerns, incidents and grievances immediately to your manager and/or Executive Director and Director of Health Services...Any person with knowledge or suspicion of suspected violations shall report immediately, without fear of reprisal...The Executive Director is responsible for notification to the State Department of Health			

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	(per State guidelines) and other agencies, which include the Ombudsman, Adult Protective Services and/or local law enforcement agencies, as indicated...Immediately and not more than 24 hours complete an initial report to applicable state agencies..."			
R000091	5.1-3(g)(1) 410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request.			
	Based on interview and record review, the facility failed to ensure policies were followed regarding unusual occurrences of physical or verbal abuse were reported to the Indiana State Department of Health (ISDH) within 24 hours of becoming aware of the unusual occurrences for 2 of 3 residents reviewed for abuse. (Resident #E and Resident #F) Findings include: 1. Resident #E's clinical record was reviewed on 4-9-14 at 9:15 a.m. His diagnoses included, but were not limited to, traumatic brain injury related to a fall, aggressive behaviors and dementia. The record indicated he was admitted to the facility on 7-25-13 from a geriatric psychiatric	R000091	Resident E had been transferred to St. Elizabeth hospital for evaluation and treatment on March 31st, 2014. As a result of a care conference with Resident E's family resident will be transferred from St. Elizabeth to another facility as per mutual agreement. Resident #F has not exhibited symptoms of abuse and continues with his normal activities of daily living. Staff members at the Legacy were immediately inserviced on Abuse and Neglect Procedure and responsiblity to report any allegations to Executive Director or Director of Nursing immediately. Campus administrative staff reviewed the	05/08/2014

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	facility and had subsequent readmissions to the same geriatric psychiatric facility in August, 2013, January, 2014 and March, 2014 for aggressive behaviors. 2. Resident #F's clinical record was reviewed on 4-8-14 at 4:15 p.m. His diagnoses included, but were not limited to, dementia, diabetes, coronary artery disease (CAD), congestive heart failure (CHF), carotid stenosis and high blood pressure. In review of Resident #E and Resident #F's nursing progress notes, it indicated on 2-18-14 at 10:30 a.m. in the common area near the dining room, Resident #E ran up to Resident #F with a box and attempted to place the box on Resident #F's head. Resident #F struck the box with his cane, resulting in the box striking Resident #E in the head. Resident #F then struck Resident #E in the right flank of the abdomen. Records indicated the residents were separated by staff; neither resident complained of pain, nor suffered any injury. Records indicated the physicians and family members of each resident, as well as the Executive Director (ED) and the Director of Health Services (DHS) were notified of the events. In review of Resident #E and Resident #F's nursing progress notes, records indicated on 2-20-14 at 11:45 a.m., Resident #E was witnessed getting up from the dining table, walk across the room and threw cole slaw onto Resident #F. Resident #E was then observed to return to his seat at the dining table "and began laughing about what he had done." Records indicated there was no apparent injury to Resident #F and the physicians and family members of each		Policy and Procedure for Abuse and Neglect and reporting guidlines. ED/Designee will inservice staff members at the Legacy by May 8th, 2014 on Abuse and Neglect Procedure and responsibility to report allegations. ED/Designee will inservice staff on signs and symptoms of caregiver burnout by May 8th, 2014. ED/Designee will specifically ask staff members working at the Legacy on varying shifts if there have been any questionable incidents of concern involving resident abuse x 4 weeks. Per company policy ED/Designee will report all required incidents to Indiana State Department of Health. The results of the audit will be presented to the Quality Assurance Committee for recommendations. The need for ongoing audits will be determined by the QA committee.	

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	which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect...The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures...PHYSICAL ABUSE - includes hitting, slapping, pinching, spitting, holding or handling roughly, etc. It also includes controlling behavior through corporal punishment. [This includes] resident to resident abuse with or without cause; staff to resident abuse with or without injury; other (visitor, relative) to resident abuse with or without injury. VERBAL ABUSE - may include oral, written or gestured language that includes disparaging and derogatory terms to the resident/patient or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability. [This includes] staff to resident - any episode; resident to resident verbal threats of harm...Staff is required to report concerns, incidents and grievances immediately to your manager and/or Executive Director and Director of Health Services...Any person with knowledge or suspicion of suspected violations shall report immediately, without fear of reprisal...The Executive Director is responsible for notification to the State Department of Health (per State guidelines) and other agencies, which include the Ombudsman, Adult Protective Services and/or local law enforcement agencies, as indicated...Immediately and not more than 24 hours complete an initial report to applicable state agencies..." 5.1-3(h)(2)			