

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155246	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/03/2014
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NAME OF PROVIDER OR SUPPLIER WATERS OF DUNELAND THE	STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR CHESTERTON, IN 46304
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F000000	<p>This visit was for the Investigation of Complaint IN00160170. This visit resulted in a Partially Extended Survey-Substandard Quality of Care.</p> <p>Complaint IN00160170- Substantiated. Federal/State deficiencies related to the allegations are cited at F225, F226, and F323.</p> <p>Survey dates: December 1, 2014 Extended survey dates: December 2 & 3, 2014</p> <p>Facility number: 000150 Provider number: 155246 AIM number: 100267000</p> <p>Survey team: Janet Adams, RN-TC</p> <p>Census bed type: SNF/NF: 88 Total: 88</p> <p>Census payor type: Medicare: 15 Medicaid: 63 Other: 10 Total: 88</p>	F000000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.	

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=F	<p>Sample: 4 Supplemental sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on December 10, 2014, by Janelyn Kulik, 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> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source</p>			

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	<p>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 record review and interview, the facility failed to ensure an allegation of inappropriate touching of one resident to another was investigated and reported to the Indiana State Department of Health timely for 1 of 3 residents reviewed for abuse in the sample of 4. This deficient practice had the potential to affect 88 of 88 residents residing in the facility. (Residents #D and #F)</p> <p>Findings include:</p> <p>1. The record for Resident #D was reviewed on 12/1/14 at 6:15 a.m. The 11/2014 Nursing Progress Notes were</p>	F000225	<p>IMMEDIATE ACTION(S) TAKEN FOR THE RESIDENT(S) FOUND TO HAVE AFFECTED INCLUDE: F225</p> <p>During the course of the survey the fact that an allegation of (inappropriate touching) occurred to Resident D by Resident F was discovered. This was in a progress note in the medical record of Resident F. Immediately upon acknowledgment of this note by the administrative staff that were present, a full investigation was initiated. After numerous interviews and statement gathering from Resident D, Resident D 's family and appropriate staff it was determined</p>	01/02/2015

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	<p>reviewed. An entry made on 11/25/14 at 4:32 a.m. indicated a CNA heard a noise in the resident's room and upon entering the room saw the resident's room mate (Resident #F) with his leg rest from his wheel chair over the resident. The CNA noted blood to the resident's face and arms and called for help. Nurse entered the room and observed blood to the face, arms, and hands, and lacerations and skin tears to the resident's arms and hands. The Physician was called at 12:30 a.m., 911 was called at 12:35 a.m. 911 arrived at 12:45 a.m. and was accompanied by a Police Officer. 911 left at 12:50 a.m. The next entry in the Nursing Progress Notes was made on 11/25/14 at 4:40 a.m. This entry indicated the hospital called to give report to the Nurse and the resident was to be transferred back to the facility via ambulance. The resident returned to the facility at 4:25 a.m. The resident's family was present and the resident was placed into bed. Sutures to the the left side of the mouth and the left orbital (area around the eye) areas were observed. Purple bruising was noted to the left side of the face and jaw. Multiple cuts were noted over the face. A dressing was in place to the right arm. The resident had some discomfort and was given something for the pain.</p> <p>Continued review of the 11/2014 Nursing</p>		<p>that what had happened was in fact a (witnessed by C N A) placing of his hand (Resident F's) onto the exposed midriff of Resident D. This occurred while Resident D was standing in a lift with his hands raised which exposed Resident D's midriff. The touch was not aggressive or sexual per witness. The investigation results were shared with the surveyors the Resident family and the Resident physician. There was no apparent harm from this occurrence. The administrator and DON were reeducated on the requirement of immediately reporting any such allegation of potential abuse as in this case when he (Administrator) was approached by the family of Resident D as to their question of (groping) as related to their Father. Further, of immediately initiating an investigation and taking appropriate action(s) based on the findings of the investigation including but not limited to further reporting to all appropriate parties, making sure all Residents are safe, obtaining and implementing any new needed orders and updating the plans of care of the Resident(s) affected.</p> <p>IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL OF BEING AFFECTED WAS ACCOMPLISHED BY :</p> <p>Residents who reside in the facility and could have come into contact with Resident F had the potential to be affected by this finding. All</p>	

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	<p>Progress Notes indicated there were no entries made on 11/24/14, 11/23/14, or 11/22/14. There was one entry made on 11/21/14 at 1:47 a.m. This entry indicated a treatment continued to the right lower extremity and the dressing in place was clean, dry, and intact. There were no entries made in 11/2014 related to any altercations or incidents of inappropriate touching occurring between the resident and his new room mate (Resident #F) on any days in November.</p> <p>When interviewed by telephone on 12/1/14 at 10:19 a.m., RN #2 indicated he had heard something from a staff member in the facility about Resident #F touching his roommate (Resident #D) inappropriately. The RN indicated he could not recall when he heard this information and stated he heard it in "passing". The RN indicated he was under the impression this was already documented because he did not observe it and it did not occur on his shift. The RN indicated he did not observe any documentation of the this in the resident's record. RN #2 indicated he did not report this to anyone.</p> <p>When interviewed on 12/1/14 at 11:05 a.m., the facility Administrator indicated he recalled speaking to a family member of Resident #D. The Administrator</p>		<p>interviewable Resident were interviewed as to whether or not they had ever been abused or had seen anyone abused at the facility. There were no negative responses period. Non verbal Residents had head to toe assessments completed by nursing with no negative findings. ACTION(S) TAKEN/SYSTEMS PUT INTO PLACE TO REDUCE THE RISK OF FUTURE OCCURANCES INCLUDE: All staff was inserviced as to the requirements of timely reporting /investigating related to abuse or potential for abuse the definition of abuse and timely reporting and investigation requirements as per facility and state/federal regulations. Any staff who fail to comply with the points of the inservice will be further educated and or progressively disciplined as appropriate up to and including termination . HOW THE CORRECTION ACTION(S) WILL BE MONITORED TO ENSURE THE PRACTICE WILL NOT RECUR: Initially, the Social Service Director was assigned to complete 5 random audits daily for one week then 3 random audits weekly ongoing to monitor for any allegations of abuse or harmful behaviors being demonstrated or witnessed by Residents. The Social Service Director will use the CMS form 20050 for the monitoring tool. The audits will be sent to the Regional Office Director who will oversee the Administrator for compliance with adherence to all parts of the ABUSE</p>	

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	<p>indicated he believed this was on Wednesday before Thanksgiving (11/26/14). The Administrator indicated the family member had said something asking him if he knew Resident #D had been "groped" by Resident #F. The Administrator indicated he did not ask the family member how they knew about this or any other details. The Administrator indicated no report was written about the above statement. The Administrator indicated he recalled the family member also stating RN #2's name. The Administrator indicated he did not talk to RN #2 until Friday (11/28/14). The Administrator also indicated the same family member spoke with him again on Friday and that was when he spoke to RN #2. The Administrator indicated he had no other written information or report on the above allegation made to him on 11/26/14. The Administrator indicated he spoke with RN #2 and the RN did mention an incident of touching but did not have the information documented.</p> <p>2. The record for Resident #F was reviewed on 12/1/14 at 6:35 a.m. The resident's diagnoses included, but were not limited to, Parkinson's, bi-polar disorder, depression, and Alzheimer dementia.</p>		<p>POLICY. Any allegations of abuse will be immediately reported to the Regional office director by telephone . Any concerns will have been immediately addressed upon discovery. The Social Service interviews will be reviewed weekly in the Quality Assurance meetings. Any concerns will be reviewed and discussed. Note: any findings will have been addressed immediately upon discovery.</p> <p>Date of Completion: 1-2-15</p>	

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	<p>The 11/2014 Social Service Notes were reviewed. There was no documentation of the resident touching his roommate (Resident #D) inappropriately.</p> <p>The Nursing Progress Notes between 11/6/14 through 11/14/14 were reviewed. There was no documentation of the resident touching his roommate inappropriately or any other altercation between the two residents.</p> <p>The November 2014 Behavior/Interventions Monthly Flow Record was reviewed. Two behaviors were listed on the flow record. They were "s/s (signs/symptoms of depression) and "any behaviors concerns". There was a number (1) marked under the section "any other behaviors" for the number of behaviors on the 11/6/14 day shift for the resident. The outcome for the above was marked with a (+) which indicated improved. There was writing column for # of Behavior Episodes in the box for the Day shift on 11/7/14 for "any other behaviors". The writing was not legible with a (1) marked under the writing. An (+) was marked under the outcome of this behavior on 11/7/14. No behaviors were marked 11/8/14 thru 11/23/14. One "any other behaviors" was marked on the day shift on 11/24/14 and one was marked on the evening shift on</p>			

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F000226 SS=F	<p>11/24/14- both of the above noted a (+) which indicated improved. A (+) was marked in the "any other behaviors" section on the night shift on 11/24/14 with nothing documented in the outcome section.</p> <p>This Federal tag relates to Complaint IN00160170.</p> <p>3.1-28(c) 3.1-28(e)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview,</p>	F000226		01/02/2015

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	<p>the facility failed to follow their Abuse Policy and protocols related to the lack of a timely investigation of an allegation of resident to resident abuse and the reporting of the allegation to the Indiana State Department of Health for 1 of 1 Residents reviewed for abuse. The deficient practice had the potential to affect 88 of 88 residents who resided the the facility. (Residents #D and #F)</p> <p>Findings include:</p> <p>1. The record for Resident #D was reviewed on 12/1/14 at 6:15 a.m. The 11/2014 Nursing Progress Notes were reviewed. An entry made on 11/25/14 at 4:32 a.m. indicated a CNA heard a noise in the resident's room and upon entering the room saw the resident's room mate (Resident #F) with his leg rest from his wheel chair over the resident. The CNA noted blood to the resident's face and arms and called for help. Nurse entered the room and observed blood to the face, arms, and hands, and lacerations and skin tears to the resident's arms and hands. The Physician was called at 12:30 a.m., 911 was called at 12:35 a.m. 911 arrived at 12:45 a.m. and was accompanied by a Police Officer. 911 left at 12:50 a.m. The next entry in the Nursing Progress Notes was made on 11/25/14 at 4:40 a.m. This entry indicated the hospital called to</p>		<p>IMMEDIATE ACTION(S) TAKEN FOR THE RESIDENT(S) FOUND TO HAVE AFFECTED INCLUDE: F226</p> <p>During the course of the survey the fact that an allegation of (inappropriate touching) occurred to Resident D by Resident F was discovered. This was in a progress note in the medical record of Resident F. Immediately upon acknowledgment of this note by the administrative staff that were present, a full investigation was initiated. After numerous interviews and statement gathering from Resident D, Resident D 's family and appropriate staff it was determined that what had happened was in fact a (witnessed by C N A) placing of his hand (Resident F's) onto the exposed midriff of Resident D. This occurred while Resident D was standing in a lift with his hands raised which exposed Resident D's midriff. The touch was not aggressive or sexual per witness. The investigation results were shared with the surveyors the Resident family and the Resident physician. There was no apparent harm from this occurrence . The administrator and DON were reeducated on the requirement of immediately reporting any such allegation of potential abuse as in this case when he (Administrator) was approached by the family of Resident D as to their question of (groping) as related to their Father. Further, of</p>	

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	<p>give report to the Nurse and the resident was to be transferred back to the facility via ambulance. The resident returned to the facility at 4:25 a.m. The resident's family was present and the resident was placed into bed. Sutures to the the left side of the mouth and the left orbital (area around the eye) areas were observed. Purple bruising was noted to the left side of the face and jaw. Multiple cuts were noted over the face. A dressing was in place to the right arm. The resident had some discomfort and was given something for the pain.</p> <p>Continued review of the 11/2014 Nursing Progress Notes indicated there were no entries made on 11/24/14, 11/23/14, or 11/22/14. There was one entry made on 11/21/14 at 1:47 a.m. This entry indicated a treatment continued to the right lower extremity and the dressing in place was clean, dry, and intact. There were no entries made in 11/2014 related to any altercations or incidents of inappropriate touching occurring between the resident and his new room mate (Resident #F) on any days in November.</p> <p>When interviewed by telephone on 12/1/14 at 10:19 a.m., RN #2 indicated he had heard something from a staff member in the facility about Resident #F touching his roommate (Resident #D)</p>		<p>immediately initiating an investigation and taking appropriate action(s) based on the findings of the investigation including but not limited to further reporting to all appropriate parties, making sure all Residents are safe, obtaining and implementing any new needed orders and updating the plans of care of the Resident(s) affected.</p> <p>IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL OF BEING AFFECTED WAS ACCOMPLISHED BY :</p> <p>Residents who reside in the facility and could have come into contact with Resident F had the potential to be affected by this finding . All interviewable Resident were interviewed as to whether or not they had ever been abused or had seen anyone abused at the facility. There were no negative responses period. Non verbal Residents had head to toe assessments completed by nursing with no negative findings.</p> <p>ACTION(S) TAKEN/SYSTEMS PUT INTO PLACE TO REDUCE THE RISK OF FUTURE OCCURANCES INCLUDE:</p> <p>All staff was inserviced as to the requirements of timely reporting /investigating related to abuse or potential for abuse the definition of abuse and timely reporting and investigation requirements as per facility and state/federal regulations. Any staff who fail to comply with the points of the inservice will be further educated and or progressively disciplined as appropriate up to and</p>	

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	<p>inappropriately. The RN indicated he could not recall when he heard this information and stated he heard it in "passing". The RN indicated he was under the impression this was already documented because he did not observe it and it did not occur on his shift. The RN indicated he did not observe any documentation of the this in the resident's record. RN #2 indicated he did not report this to anyone.</p> <p>When interviewed on 12/1/14 at 11:05 a.m., the facility Administrator indicated he recalled speaking to a family member of Resident #D. The Administrator indicated he believed this was on Wednesday before Thanksgiving (11/26/14). The Administrator indicated the family member had said something asking him if he knew Resident #D had been "groped" by Resident #F. The Administrator indicated he did not ask the family member how they knew about this or any other details. The Administrator indicated no report was written about the above statement. The Administrator indicated he recalled the family member also stating RN #2's name. The Administrator indicated he did not talk to RN #2 until Friday (11/28/14). The Administrator also indicated the same family member spoke with him again on Friday and that was</p>		<p>including termination .</p> <p>HOW THE CORRECTION ACTION(S) WILL BE MONITORED TO ENSURE THE PRACTICE WILL NOT RECUR:</p> <p>Initially, the Social Service Director was assigned to complete 5 random audits daily for one week then 3 random audits weekly ongoing to monitor for any allegations of abuse or harmful behaviors being demonstrated or witnessed by Residents. The Social Service Director will use the CMS form 20050 for the monitoring tool. The audits will be sent to the Regional Office Director who will oversee the Administrator for compliance with adherence to all parts of the ABUSE POLICY. Any allegations of abuse will be immediately reported to the Regional office director by telephone . Any concerns will have been immediately addressed upon discovery. The Social Service interviews will be reviewed weekly in the Quality Assurance meetings. Any concerns will be reviewed and discussed. Note: any findings will have been addressed immediately upon discovery.</p> <p>Date of Completion: 1-2-15</p>	

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	<p>when he spoke to RN #2. The Administrator indicated he had no other written information or report on the above allegation made to him on 11/26/14. The Administrator indicated he spoke with RN #2 and the RN did mention an incident of touching but did not have the information documented.</p> <p>2. The record for Resident #F was reviewed on 12/1/14 at 6:35 a.m. The resident's diagnoses included, but were not limited to, Parkinson's, bi-polar disorder, depression, and Alzheimer dementia.</p> <p>The 11/2014 Social Service Notes were reviewed. There was no documentation of the resident touching his roommate (Resident #D) inappropriately.</p> <p>The Nursing Progress Notes between 11/6/14 through 11/14/14 were reviewed. There was no documentation of the resident touching his roommate inappropriately or any other altercation between the two residents.</p> <p>The November 2014 Behavior/Interventions Monthly Flow Record was reviewed. Two behaviors were listed on the flow record. They were "s/s (signs/symptoms of depression) and "any behaviors concerns". There</p>			

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	<p>was a number (1) marked under the section "any other behaviors" for the number of behaviors on the 11/6/14 day shift for the resident. The outcome for the above was marked with a (+) which indicated improved. There was writing column for # of Behavior Episodes in the box for the Day shift on 11/7/14 for "any other behaviors". The writing was not legible with a (1) marked under the writing. An (+) was marked under the outcome of this behavior on 11/7/14. No behaviors were marked 11/8/14 thru 11/23/14. One "any other behaviors" was marked on the day shift on 11/24/14 and one was marked on the evening shift on 11/24/14- both of the above noted a (+) which indicated improved. A (+) was marked in the "any other behaviors" section on the night shift on 11/24/14 with nothing documented in the outcome section.</p> <p>The facility Abuse Prohibition Policy and Procedure was reviewed on 12/1/14 at 10:00 a.m. The policy indicated facility was to initiate an investigation to determine the cause and effect and provide protection to any alleged victims to prevent harm during the continuance of the investigations. The investigation was to be initiated at the time of any finding of potential abuse or neglect.</p>			

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	<p>The facility policy titled "Response to Suspected Abuse, Neglect, Mistreatment or Misappropriation of Resident Property" was also reviewed on 12/1/14. The policy indicated all allegations of abuse must be investigated. The policy also indicated all alleged violations involving mistreatment, abuse, neglect, or exploitation of a resident were to be immediately reported to the Administrator, Director of Nursing (or designees).</p> <p>The facility policy titled "Resident to Resident Abuse" was also reviewed. The policy indicated staff should immediately intervene if a resident to resident altercation occurs and immediately notify the Administrator/Designee and the Director of Nursing. All incidents were to be documented in the resident's medical record. If the involved residents were roommates and there was a controversy, the family or responsible party members were to be notified. Temporarily separating the resident residents may be necessary.</p> <p>This Federal tag relates to Complaint IN00160170.</p> <p>3.1-28(c) 3.1-28(e)</p>			

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F000323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure adequate supervision was provided for a resident related to lack of follow up monitoring to concerns of allegation of resident to resident physical contact and aggressive physical behaviors displayed. This resulted in a resident to resident altercation with a resident being hit multiple times with the leg rest of a wheelchair resulting in bruising, skin tears, and laceration requiring sutures.</p>	F000323	<p>IMMEDIATE ACTION(S) TAKEN FOR THE RESIDENT(S) FOUND TO HAVE BEEN AFFECTED INCLUDE : F323 Resident F no longer resides in facility. Resident D was immediately assessed and first aid was rendered Resident D was transported immediately to the hospital via 911. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED WAS ACCOMPLISHED BY :</p>	01/02/2015

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	<p>(Residents #D and #F) (CNA's #1 & #3) (RN #1 and RN #2)</p> <p>Finding include:</p> <p>1. The record for Resident #F was reviewed on 12/1/14 at 6:35 a.m. The resident's diagnoses included, but were not limited to, Parkinson's, bi-polar disorder, depression, and Alzheimer dementia.</p> <p>The 10/21/14 Minimum Data Set quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (11). A score of (11) indicated the resident's cognitive patterns were moderately impaired. The assessment also indicated the resident required limited assistance of one staff member for bed mobility and transfers and was able to walk in the room with supervision and set up up help by staff. The assessment also indicated the resident had received anti-depressant medication (7) days in the (7) day reference period of the assessment. The assessment also indicated the resident had no behaviors, delusions, or hallucinations.</p> <p>An Incident Report Form completed on 11/6/14 was also reviewed. This form indicated a female resident reported that</p>		<p>Residents who reside in the facility and who have come into contact with Resident F had the potential to be affected by this finding.</p> <p>ACTION(S) TAKEN /SYSTEMS PUT INTO PLACE TO REDUCE THE RISK OF FUTURE OCCURANCES INCLUDE:</p> <p>Nursing and Social Service staff were inservice as to the necessity of adherence to following all points of the Behavior Management Psychotropic Medication Protocol .</p> <p>1. Residents with behaviors will have those behaviors immediately addressed and documented including progress notes, 24 hour report (shift to shift report) and incident report if appropriate. Residents with behaviors will be addressed in the next CQI meeting.</p> <p>2. Residents who display a behavior will be placed on the Behavior Management Program and SSD/Designee will monitor daily on behavior flow sheet as long as Behavior is present.</p> <p>3. Residents who display behaviors will be placed on Alert Charting until the Behavior is resolved.</p> <p>4. Residents who display behaviors will be immediately assessed by nursing then assessed by Social Services and the appropriate doctor or Psych Services Provider within 24-72 hours of the behavior unless immediate</p>	

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	<p>Resident #F who resided on the same hall had inappropriately touched her as they were both coming out of their rooms. An investigation was initiated and Resident #F was moved to to another room on a different hall on 11/6/14. This room was noted to be the room Resident #D resided in.</p> <p>An "Incident Report Form" dated 11/25/14 was reviewed on 12/1/14 at 8:00 a.m. The form was completed by the facility. The report indicated an incident involving Residents #D and #F occurred on 11/25/14 at 12:15 a.m. The report indicated both residents resided in the same room. A CNA heard yelling and entered the room of the residents and upon entering observed Resident #F with the foot rest of a wheelchair in his hand and about to hit Resident #D. The CNA called for help while removing the wheelchair foot rest out of Resident #F's hand. The CNA then noted blood on Resident #D's face and Resident #F stated he thought Resident #D was his uncle an called him a different name. Resident #D was assessed and transported to the hospital with facial injuries. Resident #F was put on 1:1's with a staff member until he was sent out to the hospital for a Psychiatric evaluation. Resident #F had sustained a skin tear to his right hand.</p>		<p>assessment is indicated.</p> <p>5. Residents who display any type of aggressive or agitated behavior(s) will be placed on 1:1 supervision immediately and will be kept separated from other Residents until behavior is managed (for period of not less than 24hours) .</p> <p>6. All appropriate notifications to Physician(s) and families will be made immediately following a Resident's behavior.</p> <p>7. Behaviors displayed by Residents will be immediately shared with appropriate staff who are on duty and also with oncoming staff (Nurses and C N A's in particular) every shift for 24 hours so as to be certain supervision takes place (in addition to any 1:1 monitoring).</p> <p>8. Residents with behaviors will have their care plans updated to address any new or escalated behaviors as they occur.</p> <p>Any staff who fail to comply with the points of this inservice will be further educated and or progressively disciplined as appropriate up to and including termination.</p> <p>Going forward the DON/Designee will monitor behaviors for the following: Ongoing</p>	

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	<p>A facility "Resident Abuse Investigation Report" dated 11/25/14 was also reviewed. The form indicated Residents #D and #F were involved in a resident to resident altercation. The report indicated Resident #D sustained facial injuries and Resident #F sustained a skin tear to the right hand. The report indicated CNA #1 was the first staff member reporting the incident. The report indicated the IDT review of the incident indicated a causative factor was Resident #F was hallucinating. The report also indicated Resident #F would not be returning to the facility.</p> <p>Staff interviews completed during the Investigation of the above incident were reviewed. A written statement completed by RN #1 indicated CNA #3 came to the Nurses's station on 11/24/14 at 10:45 p.m. and told her and RN #3 that Resident #F had thrown his oxygen tank. Resident #F was brought to the RDR (Restorative Dining Room) for 1:1 care. At 12:00 a.m., the resident requested to go back to bed and CNA #1 took him back to bed. CNA #1 later answered another resident's call light and heard noises from Resident #F's room. She went to the room and observed Resident #F sitting in his wheel chair with a foot rest above his head. When RN #1 entered the room the foot rest was on the</p>		<ol style="list-style-type: none"> Behavior was immediately addressed/assessed/if aggressive or agitated will be placed on 1:1 until behavior is managed (for a period not less than 24 hours) Additionally, behaviors will be shared with appropriate staff who are on duty and also with oncoming staff (nursing and CNA in particular) each shift for 24 hours as to be certain supervision takes place (in addition to any 1:1 monitoring . Documented on the progress note/24 hour report/shift to shift report as appropriate/Physician and Family notification. Incident report as appropriate Addressed in the next day's CQI meeting Placed on the Behavior Management Program, SSD will monitor daily on behavior flowsheet until behavior resolved. Appropriate doctor or Psych Services provider will assess 24-72 hours unless immediate assessment is required. Residents with behaviors will have their care plans updated to address any new or escalated behaviors as they occur. <p>HOW THE CORRECTIVE ACTION(S)</p>	

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	<p>floor and was "bloody". Resident #D's face and arm were covered in blood and his left orbital area was swollen and his left eye was swollen shut. The resident had multiple lacerations to the face and the right arm. 911 and the Physician were called.</p> <p>A statement form CNA #3 was reviewed. There was no documentation in this statement related to the resident throwing his oxygen tank or any other behaviors. This statement indicated the CNA entered Resident #D's room and saw blood all over his upper body and staff waited with him until the ambulance arrived. A statement from RN #3 indicated on 11/24/14 at 10:45 p.m. CNA #3 informed her that Resident #F had "threw his portable O2 (oxygen) tank". The statement also indicated the local Police were at the facility and they spoke with both family members and also Resident #D. The Police officer saw the TV screen was busted and Resident #D wanted to press charges.</p> <p>The resident's Care Plans were reviewed. A Care Plan initiated on 8/1/2013 indicated the residents received an anti-depressant medication for a diagnosis of depression. The Care Plan was last updated with a goal date of 12/3/2014. Care Plan interventions</p>		<p>WILL BE MONITORED TO ENSURE THE PRACTICE WILL NOT RECUR:</p> <p>Results of the Behavior monitoring by the DON /Designee will be reviewed and discussed at the next day's CQI meeting and weekly at the QA meetings. Additionally, all Residents will be observed during daily Guardian Angel rounds which will continue to include observing for any signs of behaviors or anticipated behaviors. Any findings will be shared with the Administrator immediately. Any concerns or patterns will be addressed by the QA committee via an action plan. This plan will be monitored weekly by the administrator until resolution: Any identified behaviors are managed for the welfare of the Resident involved and all other Residents in the facility.</p> <p>Residents with behaviors will have their records reviewed at the Behavior Management Meetings monthly at this time the SSD will have reviewed the monthly behavior flow sheets and spearhead discussion of progress and possible needed interventions. Any concerns or patterns will be addressed by the QA committee with an action plan that will be reviewed weekly by the Administrator until resolution: Any identified behaviors are managed for the welfare of the Resident involved and all other Residents in</p>	

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	<p>included to encourage group activities to increase socialization , monitor for mood and behaviors, notify the Physician and the family of any changes, and monitor for adverse reactions. The above interventions were all initiated on 8/1/2013. No further interventions were added after 8/1/2013.</p> <p>A Care Plan initiated on 11/6/2014 indicated the resident displayed socially inappropriate behavior. Care Plan interventions on 11/6/2014 included, to educate the resident on what was and was not appropriate and to validate the resident's feelings. No further interventions were added after 11/6/2014.</p> <p>Review of a Nurse Practitioner Progress Note completed on 11/13/14 indicated the resident had been re-located to another hall due to inappropriate sexual behavior with another resident. The Progress Note also indicated "today again inappropriately touched male room mate" and patient exposed himself. Recommendations on the Progress Note included for a Urinalysis and Culture & Sensitivity test and a Complete Blood Count laboratory test to be completed.</p> <p>The November 2014 Behavior/Interventions Monthly Flow Record was reviewed. Two behaviors</p>		<p>the facility.</p> <p>Completion date: 1-2-15</p>	

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	<p>were listed on the flow record. They were "s/s (signs/symptoms of depression) and "any behaviors concerns". There was a number (1) marked under the section "any other behaviors" for the number of behaviors on the 11/6/14 day shift for the resident. The outcome for the above was marked with a (+) which indicated improved. There was writing column for # of Behavior Episodes in the box for the Day shift on 11/7/14 for "any other behaviors". The writing was not legible with a (1) marked under the writing. An (+) was marked under the outcome of this behavior on 11/7/14. No behaviors were marked 11/8/14 thru 11/23/14. One "any other behaviors" was marked on the day shift on 11/24/14 and one was marked on the evening shift on 11/24/14- both of the above noted a (+) which indicated improved. A (+) was marked in the "any other behaviors" section on the night shift on 11/24/14 with nothing documented in the outcome section.</p> <p>When interviewed on 12/1/14 at 5:15 a.m., RN #1 indicated she worked the night shift starting on 11/24/14 into 11/25/14 when Resident #F hit his roommate (Resident #D). The RN indicated she was not assigned to care for these residents that shift. RN #1 indicated a CNA had walked into the</p>			

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	<p>room and observed Resident #F sitting in a wheelchair next to Resident #D's bed and was holding the foot rest from his wheelchair in his hand. The CNA removed the resident from the room. The RN indicated both she and the other Nurse came to the room and observed Resident #D in his bed and he was covered in blood on his face, arm, and neck. Resident #D also had abrasions on his face and his left orbital area was swollen. Lacerations were also present to the Resident #D's left lower lip and left eye areas. RN #1 indicated first aid was given and 911 was called and Resident #D was sent to the hospital. RN #1 indicated Resident #D told her Resident #F just came over and started hitting him and the resident asked her why he did that.</p> <p>When interviewed again on 12/1/14 at 9:25 a.m., RN #1 indicated at the start of the night shift on 11/24/14, she and another Nurse were counting narcotics at the Nurses' station. RN #1 indicated she recalled hearing CNA #3 saying something about Resident #F throwing his oxygen tank but did not hear anything more. The RN indicated she was not assigned to care for Resident #F and did not know anything more then that.</p>			

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	<p>When interviewed on 12/1/14 at 5:45 a.m. CNA #1 indicated she was assigned to care for Residents #D and #F on the night shift beginning on 11/24/14 at 10:30 p.m. The CNA indicated when she came in that night Resident #F was sitting up in unit dining room with other CNA's sitting with him. The CNA she unusually works the night shift and had been assigned to care for Resident #F several times on her shift. CNA #1 indicated it was unusual to see Resident #F sitting up at the start of her shift. The CNA indicated the Evening Shift CNA's reported to her that everything was fine and did not tell her why Resident #F was up in the chair in the dining room. The CNA also indicated no one had told her about Resident #F having any behaviors. CNA #1 indicated she asked Resident #F if he wanted to go to bed and then transferred him to his room and into bed. The CNA indicated when she left the room Resident #F was in bed. She then left the room and went to help a another resident and heard the resident's roommate (Resident #D) yelling for help. The CNA indicated when she went to the room, Resident #F was sitting in his wheelchair with the leg rest from the wheel chair in his hand and she removed it from his hand and took him out of the room. The other CNA's and Nurses were coming into the room also.</p>			

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	<p>When interviewed by telephone on 12/1/14 at 10:19 a.m., RN #2 indicated he had heard something from a staff member in the facility about Resident #F touching his roommate (Resident #D) inappropriately. The RN indicated he could not recall when he heard this information and stated he heard it in "passing". The RN indicated he was under the impression this was already documented because he did not observe it and it did not occur on his shift. The RN indicated he did not observe any documentation of this in the resident's record. RN #2 indicated he did not report this to anyone.</p> <p>When interviewed on 12/1/14 at 9:10 a.m., the DON (Director of Nursing) indicated an incident occurred between Residents #F and Resident #D at 12:15 a.m. on 11/25/14. The DON indicated the residents were roommates. The DON indicated she was called and came to the facility. The staff reported that Resident #F had been observed in the room with the foot rest of his wheelchair in his hand and Resident #D was observed in bed with injuries to his face. The DON indicated she was not aware of any other reported incidents between the roommates and stated the roommates seemed to get along. The DON indicated</p>			

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	<p>earlier that day Resident #F had pushed a vase off the table around lunch time and later in the day had made a statement about the people on the TV talking. The DON indicated these two behaviors were unusual for Resident #D. The DON indicated Resident #F was out to the hospital on 11/25/14 for a psychiatric evaluation and would not be returning to the facility.</p> <p>Continued interview with the DON indicated the 11/25/14 incident was reviewed and interviews with staff did note Resident #F threw his portable oxygen tank earlier in the evening of 11/24/14 and was taken to the Rehab unit dining room for 1:1 supervision. The DON indicated the CNA later put him to bed and stayed with him and he fell asleep.</p> <p>The DON and the facility Administrator were interviewed on 12/1/14 at 9:30 a.m. The DON indicated she did not know any other details of the event noted on the written statement about Resident #F throwing his oxygen tank in the evening of 11/24/14. The DON indicated there was no documentation of this in Resident #F's record and no incident report was completed. The DON indicated she did not further investigate the above. The DON indicated staff were supposed to</p>			

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	<p>document behaviors and incidents.</p> <p>When interviewed on 12/1/14 at 10:10 a.m., LPN #1 indicated she unusually worked the Day shift. The LPN indicated she worked on 11/12/14 and 11/13/14. The LPN indicated she was not aware of any inappropriate behaviors for either Resident#D or Resident #F on those dates. The LPN indicated she was aware of the incident which recently occurred between these two residents. The LPN indicated she spoke with the Nurse Practitioner on 11/13/14 about Resident #F not acting like himself, sleeping more, and being confused to questions. The LPN indicated she was not aware of Resident #F inappropriately touching any other male resident.</p> <p>When interviewed on 12/1/14 at 11:05 a.m., the facility Administrator indicated he recalled speaking to a family member of Resident #D. The Administrator indicated he believed this was on Wednesday before Thanksgiving (11/26/14). The Administrator indicated the family member had said something asking him if he knew Resident #D had been "groped" by Resident #F.. The Administrator indicated he did not ask the family member how they knew about this or any other details. The Administrator indicated no report was</p>			

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	<p>written about the above statement. The Administrator indicated he recalled the family member also stating RN #2's name. The Administrator indicated he did not talk to RN #2 until Friday (11/28/14). The Administrator also indicated the same family member spoke with him again on Friday and that was when he spoke to RN #2 The Administrator indicated he had no other written information or report on the above allegation made to him on 11/26/14. The Administrator indicated he spoke with RN #2 and the RN did mention an incident of touching but did not have the information documented. The Administrator indicated he was not aware of the 11/13/14 Nurse Practitioner Progress Note made in Resident #F's chart related to inappropriately touching his roommate. The Administrator indicated the Nurse Practitioner did not inform him nor did any staff member on 11/13/14.</p> <p>When interviewed on 12/1/14 at 11:20 a.m., the Director of Nursing indicated she also had not been aware of the 11/13/14 Nurse Practitioner note and no staff had informed her about any occurrence of Resident #F touching his roommate Resident #D.</p> <p>When interview via telephone on 12/1/14</p>			

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	<p>at 11:30 a.m., the Nurse Practitioner who completed the 11/13/14 Progress Note for Resident #D was interviewed via phone. She recalled a staff nurse informed her of the residents behavior and with the then male roommate. The Nurse Practitioner indicated she had been aware the resident had a recent room change due to a previous behavior with another resident on the other hall. The Nurse Practitioner indicated she did not recall the name of the Nurse who told her the above.</p> <p>2. On 12/1/14 at 6:00 a.m., Resident #D was observed sitting in a wheel chair in his room. Dark ecchymotic (bruised) areas were noted under the resident's left eye, the left cheek area towards the jaw line, and under the jaw to the neck area. There were small scattered scab areas to the forehead also noted.</p> <p>The record for Resident #D was reviewed on 12/1/14 at 6:15 a.m. The resident's diagnoses included, but were not limited to, depression, coronary artery disease, stroke, and chronic kidney disease.</p> <p>The 10/1/14 Minimum Data Set quarterly assessment indicates the resident's BIMS (Brief Interview for Mental Status) score was (8). A score of (8) indicated the resident's cognitive patterns were</p>			

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	<p>moderately impaired. The assessment indicated the resident did not display any signs of delirium or acute mental status changes and had no behaviors. The assessment also indicated the resident required extensive assistance (resident involved in activity, staff provide weight bearing support) of one staff member for bed mobility, personal hygiene, and dressing. The assessment indicated the resident required extensive assistance of two or more staff members for transfers and had impairment in range of motion in one upper and one lower extremity.</p> <p>The 11/2014 Nursing Progress Notes were reviewed. An entry made on 11/25/14 at 4:32 a.m. indicated a CNA heard a noise in the resident's room and upon entering the room saw the resident's room mate (Resident #F) with his leg rest from his wheelchair over the resident. The CNA noted blood to the resident's face and arms and called for help. Nurse entered the room and observed blood to the face, arms, and hands and lacerations and skin tears to the resident's arms and hands. The Physician was called at 12:30 a.m., 911 was called at 12:35 a.m. 911 arrived at 12:45 a.m. and was accompanied by a Police Officer. 911 left at 12:50 a.m. The next entry in the Nursing Progress Notes was made on 11/25/14 at 4:40 a.m.</p>			

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	<p>This entry indicated the hospital called to give report to the Nurse and the resident was to be transferred back to the facility via ambulance. The resident returned to the facility at 4:25 a.m. The resident's family was present and the resident was placed into bed. Sutures to the the left side of the mouth and the left orbital (area around the eye) areas were observed. Purple bruising was noted to the left side of the face and jaw. Multiple cuts were noted over the face. A dressing was in place to the right arm. The resident had some discomfort and was given something for the pain.</p> <p>Continued review of the 11/2014 Nursing Progress Notes indicated there were no entries made on 11/24/14, 11/23/14, or 11/22/14. There was one entry made on 11/21/14 at 1:47 a.m. This entry indicated a treatment continued to the right lower extremity and the dressing in place was clean, dry, and intact. There were no entries made in 11/2014 related to any altercations or incidents of inappropriate touching occurring between the resident and his new room mate (Resident #F) on any days in November.</p> <p>Review of the 11/25/14 hospital Emergency Room hospital "After Visit Summary" records indicated the resident's "Diagnoses this visit" included,</p>			

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	<p>victim of a physical assault, multiple abrasions, multiple skin tears, facial lacerations and a periorbital (area around the eye) contusion.</p> <p>A Skin/Wound Note was completed on 11/25/14 at 8:00 a.m. The note was completed by an LPN. The note indicated the resident was noted to have a laceration just below the left eye and another laceration to the left outer mouth area. Both the lacerations had sutures in place. The note also indicated red and purple bruising was noted to the left peri-orbital area and dark purple and red bruising was noted to the the resident's left cheek and jaw line down the left neck. The left cheek and jaw area was also edematous (swollen). A skin tears were noted to the back of the right hand, the right upper forearm, and the right inner forearm with no active bleeding. Red, blue, and purple scattered bruising was noted to the right chest. The back of the resident's left hand was noted with 11 cm (centimeters) x 7 cm purple bruising.</p> <p>Weekly Skin Assessment sheets were initiated on 11/25/14. A total of (9) sheets were completed as follows:</p> <p>11/25/14 at 8:00 a.m.- left periorbital laceration to the face which measured 0.1 cm x 2 cm. Two sutures were present and</p>			

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	<p>dark purple and red bruising was toed to the left peri-orbital area. The resident did state the area was "tender to touch."</p> <p>11/25/14 at 8:03 a.m.- left outer mouth laceration with two sutures intact. The bruising to surrounding tissue was dark purple and red bruising and edema noted. The resident did state his face was tender to touch.</p> <p>11/25/14 at 8:18 a.m.- skin tear to the back of right hand measuring 3 cm x 3 cm x 0.1 cm with no active bleeding. Some purple bruising and edema noted to the right middle finger.</p> <p>11/25/14 at 8:23 a.m.- skin tear to the right outer forearm measuring 3 cm x 2 cm x 0.1 cm. No active bleeding. Dark purple bruising to the peri-wound tissue noted.</p> <p>11/25/14 at 8:45 a.m.- scattered small skin tears bridged together on the left forearm.</p> <p>11/25/14 at 8:51 a.m.- skin tear to the right upper forearm measuring 2.5 cm x 3.5 cm x 0.1 cm. Surrounding tissue dark purple bruising.</p> <p>11/25/14 at 8:55 a.m.- scattered bruising to the right chest area. Bruising blue, red,</p>			

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	<p>and purple.</p> <p>11/25/14 at 9:04 a.m.- scattered small abrasion to the right scalp.</p> <p>11/25/14 at 8:51 a.m.- skin tear noted to the right upper forearm measuring 2.5 cm x 3.5 cm x 0.1 cm.</p> <p>An IDT (Interdisciplinary Team) note was completed by Social Services on 11/25/14 at 9:46 a.m. The note indicated the Social Service visited with the resident's and he was eating breakfast in his room. The resident was asked what happened and the resident stated "The guy hit me."</p> <p>Review of a 11/26/14 Physician Progress Note indicated the resident was assaulted by his room mate and was hit multiple times with the leg of a wheel chair. The resident sustained contusions on neck, scalp, and face. The Progress Note indicated a CT scan of the head had been completed on 11/25/14 and was negative for a bleed. The Progress Note also indicated CT scans of the facial bones were negative for fractures, and a MRI was positive for a deviated septum.</p> <p>The "Behavior Management Psychotropic Medication Protocol" policy was reviewed on 12/2/14 at 1:50 p.m. There</p>			

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	<p>was no date on the policy. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated "Residents with behaviors that are displayed routinely, that effect the resident's psychosocial well-being or that of other residents, or behaviors that can have the potential for harm to self or others will be assessed with the development of a behavior program." The policy also indicated when established residents have a new onset of adverse behaviors the behaviors were to be documented and communicated to the Social Service. The resident was to be placed on the 24 hour report documentation record. Social service was to assess the resident and complete a Monthly Flow Records. Staff were to notify the attending Physician to rule out possible medical causes. The resident's Care Plan was to be updated to include the problem behavior, goals, and approaches. The problem behavior, approaches, and goals were to be included on the Care Plan. The documentation was to be reviewed by the Behavior Committee to determine a plan. This Federal tag relates to Complaint IN00160170.</p> <p>3.1-45(a)(2)</p>			

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