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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 04/09/2012 |
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| NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012 |
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| F0000 | <p>This visit was for the Investigation of Complaint IN00106344.</p> <p>Complaint IN00106344 substantiated, federal/state deficiencies related to the allegations cited at F225 and F226.</p> <p>Survey date: April 9, 2012</p> <p>Facility number: 011045 Provider number: 155698 AIM number: 200380790</p> <p>Surveyor: Jeri Curtis, RN</p> <p>Census bed type: SNF: 11 SNF/NF: 32 Residential: 24 Total: 67</p> <p>Census payor type: Medicare: 11 Medicaid: 11 Other: 45 Total: 67</p> <p>Sample: 3</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> | F0000 | <p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Complaint Survey of 4/9/2012. Please accept this plan of correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p> | |

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

TITLE

(X6) DATE

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

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| | Quality review completed 4/12/12 Cathy Emswiller RN | | | |

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| F0225 SS=D | <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly 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 allegations of</p> | F0225 | F 225 Corrective actions accomplished for those residents found to be affected | 05/09/2012 | | | |

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| | <p>verbal abuse and the misappropriation of property were thoroughly investigated, and further potential abuse was prevented during the investigation, for 1 (Resident A) of 2 residents among the sample of 3 reviewed for allegations of abuse.</p> <p>Findings include:</p> <p>Family Member #1 was interviewed by telephone at 11:10 A.M., 4/9/12, and indicated she had brought several concerns, including misappropriation of a narcotic and verbal abuse, to the attention of the Administrator, the Director of Nursing (DoN), the Assistant DoN (ADoN), and the Director of Marketing. Family Member #1 indicated the Administrator had told her the concerns were investigated and nothing could be done about the missing narcotic. Family Member #1 indicated she believed the Licensed Practical Nurse (LPN #1) on duty the evening of 3/23/12, had taken the narcotic for herself.</p> <p>During an 11:40 A.M., 4/9/12, interview, the Administrator indicated the facility had received an allegation of a missing narcotic from the family of Resident (A). The Administrator indicated Resident (A) had called Family Member #1 saying she had not received a Lortab (narcotic) for pain. The Administrator indicated</p> | | <p>by the alleged deficient practice: An investigation for the allegations of verbal abuse and misappropriation of property for Resident A was completed by the Executive Director (E.D.), Director of Health Services (DHS) and Assistant Director of Health Services (ADHS). Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: all residents have the potential to be affected by the same alleged deficient practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Support Clinical Nurse will review the campus guidelines of Abuse and Neglect with the Leadership Team, including the ED, DHS, and ADHS. Specifically to the resident protection, reporting and investigating of allegations of abuse and misappropriation of property. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: Support Clinical Nurse or designee will review the campus grievance / concern forms weekly x 30 days then monthly x 5 months to ensure compliance of following the campus guidelines for Abuse and Neglect. The interviews will be presented to the monthly Quality Assurance</p> | | | | |

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| | <p>Resident (A) had alleged Tylenol had been substituted for the Lortab by Licensed Practical Nurse (LPN #1), the nurse on duty the evening of 3/23/12. The Administrator indicated Family Member #1 had made the allegation to the Marketing Director, who was the week-end manager on duty Saturday, 3/24/12. The Administrator indicated he and the DoN were notified of the incident, investigated, and did not feel it was a reportable allegation.</p> <p>The Administrator indicated the DoN had interviewed Resident (A) who had said she had received a pain medication on 3/23/12, but could not identify the medication because it had been crushed. The Administrator indicated the 3/23/12, narcotic count had been correct.</p> <p>The Administrator indicated the DoN, who was retiring soon, was off duty 4/9/12, for a family concern and not available for interview. The Administrator indicated the ADoN, who was training for the DoN position, had spoken with Family Member #1 regarding several other concerns.</p> <p>The record of Resident (A) was reviewed at 2:20 P.M., 4/9/12, and indicated a 3/19/12, admission for rehab following a compression fracture of the thoracic area and lumbar spine. The physician had ordered Lortab 5/500 milligram (mgs) to</p> | | Committee times 6 months for further recommendations. | | | | |

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| | <p>be administered 4 times daily for pain control. The physician had also ordered Tylenol (2) 325 mgs to be given every 4 hours as needed.</p> <p>Documentation in the medication administration record (MARS) of Resident (A) indicated the Lortab had been administered at the evening meal and 9 P.M., 3/23/12. Resident (A) was discharged to home on 3/29/12, with orders for home health and to continue all medications as ordered.</p> <p>The ADoN was interviewed at 2:45 P.M., 4/9/12, and indicated Family Member #1 of Resident (A) had made a complaint to the Marketing Director on 3/24/12, (Resident A) had not received a narcotic as ordered the evening of 3/23/12. The ADoN indicated she had assisted with the investigation. The ADoN indicated Family Member #1 had made a statement LPN #1 had removed the narcotic for herself and had substituted Tylenol to Resident (A). The ADoN indicated she had spoken with LPN #1, who had denied the allegation.</p> <p>The ADoN indicated Family Member #1 had also alleged on 3/21/12, an unknown employee had spoken with Resident (A) asking why (Resident A) had, "tattled on (unknown employee)," and asking if (Resident A) was trying to get the staff in trouble. The ADoN indicated the</p> | | | |

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| | <p>allegation was of an employee scolding Resident (A). The ADoN indicated she believed a copy of the investigation had been given to the Administrator who would have reported to the Indiana State Department of Health.</p> <p>LPN #1 was interviewed at 3:15 P.M., 4/9/12, and indicated she had been questioned about the substitution of a Tylenol for a narcotic to Resident (A) and had denied the allegation. LPN #1 indicated Resident (A) had requested the pain med be crushed and had taken all other s whole. LPN #1 indicated she had been on duty the week-end of 3/24-3/25/12, was told she was not to go into the room of Resident (A, but was not suspended.</p> <p>At 3:45 P.M., 4/9/12, the ADoN provided copies of the 3/23, and 3/26/12, internal investigations of the allegations brought by Family Member #1 on behalf of Resident (A). The 3/23/12, investigation was titled, 3/21-3/22/12, investigation of grievance filed by Family Member #1 of Resident (A). The 3/23/12, internal investigation indicated the ADoN had spoken with Resident (A) about an alleged statement by an unknown employee of trying to get (unknown employee) in trouble by tattling to administration.</p> | | | | | | |

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| | <p>The investigation indicated Resident (A) was unable to recall who the employee was or unable to provide a description of the person. Documentation indicated Resident (A) was only able to recall the unknown person had passed meal trays. Documentation indicated all nursing staff would be reminded of standards in meetings over the next 2 days.</p> <p>The 3/26/12, internal investigation indicated Family Member #1 was insistent the pain medication of Resident (A) was diverted the evening of 3/23/12. Documentation indicated Family Member #1 was not in the facility the evening of 3/23/12, and was told by Resident (A) she did not know if she had received pain medication. Documentation indicated Family Member #1 had assumed Resident (A) had not received the medication and had reported to the 3/24-3/25/12, week-end manager, the Marketing Director.</p> <p>Documentation indicated the narcotic count for 3/23/12, was correct, Resident (A's) MARS showed correct administration per physician order, and LPN #1 had said the medication was crushed at resident request.</p> <p>Documentation indicated during an interview Resident (A) was unsure of what medication was received because it had been crushed. Documentation also</p> | | | | |

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| | <p>indicated Resident (A) had not told staff on duty she had not received her medications, had not complained of pain, and did not mention she had the nurse crush the medications.</p> <p>The Administrator, ADoN, and Marketing Director, were interviewed jointly at 4:00 P.M., 4/9/12.</p> <p>The Administrator indicated if he had been notified of an allegation of verbal abuse, he would have reported to the Indiana State Department of Health.</p> <p>The ADoN indicated she had believed the investigation of the scolding had been sent to the Administrator.</p> <p>The Marketing Director indicated she had believed resident protection was provided by requesting LPN #1 not enter the room of (Resident A) the week-end of 3/24-3/25/12..</p> <p>The facility's 11/2012, Abuse and Neglect Procedural Guidelines was provided by the Administrator 4/9/12. The guideline purpose was corporate development and implementation processes to ensure the prevention and reporting of suspected or alleged resident abuse/neglect.</p> <p>Verbal abuse was described as oral, written, or gestured language including disparaging and derogatory terms to the resident to describe residents, regardless of age or ability to comprehend.</p> | | | | |

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| | <p>Misappropriation of property was defined as including, but not limited to, the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or funds. Identification indicated any person with knowledge or suspicion of suspected violations was to report immediately without reprisal. Abuse, neglect, and misappropriation of resident property was defined as a crime and could result in loss of professional license or certification. The shift supervisor or manager was to report immediately to the Administrator or designee. The Administrator was to notify the resident's physician and family, and Indiana State Department of Health and other agencies including the Ombudsman and Adult Protective Services. The Resident protection intervention indicated if an employee was a suspect, the employee was to be suspended pending outcome of the investigation. Reporting to the appropriate parties was to be within 24 hours of the initial report, with a 5 day final conclusion and actions to prevent recurrence.</p> <p>This federal tag relates to Complaint IN00106344.</p> <p>3.1-28(c)</p> | | | | |

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| | 3.1-28(d) 3.1-28(e) | | | |

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| F0226 SS=D | <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review, and interview, the facility failed to implement it's policy and procedures related to investigating and reporting allegations of verbal abuse and misappropriation of property, for 1 (Resident A) of 2 residents among the sample of 3 reviewed for abuse.</p> <p>Findings include:</p> <p>Family Member #1 was interviewed by telephone at 11:10 A.M., 4/9/12, and indicated she had brought several concerns, including misappropriation of a narcotic and verbal abuse, to the attention of the Administrator, the Director of Nursing (DoN), the Assistant DoN (ADoN), and the Director of Marketing. Family Member #1 indicated the Administrator had told her the concerns were investigated and nothing could be done about the missing narcotic. Family Member #1 indicated she believed the Licensed Practical Nurse (LPN #1) on duty the evening of 3/23/12, had taken the narcotic for herself.</p> | F0226 | <p>F 226Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: An investigation for the allegations of verbal abuse and misappropriation of property for Resident A was completed by the Executive Director (E.D.), Director of Health Services (DHS) and Assistant Director of Health Services (ADHS). Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: all residents have the potential to be affected by the same alleged deficient practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Support Clinical Nurse will review the campus guidelines of Abuse and Neglect with the Leadership Team, including the ED, DHS, and ADHS. Specifically to the resident protection, reporting and investigating of allegations of abuse and misappropriation of property. How the corrective measures will be monitored to</p> | 05/09/2012 | |

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| | <p>During an 11:40 A.M., 4/9/12, interview, the Administrator indicated the facility had received an allegation of a missing narcotic from the family of Resident (A). The Administrator indicated Resident (A) had called Family Member #1 saying she had not received a Lortab (narcotic) for pain. The Administrator indicated Resident (A) had alleged Tylenol had been substituted for the Lortab by Licensed Practical Nurse (LPN #1), the nurse on duty the evening of 3/23/12. The Administrator indicated Family Member #1 had made the allegation to the Marketing Director, who was the week-end manager on duty Saturday, 3/24/12. The Administrator indicated he and the DoN were notified of the incident, investigated, and did not feel it was a reportable allegation.</p> <p>The Administrator indicated the DoN had interviewed Resident (A) who had said she had received a pain medication on 3/23/12, but could not identify the medication because it had been crushed. The Administrator indicated the 3/23/12, narcotic count had been correct.</p> <p>The Administrator indicated the DoN, who was retiring soon, was off duty 4/9/12, for a family concern and not available for interview. The Administrator indicated the ADoN, who was training for the DoN position, had spoken with Family Member #1 regarding several</p> | | <p>ensure the alleged deficient practice does not recur: Support Clinical Nurse or designee will review the campus grievance / concern forms weekly x 30 days then monthly x 5 months to ensure compliance of following the campus guidelines for Abuse and Neglect. The interviews will be presented to the monthly Quality Assurance Committee times 6 months for further recommendations.</p> | | | | |

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| | <p>other concerns.</p> <p>The record of Resident (A) was reviewed at 2:20 P.M., 4/9/12, and indicated a 3/19/12, admission for rehab following a compression fracture of the thoracic area and lumbar spine. The physician had ordered Lortab 5/500 milligram (mgs) to be administered 4 times daily for pain control. The physician had also ordered Tylenol (2) 325 mgs to be given every 4 hours as needed.</p> <p>Documentation in the medication administration record (MARS) of Resident (A) indicated the Lortab had been administered at the evening meal and 9 P.M., 3/23/12. Resident (A) was discharged to home on 3/29/12, with orders for home health and to continue all medications as ordered.</p> <p>The ADoN was interviewed at 2:45 P.M., 4/9/12, and indicated Family Member #1 of Resident (A) had made a complaint to the Marketing Director on 3/24/12, (Resident A) had not received a narcotic as ordered the evening of 3/23/12.</p> <p>The ADoN indicated she had assisted with the investigation. The ADoN indicated Family Member #1 had made a statement LPN #1 had removed the narcotic for herself and had substituted Tylenol to Resident (A). The ADoN indicated she had spoken with LPN #1,</p> | | | | |

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| | <p>who had denied the allegation.</p> <p>The ADoN indicated Family Member #1 had also alleged on 3/21/12, an unknown employee had spoken with Resident (A) asking why (Resident A) had, "tattled on (unknown employee)," and asking if (Resident A) was trying to get the staff in trouble. The ADoN indicated the allegation was of an employee scolding Resident (A).</p> <p>The ADoN indicated she believed a copy of the investigation had been given to the Administrator who would have reported to the Indiana State Department of Health.</p> <p>LPN #1 was interviewed at 3:15 P.M., 4/9/12, and indicated she had been questioned about the substitution of a Tylenol for a narcotic to Resident (A) and had denied the allegation.</p> <p>LPN #1 indicated Resident (A) had requested the pain med be crushed and had taken all other s whole.</p> <p>LPN #1 indicated she had been on duty the week-end of 3/24-3/25/12, was told she was not to go into the room of Resident (A, but was not suspended.</p> <p>At 3:45 P.M., 4/9/12, the ADoN provided copies of the 3/23, and 3/26/12, internal investigations of the allegations brought by Family Member #1 on behalf of Resident (A). The 3/23/12, investigation was titled, 3/21-3/22/12, investigation of</p> | | | | | | |

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| | <p>grievance filed by Family Member #1 of Resident (A).</p> <p>The 3/23/12, internal investigation indicated the ADoN had spoken with Resident (A) about an alleged statement by an unknown employee of trying to get (unknown employee) in trouble by tattling to administration.</p> <p>The investigation indicated Resident (A) was unable to recall who the employee was or unable to provide a description of the person. Documentation indicated Resident (A) was only able to recall the unknown person had passed meal trays. Documentation indicated all nursing staff would be reminded of standards in meetings over the next 2 days.</p> <p>The 3/26/12, internal investigation indicated Family Member #1 was insistent the pain medication of Resident (A) was diverted the evening of 3/23/12. Documentation indicated Family Member #1 was not in the facility the evening of 3/23/12, and was told by Resident (A) she did not know if she had received pain medication. Documentation indicated Family Member #1 had assumed Resident (A) had not received the medication and had reported to the 3/24-3/25/12, week-end manager, the Marketing Director.</p> <p>Documentation indicated the narcotic count for 3/23/12, was correct, Resident</p> | | | |

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| | <p>(A's) MARS showed correct administration per physician order, and LPN #1 had said the medication was crushed at resident request. Documentation indicated during an interview Resident (A) was unsure of what medication was received because it had been crushed. Documentation also indicated Resident (A) had not told staff on duty she had not received her medications, had not complained of pain, and did not mention she had the nurse crush the medications.</p> <p>The Administrator, ADoN, and Marketing Director, were interviewed jointly at 4:00 P.M., 4/9/12.</p> <p>The Administrator indicated if he had not been notified of the allegation of a scolding of Resident (A) by an employee he would have reported to the Indiana State Department of Health.</p> <p>The ADoN indicated she had believed the investigation of the scolding had been sent to the Administrator.</p> <p>The Marketing Director indicated she had believed resident protection was provided by requesting LPN #1 not enter the room of (Resident A) the week-end of 3/24-3/25/12.</p> <p>The facility's 11/2012, Abuse and Neglect Procedural Guidelines was provided by the Administrator 4/9/12. The guideline</p> | | | | | | |

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| | <p>purpose was corporate development and implementation processes to ensure the prevention and reporting of suspected or alleged resident abuse/neglect.</p> <p>Verbal abuse was described as oral, written, or gestured language including disparaging and derogatory terms to the resident to describe residents, regardless of age or ability to comprehend.</p> <p>Misappropriation of property was defined as including, but not limited to, the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or funds.</p> <p>Identification indicated any person with knowledge or suspicion of suspected violations was to report immediately without reprisal. Abuse, neglect, and misappropriation of resident property was defined as a crime and could result in loss of professional license or certification.</p> <p>The shift supervisor or manager was to report immediately to the Administrator or designee.</p> <p>The Administrator was to notify the resident's physician and family, and Indiana State Department of Health and other agencies including the Ombudsman and Adult Protective Services.</p> <p>The Resident protection intervention indicated if an employee was a suspect, the employee was to be suspended pending outcome of the investigation.</p> <p>Reporting to the appropriate parties was</p> | | | |

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| | <p>to be within 24 hours of the initial report, with a 5 day final conclusion and actions to prevent recurrence.</p> <p>This federal tag relates to Complaint IN00106344.</p> <p>3.1-28(a)</p> | | | | | | |