

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155696	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/01/2011
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINTE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 COLLEGE AVE VINCENNES, IN47591		
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F0000	<p>This visit was for the Investigation of Complaint IN00098699.</p> <p>Complaint IN00098699 - Substantiated. Federal/State deficiencies related to the allegations are cited at F223, F225 and F226.</p> <p>Survey Dates: October 31 and November 1, 2011</p> <p>Facility #: 003237 Provider #: 155696 AIM #: 200374360</p> <p>Survey team: Anne Marie Crays RN</p> <p>Census bed type: SNF: 22 NF: 30 SNF/NF: 8 Residential: 18 Total: 78</p> <p>Census payor type: Medicare: 22 Medicaid: 30 Other: 26 Total: 78</p> <p>Sample: 5</p>	F0000			

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

TITLE

(X6) DATE

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

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F0223 SS=D	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 11/03/11 by Suzanne Williams, RN</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure a resident was free from verbal abuse, for 2 of 5 residents sampled for verbal abuse, in a sample of 5. Resident D, Resident C</p> <p>Findings include:</p> <p>1. On 10/31/11 at 7:30 A.M., the Director of Nursing [DON] provided an investigation into an alleged verbal abuse. The DON indicated the investigation was started on 10/26/11, when Resident D "felt like the night shift nurse was rude when he asked for a pain pill." The DON indicated the resident complained to a physical therapist, who immediately informed a nurse, who immediately informed the Administrator and DON. The DON indicated she spoke to the</p>	F0223	Resident D suffered no ill effects from the alleged deficient practice and erves as resident advocate at the facility. Resident C no longer resides at the facility. All residents in the future that have an investigation conducted as a result of alleged abuse have the potential to be affected by the alleged deficient practice therefore through inservicing and systemic changes stated below will ensure procedures are followed in accordance with company policy and state/federal requirements. All departments inserviced regarding investigation procedures and reporting requirements as well as abuse prevention. Systemic change is ED will submit all grievances immediately for review by Division Director of Operations/Clinical Support with all steps in investigation and reporting	11/28/2011

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	<p>resident and other staff, suspended the nurse, RN # 1, and then terminated the nurse after investigation.</p> <p>A written statement, dated 10/26/11 at 2:00 P.M., indicated, "...Resident states 'Nurse was rude [and] mean - refused to give me pain meds at first. I rang for them again later and nurse states 'you people and your pain pills.' She was really not in a good mood.' When asked if he knew nurses [sic] name he states '...[name of RN # 1].'..."</p> <p>An additional written statement, dated 10/26/11 at 4:00 P.M., included: "[Resident D] wanted bedtime med. [RN # 1] 'always asking for pain pills' ' don't let me get my work done.' [Resident D] 'Stop right there. I'll just do without.' ' You don't have to be rude about it.' [RN # 1] attitude changed and then got meds...then went out door 'Oh my gosh I'm getting so tired of these pills.' [Resident D]...'argue' 'snippy' Attitude before that, grumpy but not near as bad as last night was downright rude..."</p> <p>A written statement, dated 10/26/11 at 10:00 P.M., included, "Spoke with: [CNA # 1]...states [RN # 1] is 'burnt out' and does 'at times' get 'snippy' [with] residents."</p>		<p>requirements reviewed for timely submission to agencies ensured.ED will forward all reportable decisions to QA committee monthly for review of compliance with investigation and state/federal requirement x6 months and quarterly thereafter for review and further recommendations.</p>		

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	<p>On 10/31/11 at 8:00 A.M., during interview, Physical Therapist Assistant [PTA] # 1 indicated she was pushing Resident D to therapy on 10/26/11, and Resident D indicated he had "a bad night." PTA # 1 indicated Resident D told her he had asked for a pain pill, didn't get one, then asked again, and the nurse was "hateful." Resident D indicated that RN # 1 made the statement, "You people and your pain pills." PTA # 1 indicated Resident D "was upset." PTA # 1 indicated they were by the nursing station, so she immediately stopped so the resident could inform LPN # 2.</p> <p>On 10/31/11 at 8:30 A.M., during interview with LPN # 2, she indicated, "The PTA was bringing [Resident D] by and they stopped at the desk. Resident D told me the night shift nurse on TCU [transitional care unit] was rude and he had a bad night." Resident D told LPN # 2 he had to ask twice for his pain pills, and that RN # 1 told him, "You people and your pain pills." LPN # 2 indicated they immediately informed the Administrator and DON.</p> <p>On 10/31/11 at 9:05 A.M., Resident D was interviewed. He indicated, "Last week, I pulled my call light, and no one came. So I went to the door and asked for a pain pill. The nurse was belligerent. She</p>				

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	<p>had been rude before. She said, "Oh you people and your pain pills."</p> <p>2. In a confidential family interview on 10/31/11, a family member of Resident C indicated, "The night nurse is routinely rude to [Resident C]." The family member indicated, "One time, the nurse told [Resident C] she didn't have time [to assist]." The family member indicated the nurse did not take the time to listen to the resident, but "just assumed she knew why the call light was on." The family member indicated family members had reported their concerns to the staff.</p> <p>3. On 10/31/11 at 7:00 A.M., the Administrator provided the current facility policy on "Abuse and Neglect Procedural Guidelines," undated. The policy included: "Purpose: [Name of corporation] has developed and implemented processes, 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. Staff to resident - any episode...."</p>			

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F0225 SS=D	<p>This federal tag relates to Complaint IN00098699.</p> <p>3.1-27(b) 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 interview and record review, the</p>	F0225	Resident D suffered no ill effects	11/28/2011	

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	<p>facility failed to report an occurrence of alleged verbal abuse to the Indiana State Department of Health [ISDH], for 1 of 1 resident sampled for investigations into alleged abuse, in a sample of 5. Resident D</p> <p>Findings include:</p> <p>1. On 10/31/11 at 7:30 A.M., the Director of Nursing [DON] provided an investigation into alleged verbal abuse. The DON indicated the investigation was started on 10/26/11, when Resident D "felt like the night shift nurse was rude when he asked for a pain pill." The DON indicated the resident complained to a physical therapist, who immediately informed a nurse, who immediately informed the Administrator and DON. The DON indicated she spoke to the resident and other staff, suspended the nurse, RN # 1, and then terminated the nurse after investigation. The DON indicated the resident did not think the nurse was abusive or neglectful. The DON indicated she contacted the corporate nurse, who "didn't think it needed to be reported" to the ISDH.</p> <p>2. On 10/31/11 at 7:00 A.M., the Administrator provided the current facility policy on "Abuse and Neglect Procedural Guidelines," undated. The policy</p>		<p>and serves as resident advocae at the facility.All residents in the future that have an investigation conducted as a result of complaint have the potential to be affected by the alleged deficient practice therefore through inservicing and systemic changes stated below will ensure procedures are followed in accordance with company policy and state/federal requirements.All departments inserviced regarding investigation procedures and reporting requirements as well as abuse prevention.Systemic change is ED will report all grievances immediately for review by Division Director of Operations/Clinical Support with all steps in investigation and reporting requirements reviewed for timely submission to agencies ensured.ED will forward all grievances and reportables to QA committee monthly for review of compliance with investigation and state/federal requirements x6 months and quarterly thereafter for review and further recommendations.</p>		

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F0226 SS=D	<p>included: "Purpose: [Name of corporation] has developed and implemented processes, 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...The Executive Director is responsible for: Notification to the State Department of Health...and other agencies, which include the Ombudsman, Adult Protective Services and/or local law enforcement agencies, as indicated...Reporting...24 hour initial reporting to applicable state agencies...."</p> <p>This federal tag relates to Complaint IN00098699.</p> <p>3.1-28(a)</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. Based on interview and record review, the facility failed to follow their abuse prevention policy and procedure, related to reporting an occurrence of verbal abuse to the Indiana State Department of Health [ISDH], for 1 of 1 resident sampled for</p>	F0226	No residents suffered any ill effects from the alleged deficient practice as stated the resident denied it was abusive..All reidents that file a grievance/have an investigation conducted in the future have the potential to be affected and through inservicing	11/28/2011

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	<p>investigations into alleged abuse, in a sample of 5. Resident D</p> <p>Findings include:</p> <p>1. On 10/31/11 at 7:30 A.M., the Director of Nursing [DON] provided an investigation into alleged verbal abuse. The DON indicated the investigation was started on 10/26/11, when Resident D "felt like the night shift nurse was rude when he asked for a pain pill." The DON indicated the resident complained to a physical therapist, who immediately informed a nurse, who immediately informed the Administrator and DON. The DON indicated she spoke to the resident and other staff, suspended the nurse, RN # 1, and then terminated the nurse after investigation. The DON indicated the resident did not think the nurse was abusive or neglectful. The DON indicated she contacted the corporate nurse, who "didn't think it needed to be reported" to the ISDH.</p> <p>2. On 10/31/11 at 7:00 A.M., the Administrator provided the current facility policy on "Abuse and Neglect Procedural Guidelines," undated. The policy included: "Purpose: [Name of corporation] has developed and implemented processes, which strive to ensure the prevention and reporting of</p>		<p>and systemic changes stated below will ensure procedures are followed in accordance with company policy and state/federal requirements. All department leaders will have directed inservice regarding investigation procedures and reporting requirements. Systemic change is ED will submit all grievances immediately for review by Division Director of Operations/Clinical Support with all steps in investigation and reporting requirements reviewed and timely submission to agencies ensured. ED will forward all allegations of abuse to QA committee monthly for review of compliance with investigation and reporting requirements x6 months and quarterlt thereafter for review and further recommendations.</p>		

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	<p>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...The Executive Director is responsible for: Notification to the State Department of Health...and other agencies, which include the Ombudsman, Adult Protective Services and/or local law enforcement agencies, as indicated...Reporting...24 hour initial reporting to applicable state agencies...."</p> <p>This federal tag relates to Complaint IN00098699.</p> <p>3.1-28(a)</p>				