

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155621 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>01/05/2011 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>PINE HAVEN HEALTH AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3400 STOCKER DR<br>EVANSVILLE, IN 47720 |
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| <p>F 000</p> <p>INITIAL COMMENTS</p> <p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00084081.</p> <p>Complaint IN00084081 - Substantiated. Federal/state deficiencies related to the allegations are cited at F223, F225, F226, F250 and F280.</p> <p>Survey dates: December 27, 28, 29, 30, 2010, January 3, 4, 5, 2011</p> <p>Facility number: 000442<br/>Provider number: 155621<br/>AIM number: 100266510</p> <p>Survey team:<br/>Diane Hancock, RN, TC<br/>Sue Webster, RN<br/>Jodi Meyer, RN<br/>Guylene Maurer, RD (12/27-12/30/10, 1/3, 1/4/11)</p> <p>Census bed type:<br/>SNF 45<br/>SNF/NF 58<br/>Total 103</p> <p>Census payor type:<br/>Medicare 14<br/>Medicaid 44<br/>Other 45<br/>Total 103</p> <p>Sample: 21<br/>Supplemental sample: 13</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> | <p>F 000</p> <p>Introduction</p> <p>Preparation and completion of this Plan of Correction does not constitute an admission or agreement with the truth of the facts alleged, or the validity of the conclusions set forth, in the Statement of Deficiencies rendered by the reviewing agency. This Plan of Correction is prepared and executed because State and Federal laws require it. The Provider maintains that the alleged deficiencies do not limit the Provider's capacity to render adequate patient care.</p> <p>Furthermore, the Provider asserts that, as of the date(s) indicated in the Plan, it is, or will be, in substantial compliance with regulations governing the licensure and operation of long term care facilities, and that this Plan of Correction, in its entirety, constitutes the Provider's credible allegation of such compliance.</p> |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br><i>Kathy Shoop</i> | TITLE<br><i>Administrator</i> | (X6) DATE<br><i>1/27/11</i> |
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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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| F 000   | Continued From page 1  | F 000  | F223 – Free from Abuse / Involuntary Seclusion:  |   |
| F 223<br>SS=D   | <p>Quality review 1/11/11 by Suzanne Williams, RN 483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</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>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview and record review, the facility failed to ensure resident to resident sexual contact did not occur between cognitively impaired residents, for 2 of 2 sampled residents with such behaviors, in the total sample of 21 (Residents N, O). The residents exhibited behaviors of fondling/manipulating genital areas of each other without adequate intervention to prevent the behaviors from reoccurring.</p> <p>Findings include:</p> <p>1. During the initial tour on 12/27/10 at 10:18 a.m., LPN #4, the unit manager, identified Resident N as having dementia and being cognitively impaired.</p> <p>On 12/28/10 at 10:45 a.m., Certified Nursing Assistant [CNA] #6 was overheard telling resident N he would like it where he was going. Resident N had resided on the North unit for several years. When queried about the comment, the CNA indicated resident N was being transferred to</p> | F 223  | <ol style="list-style-type: none"> <li>1. The two residents involved were referred to a short term inpatient gero-psych unit for evaluation to address behaviors. One resident was relocated on 12/30 to a different unit in the facility. Care plans reviewed.</li> <li>2. Any resident has the potential to be affected by the alleged deficient practice. Behavior minutes reviewed for any other report of similar behaviors by residents. Care plans reviewed for those on behavior monitor.</li> <li>3. A mandatory in-service was presented by the Ombudsman on 1/13 on abuse prevention policies and processes. Daily report is obtained by the two compliance nurses; 24 hour daily report logs reviewed by compliance nurses. CN (compliance nurse) will inquire daily from reporting nurse if, on the previous day, any allegations of abuse occurred at any level. All required documentation in regard to an allegation will be reviewed; care plan and interventions will be reviewed; notification of SS (Social Services) will be verified.</li> </ol> |   |

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| F 223   | <p>Continued From page 2<br/>another room on the South unit.</p> <p>Resident N's clinical record was reviewed on 12/29/10 at 1:30 p.m. The record contained diagnoses that included, but were not limited to, alcoholism, alcoholic cirrhosis, alcohol induced persisting dementia and depression.</p> <p>The Nurses' Notes contained the following entries:</p> <p>"12/25/10 1 p.m. - Res continues to touch female peers inappropriately. Reach's [sic] &amp; pulls w/c [wheelchair] alarm off bottom of w/c and turns off &amp; attempts to transfer self."</p> <p>12/28/10 1:30 p.m. - "Transferred to [room number]-report given to nurse."</p> <p>The Social Service progress notes, dated 12/28/10 [no time] contained the following entry: "Due to unsuccessful interventions I called daughter /POA [power of attorney] [name] for consent to move [resident's name] to a male room available on the South unit..."</p> <p>Next entry, dated 12/28/10 [no time], contained the following entry: "I spoke with resident regarding his room change. I explained to resident that the room change was due to his continued behaviors."</p> <p>The Social Service Progress Notes, written before the transfer, were reviewed at that time and contained the following entries related to the inappropriate touching of female residents:</p> <p>"5/28/10 [no time] It was reported to me that resident has inappropriately touched female staff</p> | F 223  | <p>4. Reported allegations of abuse will be documented by the compliance nurses and reviewed with the Director of Nursing on a daily basis. Log of allegations will be collected monthly and this monitor will continue for a minimum of six months and will be assessed for continued review at the quarterly QA meeting.</p> <p>5. 1/28</p> | 1/28/11   |

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| F 223 | <p>Continued From page 3</p> <p>and a resident. I explained to resident that it is inappropriate to touch other people and he need to keep his hands to himself. Resident stated 'but I'm a man...'</p> <p>Additional Social Service notes, dated 6/30/10, 9/13/10, 9/15/10, 11/22/10, and 12/1/10, addressed continued sexually inappropriate touching of female residents [not specific to whom] and staff.</p> <p>The Monthly Mood and Behavior Monitoring Flowsheet, reviewed at that time, contained the documentation of the number of occurrences of the resident's physically inappropriate touching. June 2010 (4), July (3), August (9), September (18), and October the first through the ninth (8). The record lacked any additional tracking of behaviors for the rest of October, November or December 2010.</p> <p>The consulting psychiatrist's Physician Progress Note, dated 11/21/10, included the following history: "staff reports that pt has been rubbing female resident, has been touching her inappropriately and has been putting his hands down her shirt. Pt denies any problem or any concerns when asked about behaviors he said, 'fooling around.' Denied hopelessness or helplessness."</p> <p>The treatment plan from the psychiatrist was as follows: "Pt understands that he can't lay his hands on any one. 'no fun' he said upon redirection. Kindly contact me should behavior return. Follow up in 2 months."</p> <p>The Nurses' Notes contained entries relating to this resident's inappropriate sexual behaviors of</p> | F 223 | <p>F223 Addendum</p> <p>The inservice by the ombudsman included definitions of neglect and abuse and indicators of abuse assessment (including physical indicators, behavioral indicators, indicators from family care giver). Information was provided on the definition of sexual abuse along with various examples of sexual abuse. Several examples were presented to emphasize the difference between a consenting adult vs. a resident with a cognitive impairment. Staff signed an acknowledgement that they had received education and training on abuse prohibition policy, including sexual abuse and the means of reporting these issues to management within the facility. This acknowledgement included noting receipt of the policy on abuse, a check list of interventions to complete if such an event occurs and explanation of disciplinary action for failure to follow policy.</p> |  |
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| F 223   | <p>Continued From page 4</p> <p>holding another resident's hand, rubbing and patting arms, discussion of sex with female residents, and/or being in a female resident's room since 4/28/10.</p> <p>The record lacked documentation in the Nurses' Notes of any behaviors from 6/17/10 until 9/13/10. On 9/13/10 at 10:00 a.m., the entry was as follows: "Res making inappropriate touching gestures on female peers. Redirected and told res gesture is inappropriate and not acceptable. Occurrence happened X 3. Redirected to room and removed female peers. Female peer initiated invite X 1."</p> <p>9/13/10 10:10 a.m. "SS [social service] notified of touching incidents."</p> <p>On 9/17/10 at 1:45 p.m., the physician was notified of the "sexual behavior problem res is having." The physician's response was "his is a result of his alcoholic dementia. Suggest that we continue to verbally cue him to not touch female residents. Also suggest that he be separated from female resident when verbal cueing does not work. He said that [no] med will help these behaviors, therefore there is no new orders."</p> <p>Resident N's last completed full Minimum Data Set Assessment, dated 6/22/10, indicated the resident had short term and long term memory problems and was moderately impaired in decision making. The assessment indicated the resident exhibited socially inappropriate behaviors 1-3 days in the past 7 days. The Resident Assessment Protocol summary indicated the resident was charted as rubbing a female resident's arm, and was educated as to the inappropriateness of the action.</p> | F 223  |   |                      |   |

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| F 223   | <p>Continued From page 5</p> <p>The resident's care plan was reviewed during the record review. The care plans for "socially inappropriate touching of staff and peers due to dementia/ impaired cognition," and "impaired cognitive status of decision making, memory and recall problems" had been updated on 9/13/10.</p> <p>The goal for the inappropriate touching and sexually inappropriate comments related to dementia, was to have no episodes of inappropriate touching.</p> <p>The interventions were to assess/record changes in behavior, report to physician significant changes in behavioral status, provide non-confrontational environment for care, anticipate needs and provide them before the resident becomes overly stressed, explain to resident in advance, share with resident other options for dealing with feelings, reinforce positive behavior, intervene during behavioral outbursts to protect the safety of the resident and others by: remove res from scene and redirect, and investigate/monitor the need for psychological/psychiatric support. Provide services if desired by the resident/family and ordered by physician.</p> <p>An additional care plan, dated 10/5/10, identified "Sexually inappropriate AEB [as evidenced by] inappropriate sexual comments, inappropriate touch [sic] of peers." The goal was "will have improvement in behaviors by the decrease of the frequency, intensity, and/or duration of aberrant activity."</p> <p>Interventions included: "Assess/record changes in behavior, report to physician significant</p> | F 223  |   |                      |   |

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| F 223   | <p>Continued From page 6</p> <p>changes in behavioral status, provide non-confrontational environment for care, reinforce positive behavior, administer and monitor effectiveness/side effects of medications per order, and investigate/monitor the need for psychological/psychiatric support and provide services if desired by the resident/family and ordered by the physician."</p> <p>Both care plans lacked proactive interventions to prevent contact with female peers.</p> <p>On 12/29/10 at 3:10 p.m., LPN #4 was queried about the behaviors and the room change. The LPN indicated that resident N's behaviors had increased after female resident O was transferred to the unit in March 2010, with an escalation in the number of episodes starting in August.</p> <p>LPN #4 indicated it had been reported to her by the evening shift nurse, on two separate occasions, that resident N had been observed in the company of a female resident (Resident O) when resident O had been manipulating his genitals. LPN #4 indicated the female resident involved would occasionally motion with her finger for resident N to come to her.</p> <p>LPN #4 indicated resident N had also been observed rubbing the arm of another female resident and that the female resident didn't like it. LPN #4 indicated the family physician and the psychiatrist had been notified but had issued no orders other than to the watch the residents and keep them away from each other. LPN #4 indicated this was extremely difficult due to the location of the residents' rooms being near each other and out of view unless staff remained in the dining/lounge area of the unit.</p> | F 223  |   |                      |   |

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| F 223   | <p>Continued From page 7</p> <p>The LPN indicated the incidents had been reported to social service staff repeatedly. She indicated the social service staff were responsible for residents with behaviors to notify the psychiatrist, set up appointments, and work on what to do for the behaviors.</p> <p>LPN #4 indicated the resident had been evaluated for a level two screening [a mental health evaluation], by an outside caseworker, and it had been on her advice that the resident had been transferred to an available bed on the South unit, to keep him away from Resident O.</p> <p>On 1/3/11 at 10:09 a.m., the Social Service Director [SSD] was queried about resident N's behaviors. She indicated she was in the process of trying to get him transferred to an inpatient psychiatric center that day. She stated "probably should have done that sooner." She indicated the resident had a problem with impulse control and that the attending physician had not been aggressive in his treatment.</p> <p>The SSD indicated that she was unaware of the resident having been fondled by the female resident. She indicated she only knew about him touching the female's breasts, hugging and rubbing females. She indicated it had not been reported to the state because it was "so sporadic, weeks when nothing would happen."</p> <p>SS [Social Service employee] #1 was present at the time of the interview. SS #1 indicated she was responsible for the residents on the North and South units. When she was queried about the behaviors, she stated, "if they are really bad, it's talked about in the daily meeting, otherwise in</p> | F 223  |   |   |

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| F 223   | <p>Continued From page 8</p> <p>the weekly Friday behavior meeting." SS #1 indicated when behaviors occurred, she would go and talk with the residents about the inappropriateness of the touching. She indicated she was only aware of resident N's fondling the breast of a female resident (O), inappropriate touching and prolonged hugs.</p> <p>The SSD and SS #1 denied being made aware of any manipulation of the genitals of resident N and indicated the resident had never been on any one to one monitoring. Neither indicated they had informed the Administrator of the known behavior of Resident N fondling Resident O's breast.</p> <p>On 1/3/11 at 12:05 p.m., the Behavior Manager Meeting notes were reviewed. The notes only contained the dates, name of residents addressed and the type of behavior, i.e. inappropriate touching. On the following dates [no times] the notes identified the resident had been discussed in the meeting because of "inappropriate touching of females," 9/17/10, 9/23/10, 11/2/10, 12/3/10, and 12/17/10.</p> <p>On 1/3/11 at 5:45 p.m., RN #3, the evening shift nurse on resident N's unit, was queried about the behaviors. She indicated resident N would touch resident O inappropriately. She indicated the CNA came and got her when the residents were observed together; she had seen Resident O with her hands on his thigh area and genitals, on the outside of his clothes, and she had reported the incidents to the unit manager LPN #4.</p> <p>On 1/3/11 at 11:25 a.m. the above information was reviewed with the facility Administrator [ADM], Director of Nursing Service [DNS] and RN #1. All three indicated they were unaware of the</p> | F 223  |   |                      |   |

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| F 223 | <p>Continued From page 9</p> <p>extent of the inappropriate behaviors. The DNS stated he was "only aware of hand holding." RN #1 stated, "only hand holding reported to me," and "should document what the inappropriate touching is."</p> <p>2. During the initial tour, on 12/27/10 at 10:21 a.m., resident O was identified, by LPN #4, as having had history of a stroke resulting in right side paralysis. The resident was observed seated in a wheelchair participating in a group activity. LPN #4 indicated the resident was cognitively impaired.</p> <p>Resident O's clinical record was reviewed on 12/29/10 at 3:15 p.m. The record contained diagnoses that included, but were not limited to, morbid obesity, hemiplegia, anxiety disorder, cerebrovascular disease, and subarachnoid hematoma.</p> <p>Resident O's most recent Minimum Data Set Assessment, an annual assessment, was dated 11/25/2010. The assessment indicated the resident had long term memory deficits, was not oriented to time and had problems with inattention. The assessment indicated the resident had behaviors; however, it did not indicate the behaviors were directed toward others.</p> <p>The record contained a level II mental health assessment, dated 2/22/10. The narrative description indicated that she had made "sexually inappropriate" remarks to a male aide. She reportedly stated "don't you want to have sex with me?"</p> <p>A review of the Nurses' Notes indicated the</p> | F 223 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
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| F 223 | <p>Continued From page 10</p> <p>following entries:</p> <p>9/13/10 10 a.m. "Res asking male peer to come over to her w/c. Male peer inappropriately touching female peer. Redirected and talked [with] res about inappropriate touching to her from male peer. SS notified &amp; res put on behavior charting."</p> <p>9/14/10 3:30 p.m. "Inappropriate inviting of male peer [with] touching x 1."</p> <p>9/29/10 3:25 p.m. "...was hugging another resident in a.m. Separated and told inappropriate."</p> <p>10/25/10 12:30 p.m. "Res in SDR [South dining room] for lunch. Res was moving w/c to side &amp; bumping peer [with] wheelchair. Staff moved res over and she was mumbling to peer then threw some food @ peer..."</p> <p>10/29/10 1:20 p.m. "Res very rude and demanding this shift. Kicking open BR door when peers are in B R..."</p> <p>12/28/10 10 p.m. "Resident noted calling others "asshole." Cursing at staff and other residents..."</p> <p>The Social Service Progress Notes were then reviewed. The notes contained the following entries:</p> <p>9/14/10 [no time] contained the following entry: "Talked with resident about male resident touching her inappropriately. I told resident that she can say no, move away and tell the nurse. Resident stated understanding."</p> <p>The monthly mood/behavior monitoring flowsheet,</p> | F 223 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

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| F 223 | <p>Continued From page 11 dated September 2010 identified "requesting touching from male peers" seven times from September 12-30.</p> <p>A care plan was implemented on 10/8/10 by social services for "inappropriately touching of peer" related to "requesting touching from male resident."</p> <p>The interventions were to:<br/>                 "Assess/record changes in behavior."<br/>                 "Report to physician significant changes."<br/>                 "Provide non-confrontational environment for care."<br/>                 "Investigate/monitor the need for psychological/psychiatric support. Provide services if desired by the resident/family and ordered by physician."</p> <p>The care plan lacked proactive interventions to prevent contact with male peer.</p> <p>On 12/29/10 at 3:10 p.m., LPN # 4 was interviewed about the behaviors and the room change of Resident N. The LPN indicated that resident N's behaviors had increased after female resident O was transferred to the unit in March 2010, with an escalation in the number of episodes starting in August.</p> <p>LPN #4 indicated it had been reported to her by the evening shift nurse, on two separate occasions, that resident N had been observed in the company of a female resident (O) when resident O had been manipulating his genitals. LPN #4 indicated that the female resident (O) involved would occasionally motion with her finger for resident N to come to her.</p> | F 223 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

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| F 223   | Continued From page 12<br>LPN #4 stated, "so much happens I'm sure it doesn't all get charted."<br><br>When queried about the lack of behavior monitoring flowsheet relating to the inappropriate touching, LPN #4 indicated that when they identified that the behavior was continuing, then they care planned it, but they didn't use the monitoring sheets any more.<br><br>The LPN indicated the incidents had been reported to social service staff repeatedly. She indicated the social service staff were responsible for residents with behaviors to notify the psychiatrist, set up appointments, and work on what to do for the behaviors.<br><br>3. The Abuse Prohibition Policy and Procedure was provided by the Administrator on 12/27/10 at 11:30 a.m. The policy was dated 8/6/08. The policy indicated "Allegations/suspicious/reports of abuse will be investigated immediately to ensure the safety and well being of the resident." The definition of sexual abuse in the policy was as follows: "sexual abuse is sexual contact that results from threats, force or the inability of the person to give consent."<br><br>This federal tag relates to complaint IN00084081. | F 223  |   |                      |   |
| F 225<br>SS=D   | 3.1-27(a)(1)<br>483.13(c)(1)(ii)-(iii), (c)(2) - (4)<br>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>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   | F 225  |   |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

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| F 225   | <p>Continued From page 13</p> <p>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>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview and record review, the facility failed to ensure resident to resident sexual contact between cognitively impaired residents was reported to the administrator of the facility immediately, and to</p> | F 225  | <p>F225 – Investigate/Report Allegation/ Individuals</p> <ol style="list-style-type: none"> <li>Minutes from Behavior Meeting were reviewed for any residents involved in incidents of sexual contact; the two residents noted were evaluated at an inpatient gero-psych unit. One resident was relocated on 12/30 to a different unit in the facility. Care plans reviewed.</li> <li>Any resident has the potential to be affected by the alleged deficient practice. Staff was in-serviced by the local Ombudsman in a mandatory in-service in regard to abuse prevention policies and processes. Behavior minutes reviewed for any other report of similar behaviors by residents. Care plans reviewed for those on behavior monitor.</li> <li>Daily report is obtained by the two compliance nurses; 24 hour daily report logs reviewed by compliance nurses. CN will inquire daily from reporting nurse if, on the previous day, any allegations of abuse occurred at any level. If any new occurrence is reported that was not immediately reported to either the</li> </ol> |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

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| F 225 | <p>Continued From page 14</p> <p>the State Agency, and was prevented from recurring, for 2 of 2 sampled residents with such behaviors, in the total sample of 21 (Residents N, O). The residents exhibited behaviors of fondling/manipulating genital areas of each other on multiple occasions.</p> <p>Findings include:</p> <p>1. During the initial tour on 12/27/10 at 10:18 a.m., LPN #4, the unit manager, identified Resident N as having dementia and being cognitively impaired.</p> <p>On 12/28/10 at 10:45 a.m., Certified Nursing Assistant [CNA] #6 was overheard telling resident N he would like it where he was going. Resident N had resided on the North unit for several years. When queried about the comment, the CNA indicated resident N was being transferred to another room on the South unit.</p> <p>Resident N's clinical record was reviewed on 12/29/10 at 1:30 p.m. The record contained diagnoses that included, but were not limited to, alcoholism, alcoholic cirrhosis, alcohol induced persisting dementia and depression.</p> <p>The Nurses' Notes contained the following entries:</p> <p>"12/25/10 1 p.m. - Res continues to touch female peers inappropriately. Reach's [sic] &amp; pulls w/c [wheelchair] alarm off bottom of w/c and turns off &amp; attempts to transfer self."</p> <p>12/28/10 1:30 p.m. - "Transferred to [room number]-report given to nurse."</p> | F 225 | <p>Director of Nursing or the Administrator, staff will be disciplined.</p> <p>4. Reported allegations of abuse will be documented by the compliance nurses and reviewed with the Director of Nursing on a daily basis. Log of allegations will be collected monthly and this monitor will continue for a minimum of six months and will be assessed for continued review at the quarterly QA meeting.</p> <p>5. 1/28</p> | 1/28/11 |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

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| F 225 | <p>Continued From page 15</p> <p>The Social Service progress notes, dated 12/28/10 [no time] contained the following entry: "Due to unsuccessful interventions I called daughter /POA [power of attorney] [name] for consent to move [resident's name] to a male room available on the South unit..."</p> <p>Next entry, dated 12/28/10 [no time], contained the following entry: "I spoke with resident regarding his room change. I explained to resident that the room change was due to his continued behaviors."</p> <p>The Social Service Progress Notes, written before the transfer, were reviewed at that time and contained the following entries related to the inappropriate touching of female residents:</p> <p>"5/28/10 [no time] It was reported to me that resident has inappropriately touched female staff and a resident. I explained to resident that it is inappropriate to touch other people and he need to keep his hands to himself. Resident stated 'but I'm a man...'"</p> <p>Additional Social Service notes, dated 6/30/10, 9/13/10, 9/15/10, 11/22/10, and 12/1/10, addressed continued sexually inappropriate touching of female residents [not specific to whom] and staff.</p> <p>The Monthly Mood and Behavior Monitoring Flowsheet, reviewed at that time, contained the documentation of the number of occurrences of the resident's physically inappropriate touching. June 2010 (4), July (3), August (9), September (18), and October the first through the ninth (8). The record lacked any additional tracking of behaviors for the rest of October, November or</p> | F 225 | <p>F 225 <i>Addendum</i></p> <p>The inservice by the ombudsman included definitions of neglect and abuse and indicators of abuse assessment (including physical indicators, behavioral indicators, indicators from family care giver). Information was provided on the definition of sexual abuse along with various examples of sexual abuse. Several examples were presented to emphasize the difference between a consenting adult vs. a resident with a cognitive impairment. Staff signed an acknowledgement that they had received education and training on abuse prohibition policy, including sexual abuse and the means of reporting these issues to management within the facility. This acknowledgement included noting receipt of the policy on abuse, a check list of interventions to complete if such an event occurs and explanation of disciplinary action for failure to follow policy.</p> <p>Any report of resident to resident contact between cognitively impaired residents will be reported to nursing administration either through Social Services or direct care staff; nursing administration will immediately notify to the Administrator. Compliance nurses will inquire daily about any</p> |  |
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*Admin*  
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

|   |  |  |   |   |
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| F 225   | <p>Continued From page 16<br/>December 2010.</p> <p>The consulting psychiatrist's Physician Progress Note, dated 11/21/10, included the following history: "staff reports that pt has been rubbing female resident, has been touching her inappropriately and has been putting his hands down her shirt. Pt denies any problem or any concerns when asked about behaviors he said, 'fooling around.' Denied hopelessness or helplessness."</p> <p>The treatment plan from the psychiatrist was as follows: "Pt understands that he can't lay his hands on any one. 'no fun' he said upon redirection. Kindly contact me should behavior return. Follow up in 2 months."</p> <p>The Nurses' Notes contained entries relating to this resident's inappropriate sexual behaviors of holding another resident's hand, rubbing and patting arms, discussion of sex with female residents, and/or being in a female resident's room since 4/28/10.</p> <p>The record lacked documentation in the Nurses' Notes of any behaviors from 6/17/10 until 9/13/10. On 9/13/10 at 10:00 a.m., the entry was as follows: "Res making inappropriate touching gestures on female peers. Redirected and told res gesture is inappropriate and not acceptable. Occurrence happened X 3. Redirected to room and removed female peers. Female peer initiated invite X 1."</p> <p>9/13/10 10:10 a.m. "SS [social service] notified of touching incidents."</p> <p>On 9/17/10 at 1:45 p.m., the physician was</p> | F 225  | <p>allegations of abuse when reviewing daily report with nursing staff. Compliance nurse will also notify Director of Nursing and Administrator of any allegations discovered during daily report that were not already reported. The Administrator will complete a full investigation and file the appropriate report with the ISDH.</p> |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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| F 225 | <p>Continued From page 17</p> <p>notified of the "sexual behavior problem res is having." The physician's response was "his is a result of his alcoholic dementia. Suggest that we continue to verbally cue him to not touch female residents. Also suggest that he be separated from female resident when verbal cueing does not work. He said that [no] med will help these behaviors, therefore there is no new orders."</p> <p>Resident N's last completed full Minimum Data Set Assessment, dated 6/22/10, indicated the resident had short term and long term memory problems and was moderately impaired in decision making. The assessment indicated the resident exhibited socially inappropriate behaviors 1-3 days in the past 7 days. The Resident Assessment Protocol summary indicated the resident was charted as rubbing a female resident's arm, and was educated as to the inappropriateness of the action.</p> <p>The resident's care plan was reviewed during the record review. The care plans for "socially inappropriate touching of staff and peers due to dementia/ impaired cognition," and "impaired cognitive status of decision making, memory and recall problems" had been updated on 9/13/10.</p> <p>The goal for the inappropriate touching and sexually inappropriate comments related to dementia, was to have no episodes of inappropriate touching.</p> <p>The interventions were to assess/record changes in behavior, report to physician significant changes in behavioral status, provide non-confrontational environment for care, anticipate needs and provide them before the resident becomes overly stressed, explain to</p> | F 225 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 225              | <p>Continued From page 18</p> <p>resident in advance, share with resident other options for dealing with feelings, reinforce positive behavior, intervene during behavioral outbursts to protect the safety of the resident and others by: remove res from scene and redirect, and investigate/monitor the need for psychological/psychiatric support. Provide services if desired by the resident/family and ordered by physician.</p> <p>An additional care plan, dated 10/5/10, identified "Sexually inappropriate AEB [as evidenced by] inappropriate sexual comments, inappropriate touch [sic] of peers." The goal was "will have improvement in behaviors by the decrease of the frequency, intensity, and/or duration of aberrant activity."</p> <p>Interventions included: "Assess/record changes in behavior, report to physician significant changes in behavioral status, provide non-confrontational environment for care, reinforce positive behavior, administer and monitor effectiveness/side effects of medications per order, and investigate/monitor the need for psychological/psychiatric support and provide services if desired by the resident/family and ordered by the physician."</p> <p>Both care plans lacked proactive interventions to prevent contact with female peers:</p> <p>On 12/29/10 at 3:10 p.m., LPN #4 was queried about the behaviors and the room change. The LPN indicated that resident N's behaviors had increased after female resident O was transferred to the unit in March 2010, with an escalation in the number of episodes starting in August.</p> | F 225         |   |                      |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 225   | <p>Continued From page 19</p> <p>LPN #4 indicated it had been reported to her by the evening shift nurse, on two separate occasions, that resident N had been observed in the company of a female resident (Resident O) when resident O had been manipulating his genitals. LPN #4 indicated the female resident involved would occasionally motion with her finger for resident N to come to her.</p> <p>LPN #4 indicated resident N had also been observed rubbing the arm of another female resident and that the female resident didn't like it. LPN #4 indicated the family physician and the psychiatrist had been notified but had issued no orders other than to the watch the residents and keep them away from each other. LPN #4 indicated this was extremely difficult due to the location of the residents' rooms being near each other and out of view unless staff remained in the dining/lounge area of the unit.</p> <p>The LPN indicated the incidents had been reported to social service staff repeatedly. She indicated the social service staff were responsible for residents with behaviors to notify the psychiatrist, set up appointments, and work on what to do for the behaviors.</p> <p>LPN #4 indicated the resident had been evaluated for a level two screening [a mental health evaluation], by an outside caseworker, and it had been on her advice that the resident had been transferred to an available bed on the South unit, to keep him away from Resident O.</p> <p>On 1/3/11 at 10:09 a.m., the Social Service Director [SSD] was queried about resident N's behaviors. She indicated she was in the process of trying to get him transferred to an inpatient</p> | F 225  |   |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
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OMB NO. 0938-0391

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| F 225 | <p>Continued From page 20</p> <p>psychiatric center that day. She stated "probably should have done that sooner." She indicated the resident had a problem with impulse control and that the attending physician had not been aggressive in his treatment.</p> <p>The SSD indicated that she was unaware of the resident having been fondled by the female resident. She indicated she only knew about him touching the female's breasts, hugging and rubbing females. She indicated it had not been reported to the state because it was "so sporadic, weeks when nothing would happen."</p> <p>SS [Social Service employee] #1 was present at the time of the interview. SS #1 indicated she was responsible for the residents on the North and South units. When she was queried about the behaviors, she stated, "if they are really bad, it's talked about in the daily meeting, otherwise in the weekly Friday behavior meeting." SS #1 indicated when behaviors occurred, she would go and talk with the residents about the inappropriateness of the touching. She indicated she was only aware of resident N's fondling the breast of a female resident (O), inappropriate touching and prolonged hugs.</p> <p>The SSD and SS #1 denied being made aware of any manipulation of the genitals of resident N and indicated the resident had never been on any one to one monitoring. Neither indicated they had informed the Administrator of the known behavior of Resident N fondling Resident O's breast.</p> <p>On 1/3/11 at 12:05 p.m., the Behavior Manager Meeting notes were reviewed. The notes only contained the dates, name of residents addressed and the type of behavior, i.e.</p> | F 225 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 225 | <p>Continued From page 21</p> <p>inappropriate touching. On the following dates [no times] the notes identified the resident had been discussed in the meeting because of "inappropriate touching of females," 9/17/10, 9/23/10, 11/2/10, 12/3/10, and 12/17/10.</p> <p>On 1/3/11 at 5:45 p.m., RN #3, the evening shift nurse on resident N's unit, was queried about the behaviors. She indicated resident N would touch resident O inappropriately. She indicated the CNA came and got her when the residents were observed together; she had seen Resident O with her hands on his thigh area and genitals, on the outside of his clothes, and she had reported the incidents to the unit manager LPN #4.</p> <p>On 1/3/11 at 11:25 a.m. the above information was reviewed with the facility Administrator [ADM], Director of Nursing Service [DNS] and RN #1. All three indicated they were unaware of the extent of the inappropriate behaviors. The DNS stated he was "only aware of hand holding." RN #1 stated, "only hand holding reported to me," and "should document what the inappropriate touching is."</p> <p>2. During the initial tour, on 12/27/10 at 10:21 a.m., resident O was identified, by LPN #4, as having had history of a stroke resulting in right side paralysis. The resident was observed seated in a wheelchair participating in a group activity. LPN #4 indicated the resident was cognitively impaired.</p> <p>Resident O's clinical record was reviewed on 12/29/10 at 3:15 p.m. The record contained diagnoses that included, but were not limited to, morbid obesity, hemiplegia, anxiety disorder, cerebrovascular disease, and subarachnoid</p> | F 225 |  |  |
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 225 | <p>Continued From page 22 hematoma.</p> <p>Resident O's most recent Minimum Data Set Assessment, an annual assessment, was dated 11/25/2010. The assessment indicated the resident had long term memory deficits, was not oriented to time and also had problems with inattention. The assessment indicated the resident had behaviors; however, it did not indicate the behaviors were directed toward others.</p> <p>The record contained a level II mental health assessment, dated 2/22/10. The narrative description indicated that she had made "sexually inappropriate" remarks to a male aide. She reportedly stated "don't you want to have sex with me?"</p> <p>A review of the Nurses' Notes indicated the following entries:<br/>9/13/10 10 a.m. "Res asking male peer to come over to her w/c. Male peer inappropriately touching female peer. Redirected and talked [with] res about inappropriate touching to her from male peer. SS notified &amp; res put on behavior charting."<br/>9/14/10 3:30 p.m. "Inappropriate inviting of male peer [with] touching x 1."<br/>9/29/10 3:25 p.m. "...was hugging another resident in a.m. Separated and told inappropriate."<br/>10/25/10 12:30 p.m. "Res in SDR [South dining room] for lunch. Res was moving w/c to side &amp; bumping peer [with] wheelchair. Staff moved res over and she was mumbling to peer then threw</p> | F 225 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

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| F 225   | <p>Continued From page 23<br/>some food @ peer..."</p> <p>10/29/10 1:20 p.m. "Res very rude and demanding this shift. Kicking open BR door when peers are in B R..."</p> <p>12/28/10 10 p.m. "Resident noted calling others "asshole." Cursing at staff and other residents..."</p> <p>The Social Service Progress Notes were then reviewed. The notes contained the following entries:</p> <p>9/14/10 [no time] contained the following entry: "Talked with resident about male resident touching her inappropriately. I told resident that she can say no, move away and tell the nurse. Resident stated understanding."</p> <p>The monthly mood/behavior monitoring flowsheet, dated September 2010 identified "requesting touching from male peers" seven times from September 12-30.</p> <p>A care plan was implemented on 10/8/10 by social services for "inappropriately touching of peer" related to "requesting touching from male resident."</p> <p>The interventions were to:<br/>"Assess/record changes in behavior."<br/>"Report to physician significant changes."<br/>"Provide non-confrontational environment for care."<br/>"Investigate/monitor the need for psychological/psychiatric support. Provide services if desired by the resident/family and ordered by physician."</p> | F 225  |   |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 225   | <p>Continued From page 24</p> <p>The care plan lacked proactive interventions to prevent contact with male peer.</p> <p>On 12/29/10 at 3:10 p.m. LPN # 4 was queried about the behaviors and the room change of Resident N. The LPN indicated that resident N's behaviors had increased after female resident O was transferred to the unit in March 2010, with an escalation in the number of episodes starting in August.</p> <p>LPN #4 indicated it had been reported to her by the evening shift nurse, on two separate occasions, that resident N had been observed in the company of a female resident (O) when resident O had been manipulating his genitals. LPN #4 indicated that the female resident (O) involved would occasionally motion with her finger for resident N to come to her.</p> <p>LPN #4 stated, "so much happens I'm sure it doesn't all get charted."</p> <p>When queried about the lack of behavior monitoring flowsheet relating to the inappropriate touching, LPN #4 indicated that when they identified that the behavior was continuing, then they care planned it, but they didn't use the monitoring sheets any more.</p> <p>The LPN indicated the incidents had been reported to social service staff repeatedly. She indicated the social service staff were responsible for residents with behaviors to notify the psychiatrist, set up appointments, and work on what to do for the behaviors.</p> <p>3. The Abuse Prohibition Policy and Procedure was provided by the Administrator on 12/27/10 at</p> | F 225  |   |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
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| F 225   | <p>Continued From page 25</p> <p>11:30 a.m. The policy was dated 8/6/08. The policy included, but was not limited to, the following: "Allegations/suspicious/reports of abuse will be investigated immediately to ensure the safety and well being of the resident." The definition of sexual abuse in the policy was as follows: "sexual abuse is sexual contact that results from threats, force or the inability of the person to give consent."</p> <p>For Prevention, "reported instances of any of the above situations will be investigated immediately and reported to the appropriate authorities and agencies. A determination should be made by immediate care team members as to the appropriateness of keeping the resident in the same setting where the alleged incident occurred..."</p> <p>4. The policy and procedure for "Reportable Unusual Occurrences to the State" was provided by the Director of Nurses on 1/5/11 at 1:50 p.m. The policy indicated the following: "All unusual occurrences reported to the Indiana State Department of Health (ISDH) will be recorded/tracked/monitored to ensure residents are receiving appropriate care and services."</p> <p>The Procedure included, but was not limited to, the following: "Facilities are required by law to report unusual occurrences within 24 hours of occurrence to the Long Term Care Division. CFR [Code of Federal Regulations] 483.13(c)(2) states that '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...'"</p> | F 225  |   |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

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|--------------------|--|---------------|---|----------------------|
| F 225              | Continued From page 26<br>"The facility must contact the ISDH within 24 hours upon determining a situation exists (or existed) that is reportable under these guidelines."<br><br>This federal tag relates to complaint IN00084081.  | F 225         |   |                      |
| F 226<br>SS=D      | 3.1-28(c)<br>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to implement their abuse policy to ensure resident to resident sexual contact between cognitively impaired residents did not occur, to ensure the behavior was reported to the administrator of the facility immediately, and to the State Agency, for 2 of 2 sampled residents with such behaviors, in the total sample of 21 (Residents N, O). The residents exhibited behaviors of fondling/manipulating genital areas of each other on multiple occasions, without revision of interventions, investigation and notification.<br><br>Findings include:<br><br>1. During the initial tour on 12/27/10 at 10:18 a.m., LPN #4, the unit manager, identified Resident N as having dementia and being cognitively impaired. | F 226         | F226 – Develop/Implement Abuse/Neglect Policies<br><br>1. Residents involved were referred to an inpatient geropsych unit for evaluation to address behaviors. One resident was relocated on 12/30 to a different unit in the facility. Care plans reviewed.<br><br>2. Any resident has the potential to be affected by the alleged deficient practice. Staff was in-serviced by the local Ombudsman in a mandatory in-service in regard to abuse prevention policies and processes. Behavior minutes reviewed for any other report of similar behaviors by residents. Care plans reviewed for those on behavior monitor.<br><br>3. Daily report is obtained by the two compliance nurses; 24 hour daily report logs reviewed by compliance nurses. CN will inquire daily from reporting nurse if, on |                      |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

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| F 226   | <p>Continued From page 27</p> <p>On 12/28/10 at 10:45 a.m., Certified Nursing Assistant [CNA] #6 was overheard telling resident N he would like it where he was going. Resident N had resided on the North unit for several years. When queried about the comment, the CNA indicated resident N was being transferred to another room on the South unit.</p> <p>Resident N's clinical record was reviewed on 12/29/10 at 1:30 p.m. The record contained diagnoses that included, but were not limited to, alcoholism, alcoholic cirrhosis, alcohol induced persisting dementia and depression.</p> <p>The Nurses' Notes contained the following entries:</p> <p>"12/25/10 1 p.m. - Res continues to touch female peers inappropriately. Reach's [sic] &amp; pulls w/c [wheelchair] alarm off bottom of w/c and turns off &amp; attempts to transfer self."</p> <p>12/28/10 1:30 p.m. - "Transferred to [room number]-report given to nurse."</p> <p>The Social Service progress notes, dated 12/28/10 [no time] contained the following entry: "Due to unsuccessful interventions I called daughter /POA [power of attorney] [name] for consent to move [resident's name] to a male room available on the South unit..."</p> <p>Next entry, dated 12/28/10 [no time], contained the following entry: "I spoke with resident regarding his room change. I explained to resident that the room change was due to his continued behaviors."</p> | F 226  | <p>the previous day, any allegations of abuse occurred at any level. If any new occurrence is reported that was not immediately reported to either the Director of Nursing or the Administrator, staff will be disciplined.</p> <p>4. Reported allegations of abuse will be documented by the compliance nurses and reviewed with the Director of Nursing on a daily basis. Log of allegations will be collected monthly and this monitor will continue for a minimum of six months and will be assessed for continued review at the quarterly QA meeting.</p> <p>5. 1/28</p> | 1/28/11              |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
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| F 226 | <p>Continued From page 28</p> <p>The Social Service Progress Notes, written before the transfer, were reviewed at that time and contained the following entries related to the inappropriate touching of female residents:</p> <p>"5/28/10 [no time] It was reported to me that resident has inappropriately touched female staff and a resident. I explained to resident that it is inappropriate to touch other people and he need to keep his hands to himself. Resident stated 'but I'm a man...'"</p> <p>Additional Social Service notes, dated 6/30/10, 9/13/10, 9/15/10, 11/22/10, and 12/1/10, addressed continued sexually inappropriate touching of female residents [not specific to whom] and staff:</p> <p>The Monthly Mood and Behavior Monitoring Flowsheet, reviewed at that time, contained the documentation of the number of occurrences of the resident's physically inappropriate touching. June 2010 (4), July (3), August (9), September (18), and October the first through the ninth (8). The record lacked any additional tracking of behaviors for the rest of October, November or December 2010.</p> <p>The consulting psychiatrist's Physician Progress Note, dated 11/21/10, included the following history: "staff reports that pt has been rubbing female resident, has been touching her inappropriately and has been putting his hands down her shirt. Pt denies any problem or any concerns when asked about behaviors he said, 'fooling around.' Denied hopelessness or helplessness."</p> <p>The treatment plan from the psychiatrist was as</p> | F 226 | <p>F 226 <i>Addendum</i></p> <p>The inservice by the ombudsman included definitions of neglect and abuse and indicators of abuse assessment (including physical indicators, behavioral indicators, indicators from family care giver). Information was provided on the definition of sexual abuse along with various examples of sexual abuse. Several examples were presented to emphasize the difference between a consenting adult vs. a resident with a cognillve impairment. Staff signed an acknowledgement that they had received education and training on abuse prohibition policy, including sexual abuse and the means of reporting these issues to management within the facility. This acknowledgement included noting receipt of the policy on abuse, a check list of interventions to complete if such an event occurs and explanation of disciplinary action for failure to follow policy.</p> <p>Any report of resident to resident contact between cognitively impaired residents will be reported to nursing administration either through Social Services or direct care staff; Nursing administration will immediately notify the Administrator. Compliance nurses will inquire daily about any allegations of abuse when reviewing daily report with nursing staff. Compliance nurse will also notify</p> |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 226   | <p>Continued From page 29</p> <p>follows: "Pt understands that he can't lay his hands on any one. 'no fun' he said upon redirection. Kindly contact me should behavior return. Follow up in 2 months."</p> <p>The Nurses' Notes contained entries relating to this resident's inappropriate sexual behaviors of holding another resident's hand, rubbing and patting arms, discussion of sex with female residents, and/or being in a female resident's room since 4/28/10.</p> <p>The record lacked documentation in the Nurses' Notes of any behaviors from 6/17/10 until 9/13/10. On 9/13/10 at 10:00 a.m., the entry was as follows: "Res making inappropriate touching gestures on female peers. Redirected and told res gesture is inappropriate and not acceptable. Occurrence happened X 3. Redirected to room and removed female peers. Female peer initiated invite X 1."</p> <p>9/13/10 10:10 a.m. "SS [social service] notified of touching incidents."</p> <p>On 9/17/10 at 1:45 p.m., the physician was notified of the "sexual behavior problem res is having." The physician's response was "his is a result of his alcoholic dementia. Suggest that we continue to verbally cue him to not touch female residents. Also suggest that he be separated from female resident when verbal cueing does not work. He said that [no] med will help these behaviors, therefore there is no new orders."</p> <p>Resident N's last completed full Minimum Data Set Assessment, dated 6/22/10, indicated the resident had short term and long term memory problems and was moderately impaired in</p> | F 226  | <p>Director of Nursing and Administrator of any allegations discovered during daily report that were not already reported. The Administrator will complete a full investigation and file the appropriate report with the ISDH.</p> |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 226   | <p>Continued From page 30</p> <p>decision making. The assessment indicated the resident exhibited socially inappropriate behaviors 1-3 days in the past 7 days. The Resident Assessment Protocol summary indicated the resident was charted as rubbing a female resident's arm, and was educated as to the inappropriateness of the action.</p> <p>The resident's care plan was reviewed during the record review. The care plans for "socially inappropriate touching of staff and peers due to dementia/ impaired cognition," and "impaired cognitive status of decision making, memory and recall problems" had been updated on 9/13/10.</p> <p>The goal for the inappropriate touching and sexually inappropriate comments related to dementia, was to have no episodes of inappropriate touching.</p> <p>The interventions were to assess/record changes in behavior, report to physician significant changes in behavioral status, provide non-confrontational environment for care, anticipate needs and provide them before the resident becomes overly stressed, explain to resident in advance, share with resident other options for dealing with feelings, reinforce positive behavior, intervene during behavioral outbursts to protect the safety of the resident and others by: remove res from scene and redirect, and investigate/monitor the need for psychological/psychiatric support. Provide services if desired by the resident/family and ordered by physician.</p> <p>An additional care plan, dated 10/5/10, identified "Sexually inappropriate AEB [as evidenced by] inappropriate sexual comments, inappropriate</p> | F 226  |   |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

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| F 226   | <p>Continued From page 31</p> <p>touch [sic] of peers." The goal was "will have improvement in behaviors by the decrease of the frequency, intensity, and/or duration of aberrant activity."</p> <p>Interventions included: "Assess/record changes in behavior, report to physician significant changes in behavioral status, provide non-confrontational environment for care, reinforce positive behavior, administer and monitor effectiveness/side effects of medications per order, and investigate/monitor the need for psychological/psychiatric support and provide services if desired by the resident/family and ordered by the physician."</p> <p>Both care plans lacked proactive interventions to prevent contact with female peers.</p> <p>On 12/29/10 at 3:10 p.m., LPN #4 was queried about the behaviors and the room change. The LPN indicated that resident N's behaviors had increased after female resident O was transferred to the unit in March 2010, with an escalation in the number of episodes starting in August.</p> <p>LPN #4 indicated it had been reported to her by the evening shift nurse, on two separate occasions, that resident N had been observed in the company of a female resident (Resident O) when resident O had been manipulating his genitals. LPN #4 indicated the female resident involved would occasionally motion with her finger for resident N to come to her.</p> <p>LPN #4 indicated resident N had also been observed rubbing the arm of another female resident and that the female resident didn't like it. LPN #4 indicated the family physician and the</p> | F 226  |   |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
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| F 226   | <p>Continued From page 32</p> <p>psychiatrist had been notified but had issued no orders other than to the watch the residents and keep them away from each other. LPN #4 indicated this was extremely difficult due to the location of the residents' rooms being near each other and out of view unless staff remained in the dining/lounge area of the unit.</p> <p>The LPN indicated the incidents had been reported to social service staff repeatedly. She indicated the social service staff were responsible for residents with behaviors to notify the psychiatrist, set up appointments, and work on what to do for the behaviors.</p> <p>LPN #4 indicated the resident had been evaluated for a level two screening [a mental health evaluation], by an outside caseworker, and it had been on her advice that the resident had been transferred to an available bed on the South unit, to keep him away from Resident O.</p> <p>On 1/3/11 at 10:09 a.m., the Social Service Director [SSD] was queried about resident N's behaviors. She indicated she was in the process of trying to get him transferred to an inpatient psychiatric center that day. She stated "probably should have done that sooner." She indicated the resident had a problem with impulse control and that the attending physician had not been aggressive in his treatment.</p> <p>The SSD indicated that she was unaware of the resident having been fondled by the female resident. She indicated she only knew about him touching the female's breasts, hugging and rubbing females. She indicated it had not been reported to the state because it was "so sporadic, weeks when nothing would happen."</p> | F 226  |   |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
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| F 226 | <p>Continued From page 33</p> <p>SS [Social Service employee] #1 was present at the time of the interview. SS #1 indicated she was responsible for the residents on the North and South units. When she was queried about the behaviors, she stated, "if they are really bad, it's talked about in the daily meeting, otherwise in the weekly Friday behavior meeting." SS #1 indicated when behaviors occurred, she would go and talk with the residents about the inappropriateness of the touching. She indicated she was only aware of resident N's fondling the breast of a female resident (O), inappropriate touching and prolonged hugs.</p> <p>The SSD and SS #1 denied being made aware of any manipulation of the genitals of resident N and indicated the resident had never been on any one to one monitoring. Neither indicated they had informed the Administrator of the known behavior of Resident N fondling Resident O's breast.</p> <p>On 1/3/11 at 12:05 p.m., the Behavior Manager Meeting notes were reviewed. The notes only contained the dates, name of residents addressed and the type of behavior, i.e. inappropriate touching. On the following dates [no times] the notes identified the resident had been discussed in the meeting because of "inappropriate touching of females," 9/17/10, 9/23/10, 11/2/10, 12/3/10, and 12/17/10.</p> <p>On 1/3/11 at 5:45 p.m., RN #3, the evening shift nurse on resident N's unit was queried about the behaviors. She indicated resident N would touch resident O inappropriately. She indicated the CNA came and got her when the residents were observed together, she had seen Resident O with her hands on his thigh area and genitals, on the</p> | F 226 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
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| F 226   | <p>Continued From page 34</p> <p>outside of his clothes, and she had reported the incidents to the unit manager LPN #4.</p> <p>On 1/3/11 at 11:25 a.m. the above information was reviewed with the facility Administrator [ADM], Director of Nursing Service [DNS] and RN #1. All three indicated they were unaware of the extent of the inappropriate behaviors. The DNS stated he was "only aware of hand holding." RN #1 stated, "only hand holding reported to me," and "should document what the inappropriate touching is."</p> <p>2. During the initial tour, on 12/27/10 at 10:21 a.m., resident O was identified, by LPN #4, as having had history of a stroke resulting in right side paralysis. The resident was observed seated in a wheelchair participating in a group activity. LPN #4 indicated the resident was cognitively impaired.</p> <p>Resident O's clinical record was reviewed on 12/29/10 at 3:15 p.m. The record contained diagnoses that included, but were not limited to, morbid obesity, hemiplegia, anxiety disorder, cerebrovascular disease, and subarachnoid hematoma.</p> <p>Resident O's most recent Minimum Data Set Assessment, an annual assessment, was dated 11/25/2010. The assessment indicated the resident had long term memory deficits, was not oriented to time and also had problems with inattention. The assessment indicated the resident had behaviors; however, it did not indicate the behaviors were directed toward others.</p> <p>The record contained a level II mental health</p> | F 226  |   |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
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| F 226   | <p>Continued From page 35</p> <p>assessment, dated 2/22/10. The narrative description indicated that she had made "sexually inappropriate" remarks to a male aide. She reportedly stated "don't you want to have sex with me?"</p> <p>A review of the Nurses' Notes indicated the following entries:</p> <p>9/13/10 10 a.m. "Res asking male peer to come over to her w/c. Male peer inappropriately touching female peer. Redirected and talked [with] res about inappropriate touching to her from male peer. SS notified &amp; res put on behavior charting."</p> <p>9/14/10 3:30 p.m. "Inappropriate inviting of male peer [with] touching x 1."</p> <p>9/29/10 3:25 p.m. "...was hugging another resident in a.m. Separated and told inappropriate."</p> <p>10/25/10 12:30 p.m. "Res in SDR [South dining room] for lunch. Res was moving w/c to side &amp; bumping peer [with] wheelchair. Staff moved res over and she was mumbling to peer then threw some food @ peer..."</p> <p>10/29/10 1:20 p.m. "Res very rude and demanding this shift. Kicking open BR door when peers are in B R..."</p> <p>12/28/10 10 p.m. "Resident noted calling others "asshole." Cursing at staff and other residents..."</p> <p>The Social Service Progress Notes were then reviewed. The notes contained the following entries:</p> | F 226  |   |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 226   | <p>Continued From page 36</p> <p>9/14/10 [no time] contained the following entry:<br/>"Talked with resident about male resident touching her inappropriately. I told resident that she can say no, move away and tell the nurse. Resident stated understanding."</p> <p>The monthly mood/behavior monitoring flowsheet, dated September 2010 identified "requesting touching from male peers" seven times from September 12-30.</p> <p>A care plan was implemented on 10/8/10 by social services for "inappropriately touching of peer" related to "requesting touching from male resident."</p> <p>The interventions were to:<br/>"Assess/record changes in behavior."<br/>"Report to physician significant changes."<br/>"Provide non-confrontational environment for care."<br/>"Investigate/monitor the need for psychological/psychiatric support. Provide services if desired by the resident/family and ordered by physician."</p> <p>The care plan lacked proactive interventions to prevent contact with male peer.</p> <p>On 12/29/10 at 3:10 p.m. LPN # 4 was queried about the behaviors and the room change of Resident N. The LPN indicated that resident N's behaviors had increased after female resident O was transferred to the unit in March 2010, with an escalation in the number of episodes starting in August.</p> <p>LPN #4 indicated it had been reported to her by the evening shift nurse, on two separate</p> | F 226  |   |                      |   |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 226   | <p>Continued From page 37</p> <p>occasions, that resident N had been observed in the company of a female resident (O) when resident O had been manipulating his genitals. LPN #4 indicated that the female resident (O) involved would occasionally motion with her finger for resident N to come to her.</p> <p>LPN #4 stated, "so much happens I'm sure it doesn't all get charted."</p> <p>When queried about the lack of behavior monitoring flowsheet relating to the inappropriate touching, LPN #4 indicated that when they identified that the behavior was continuing, then they care planned it, but they didn't use the monitoring sheets any more.</p> <p>The LPN indicated the incidents had been reported to social service staff repeatedly. She indicated the social service staff were responsible for residents with behaviors to notify the psychiatrist, set up appointments, and work on what to do for the behaviors.</p> <p>3. The Abuse Prohibition Policy and Procedure was provided by the Administrator on 12/27/10 at 11:30 a.m. The policy was dated 8/6/08. The policy included, but was not limited to, the following: "Allegations/suspicions/reports of abuse will be investigated immediately to ensure the safety and well being of the resident." The definition of sexual abuse in the policy was as follows: "sexual abuse is sexual contact that results from threats, force or the inability of the person to give consent."<br/>For Prevention, "reported instances of any of the above situations will be investigated immediately and reported to the appropriate authorities and agencies. A determination should be made by</p> | F 226  |   |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 226   | Continued From page 38<br>immediate care team members as to the appropriateness of keeping the resident in the same setting where the alleged incident occurred..."<br><br>4. The policy and procedure for "Reportable Unusual Occurrences to the State" was provided by the Director of Nurses on 1/5/11 at 1:50 p.m. The policy indicated the following: "All unusual occurrences reported to the Indiana State Department of Health (ISDH) will be recorded/tracked/monitored to ensure residents are receiving appropriate care and services."<br><br>The Procedure included, but was not limited to, the following: "Facilities are required by law to report unusual occurrences within 24 hours of occurrence to the Long Term Care Division, CFR [Code of Federal Regulations] 483.13(c)(2) states that '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...'"<br>"The facility must contact the ISDH within 24 hours upon determining a situation exists (or existed) that is reportable under these guidelines."<br><br>This federal tag relates to complaint IN00084081. | F 226  |   |                      |   |
| F 250<br>SS=D   | 3.1-28(a)<br>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE<br><br>The facility must provide medically-related social services to attain or maintain the highest   | F 250  |   |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

|   |  |  |   |   |
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| F 250   | <p>Continued From page 39</p> <p>practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview and record review, the facility failed to ensure medically related social services were provided to ensure sexually inappropriate behaviors between unrelated residents were not allowed to occur, for 2 of 2 sampled residents with behaviors, in the total sample of 21 (Residents N, O). The residents exhibited behaviors of fondling/manipulating genital areas of each other without adequate intervention to prevent the behavior.</p> <p>Findings include:</p> <p>1. During the initial tour on 12/27/10 at 10:18 a.m., LPN #4, the unit manager, identified Resident N as having dementia and being cognitively impaired.</p> <p>On 12/28/10 at 10:45 a.m., Certified Nursing Assistant [CNA] #6 was overheard telling resident N he would like it where he was going. Resident N had resided on the North unit for several years. When queried about the comment, the CNA indicated resident N was being transferred to another room on the South unit.</p> <p>Resident N's clinical record was reviewed on 12/29/10 at 1:30 p.m. The record contained diagnoses that included, but were not limited to, alcoholism, alcoholic cirrhosis, alcohol induced persisting dementia and depression.</p> | F 250  | <p>F250 Provision of Medically Related Social Services</p> <ol style="list-style-type: none"> <li>Residents involved were referred to short term inpatient gero-psych unit for evaluation to address behaviors. One resident was relocated on 12/30 to a different unit in the facility. Care plans reviewed.</li> <li>Any resident has the potential to be affected by the alleged deficient practice. Staff was in-serviced by the local Ombudsman in a mandatory in-service in regard to abuse prevention and the importance of accurate documentation of actual behavior. Behavior minutes reviewed for any other report of similar behaviors by residents. Care plans reviewed for those on behavior monitor.</li> <li>Behavior policy was reviewed and revised. Ombudsman presented in-service related to abusive behaviors, particularly sexual abuse. Any instances of sexual contact that are observed are to be reported to Director of Nursing as well as social services staff; both will review care plan and determine appropriateness of interventions.</li> </ol> |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

|   |   |  |  |   |
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| F 250   | <p>Continued From page 40</p> <p>The Nurses' Notes contained the following entries:</p> <p>"12/25/10 1 pm - Res continues to touch female peers inappropriately. Reach's [sic] &amp; pulls w/c [wheelchair] alarm off bottom of w/c and turns off &amp; attempts to transfer self."</p> <p>" 12/28/10 1:30 p.m. - "Transferred to [room number]-report given to nurse."</p> <p>The Social Service progress notes, dated 12/28/10 [no time] contained the following entry:<br/>"Due to unsuccessful interventions I called daughter /POA [power of attorney] [name] for consent to move [resident's name] to a male room available on the South unit..."</p> <p>Next entry dated 12/28/10 [no time] contained the following entry: "I spoke with resident regarding his room change. I explained to resident that the room change was due to his continued behaviors."</p> <p>The Social Service Progress Notes, written before the transfer, were reviewed at that time and contained the following entries related to the inappropriate touching of female residents:</p> <p>"5/28/10 [no time] It was reported to me that resident has inappropriately touched female staff and a resident. I explained to resident that it is inappropriate to touch other people and he need to keep his hands to himself. Resident stated 'but I'm a man...'"</p> <p>Additional notes, dated 6/30/10, 9/13/10, 9/15/10, 11/22/10, and 12/1/10, addressed continued</p> | F 250  | <p>4. Social Services will maintain a log of Behavior Meeting minutes to be reviewed weekly in IDT (Inter-Disciplinary Team) morning meeting. Specific reports of inappropriate sexual contact between residents will be discussed with appropriate interventions implemented. Such interventions will be reviewed by the IDT on a weekly basis or sooner, if needed, for effectiveness and the need to alter those or continue same interventions.</p> <p>5. 1/28</p> | 1/28/11   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

|   |  |  |  |                      |   |
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| F 250   | <p>Continued From page 41<br/>sexually inappropriate touching.</p> <p>The Monthly Mood and Behavior Monitoring Flowsheet, reviewed at that time, contained the documentation of the number of occurrences of the resident's physically inappropriate touching. June 2010 (4), July (3), August (9), September (18), and October the first through the ninth (8). The record lacked any additional tracking of behaviors for the rest of October, November or December 2010.</p> <p>The consulting psychiatrist's Physician Progress Note, dated 11/21/10, included the following history: "staff reports that pt has been rubbing female resident, has been touching her inappropriately and has been putting his hands down her shirt. Pt denies any problem or any concerns when asked about behaviors he said, 'fooling around.' Denied hopelessness or helplessness."</p> <p>The treatment plan from the psychiatrist was as follows: "Pt understands that he can't lay his hands on any one. 'no fun' he said upon redirection. Kindly contact me should behavior return. Follow up in 2 months."</p> <p>The Nurses' Notes contained entries relating to this resident's inappropriate sexual behaviors of holding another resident's hand, rubbing and patting arms, discussion of sex with female residents, and/or being in a female residents room since 4/28/10.</p> <p>The record lacked documentation in the Nurses' Notes of any behaviors from 6/17/10 until 9/13/10. On 9/13/10 at 10:00 a.m., the entry was as follows: "Res making inappropriate touching</p> | F 250  | <p>F 250 <i>Addendum</i><br/>Any reported instances of inappropriate sexual contact between residents will be discussed by the inter-disciplinary team in daily morning meeting. Revised behavior policy states: new behaviors or current increased behaviors are referred to Social Services. SS will identify interventions to manage new or worsening behaviors in care plans. Social Services and/or nursing will initiate a behavior monitoring form and gather information for accurate assessment of behavior symptoms. Social Services will evaluate care plan interventions and determine the need to proceed/not proceed with behavior management. The effectiveness of interventions, modification or changes to care plans will be part of the behavior meetings. Behavior meetings will continue to be held on a weekly basis throughout the year to review any residents with current behavior issues.</p> |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 250   | <p>Continued From page 42</p> <p>gestures on female peers. Redirected and told res gesture is inappropriate and not acceptable. Occurrence happened X 3. Redirected to room and removed female peers. Female peer initiated invite X 1."</p> <p>9/13/10 10:10 a.m. "SS [social service] notified of touching incidents."</p> <p>On 9/17/10 at 1:45 p.m., the physician was notified of the "sexual behavior problem res is having." The physician's response was "his is a result of his alcoholic dementia. Suggest that we continue to verbally cue him to not touch female residents. Also suggest that he be separated from female resident when verbal cueing does not work. He said that [no] med will help these behaviors, therefore there is no new orders."</p> <p>Resident N's last completed full Minimum Data Set Assessment, dated 6/22/10, indicated the resident had short term and long term memory problems and was moderately impaired in decision making. The assessment indicated the resident exhibited socially inappropriate behaviors 1-3 days in the past 7 days. The Resident Assessment Protocol summary indicated the resident was charted as rubbing a female resident's arm, and was educated as to the inappropriateness of the action.</p> <p>The resident's care plan was reviewed during the record review. The care plans for "socially inappropriate touching of staff and peers due to dementia/ impaired cognition," and "impaired cognitive status of decision making, memory and recall problems" had been updated on 9/13/10.</p> <p>The goal for the inappropriate touching and</p> | F 250  |   |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

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| F 250   | <p>Continued From page 43</p> <p>sexually inappropriate comments related to dementia, was to have no episodes of inappropriate touching.</p> <p>The interventions were to assess/record changes in behavior, report to physician significant changes in behavioral status, provide non-confrontational environment for care, anticipate needs and provide them before the resident becomes overly stressed, explain to resident in advance, share with resident other options for dealing with feelings, reinforce positive behavior, intervene during behavioral outbursts to protect the safety of the resident and others by: remove res from scene and redirect, and investigate/monitor the need for psychological/psychiatric support. Provide services if desired by the resident/family and ordered by physician.</p> <p>An additional care plan, dated 10/5/10, identified "Sexually inappropriate AEB [as evidenced by] inappropriate sexual comments, inappropriate touch [sic] of peers." The goal was "will have improvement in behaviors by the decrease of the frequency, intensity, and/or duration of aberrant activity."</p> <p>Interventions included: "Assess/record changes in behavior, report to physician significant changes in behavioral status, provide non-confrontational environment for care, reinforce positive behavior, administer and monitor effectiveness/side effects of medications per order, and investigate/monitor the need for psychological/psychiatric support and provide services if desired by the resident/family and ordered by the physician."</p> | F 250  |   |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 250   | <p>Continued From page 44</p> <p>Both care plans lacked proactive interventions to prevent contact with female peers.</p> <p>On 12/29/10 at 3:10 p.m., LPN #4 was queried about the behaviors and the room change. The LPN indicated that resident N's behaviors had increased after female resident O was transferred to the unit in March 2010, with an escalation in the number of episodes starting in August.</p> <p>LPN #4 indicated it had been reported to her by the evening shift nurse, on two separate occasions, that resident N had been observed in the company of a female resident (Resident O) when resident O had been manipulating his genitals. LPN #4 indicated the female resident involved would occasionally motion with her finger for resident N to come to her.</p> <p>LPN #4 indicated resident N had also been observed rubbing the arm of another female resident and that the female resident didn't like it. LPN #4 indicated the family physician and the psychiatrist had been notified but had issued no orders other than to the watch the residents and keep them away from each other. LPN #4 indicated this was extremely difficult due to the location of the residents' rooms being near each other and out of view unless staff remained in the dining/lounge area of the unit.</p> <p>The LPN indicated the incidents had been reported to social service staff repeatedly. She indicated the social service staff were responsible for residents with behaviors to notify the psychiatrist, set up appointments, and work on what to do for the behaviors.</p> <p>LPN #4 indicated the resident had been evaluated</p> | F 250  |   |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

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| F 250   | <p>Continued From page 45</p> <p>for a level two screening [a mental health evaluation], by an outside caseworker, and it had been on her advice that the resident had been transferred to an available bed on the South unit, to keep him away from Resident O.</p> <p>On 1/3/11 at 10:09 a.m., the Social Service Director [SSD] was queried about resident N's behaviors. She indicated she was in the process of trying to get him transferred to an inpatient psychiatric center that day. She stated "probably should have done that sooner." She indicated the resident had a problem with impulse control and that the attending physician had not been aggressive in his treatment.</p> <p>The SSD indicated that she was unaware of the resident having been fondled by the female resident. She indicated she only knew about him touching the females breasts, hugging and rubbing females. She indicated it had not been reported to the state because it was "so sporadic, weeks when nothing would happen."</p> <p>SS [Social Service employee] #1 was present at the time of the interview. SS #1 indicated she was responsible for the residents on the North and South units. When she was queried about the behaviors, she stated, "if they are really bad, it's talked about in the daily meeting, otherwise in the weekly Friday behavior meeting." SS #1 indicated when behaviors occurred, she would go and talk with the residents about the inappropriateness of the touching. She indicated she was only aware of resident N's fondling the breast of a female resident (O), inappropriate touching and prolonged hugs.</p> <p>The SSD and SS #1 denied being made aware of</p> | F 250  |   |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

|   |   |  |   |                      |   |
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| F 250   | <p>Continued From page 46</p> <p>any manipulation of the genitals of resident N and indicated the resident had never been on any one to one monitoring. Neither indicated they had informed the Administrator of the specific behaviors.</p> <p>On 1/3/11 at 12:05 p.m., the Behavior Manager Meeting notes were reviewed. The notes only contained the dates, name of residents addressed and the type of behavior, i.e. inappropriate touching. On the following dates [no times] the notes identified the resident had been discussed in the meeting because of "inappropriate touching of females," 9/17/10, 9/23/10, 11/2/10, 12/3/10, and 12/17/10.</p> <p>On 1/3/11 at 5:45 p.m., RN #3, the evening shift nurse on resident N's unit, was queried about the behaviors. She indicated resident N would touch resident O inappropriately. She indicated the CNA came and got her when the residents were observed together, she had seen Resident O with her hands on his thigh area and genitals, on the outside of his clothes, and she had reported the incidents to the unit manager LPN #4.</p> <p>On 1/3/11 at 11:25 a.m. the above information was reviewed with the facility Administrator [ADM], Director of Nursing Service [DNS] and RN #1. All three indicated they were unaware of the extent of the inappropriate behaviors. The DNS stated he was "only aware of hand holding." RN #1 stated, "only hand holding reported to me," and "should document what the inappropriate touching is."</p> <p>2. During the initial tour, on 12/27/10 at 10:21 a.m., resident O was identified, by LPN #4, as having had history of a stroke resulting in right</p> | F 250  |   |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 250   | <p>Continued From page 47</p> <p>side paralysis. The resident was observed seated in a wheelchair participating in a group activity. LPN #4 indicated the resident was cognitively impaired.</p> <p>Resident O's clinical record was reviewed on 12/29/10 at 3:15 p.m. The record contained diagnoses that included, but were not limited to, morbid obesity, hemiplegia, anxiety disorder, cerebrovascular disease, and subarachnoid hematoma.</p> <p>Resident O's most recent Minimum Data Set Assessment, an annual assessment, was dated 11/25/2010. The assessment indicated the resident had long term memory deficits, was not oriented to time and also had problems with inattention. The assessment indicated the resident had behaviors; however, it did not indicate the behaviors were directed toward others.</p> <p>The record contained a level II mental health assessment, dated 2/22/10. The narrative description indicated that she had made "sexually inappropriate" remarks to a male aide. She reportedly stated "don't you want to have sex with me?"</p> <p>A review of the Nurses' Notes indicated the following entries:<br/>9/13/10 10 a.m. "Res asking male peer to come over to her w/c. Male peer inappropriately touching female peer. Redirected and talked [with] res about inappropriate touching to her from male peer. SS notified &amp; res put on behavior charting."</p> <p>9/14/10 3:30 p.m. "Inappropriate inviting of male</p> | F 250  |   |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 250   | <p>Continued From page 48</p> <p>peer [with] touching x 1."</p> <p>9/29/10 3:25 p.m. "...was hugging another resident in a.m. Separated and told inappropriate."</p> <p>10/25/10 12:30 p.m. "Res in SDR [South dining room] for lunch. Res was moving w/c to side &amp; bumping peer [with] wheelchair. Staff moved res over and she was mumbling to peer then threw some food @ peer..."</p> <p>10/29/10 1:20 p.m. "Res very rude and demanding this shift. Kicking open BR door when peers are in B R..."</p> <p>12/28/10 10 p.m. "Resident noted calling others "asshole." Cursing at staff and other residents..."</p> <p>The Social Service Progress Notes were then reviewed. The notes contained the following entries:</p> <p>9/14/10 [no time] contained the following entry: "Talked with resident about male resident touching her inappropriately. I told resident that she can say no, move away and tell the nurse. Resident stated understanding."</p> <p>The monthly mood/behavior monitoring flowsheet, dated September 2010 identified "requesting touching from male peers" seven times from September 12-30.</p> <p>A care plan was implemented on 10/8/10 by social services for "inappropriately touching of peer" related to "requesting touching from male resident."</p> | F 250  |   |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155621   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                 |   | (X3) DATE SURVEY COMPLETED<br><br>C<br>01/05/2011 |
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| F 250   | <p>Continued From page 49</p> <p>The interventions were to:<br/>"Assess/record changes in behavior."<br/>"Report to physician significant changes."<br/>"Provide non-confrontational environment for care."<br/>"Investigate/monitor the need for psychological/psychiatric support. Provide services if desired by the resident/family and ordered by physician."</p> <p>The care plan lacked proactive interventions to prevent contact with male peer.</p> <p>On 12/29/10 at 3:10 p.m. LPN # 4 was queried about the behaviors and the room change of Resident N. The LPN indicated that resident N's behaviors had increased after female resident O was transferred to the unit in March 2010, with an escalation in the number of episodes starting in August.</p> <p>LPN #4 indicated it had been reported to her by the evening shift nurse, on two separate occasions, that resident N had been observed in the company of a female resident (O) when resident O had been manipulating his genitals. LPN #4 indicated that the female resident (O) involved would occasionally motion with her finger for resident N to come to her.</p> <p>LPN #4 stated, "so much happens I'm sure it doesn't all get charted."</p> <p>When queried about the lack of behavior monitoring flowsheet relating to the inappropriate touching, LPN #4 indicated that when they identified that the behavior was continuing, then they care planned it, but they didn't use the monitoring sheets any more.</p> | F 250  |   |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

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| F 250   | <p>Continued From page 50</p> <p>The LPN indicated the incidents had been reported to social service staff repeatedly. She indicated the social service staff were responsible for residents with behaviors to notify the psychiatrist, set up appointments, and work on what to do for the behaviors.</p> <p>3. On 1/4/11 at 11:30 a.m., the DNS provided a current copy of the facility Behavior Management policy with the revision date of 9/10/10.</p> <p>The policy identified the purpose as: "To provide a procedure for monitoring residents who exhibit inappropriate behavior. This policy will be used as a tool to evaluate the need for interventions, as well as the effectiveness of current interventions."</p> <p>The procedure included: "When an action of a resident is identified as something which has the potential to cause harm to the resident involved, other residents, or staff, a mood behavior monitoring sheet will be initiated. Examples of actions which would warrant this include, but are not exclusive to:<br/>Sexual- suggestive language, exposure not relating to toileting, masturbation in public places, inappropriate touching."</p> <p>"If the resident cannot be removed from the situation, efforts should be taken to keep the other residents away from them. The residents environment should be assessed ad [sic] appropriate safety measures implemented..."</p> <p>Interventions included, but were not limited to:<br/>"Once the immediate risk has been addressed, an entry shall be made in the nurse's notes as to what took place and the interventions that were</p> | F 250  |   |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

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|---|--|--|--|----------------------|---|
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| F 250   | Continued From page 51<br>done. A behavior monitor will be started and the resident put on alert charting."<br><br>"If this behavior is an ongoing threat, it is the option to initiate a 30 day involuntary discharge notice."<br><br>"If the behavior is socially inappropriate in a resident who has cognitive impairment: "A care plan will be developed to reflect the interventions, which will be taken when this behavior does occur and address any necessary pharmacological interventions."<br><br>"Any incidence of the behavior will be documented in the nurse's notes, listing what happened and which of the interventions were used in accordance with the care plan."<br><br>"Social Service will assess the occurrence of this behavior on a quarterly basis..."<br><br>This federal tag relates to complaint IN00084081. | F 250  |  |                      |   |
| F 279<br>SS=D   | 3.1-34(a)<br>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  | F 279  | F279 Develop Comprehensive Care Plans<br><br>1. Resident observed had pressure relieving cushion added to wheelchair on 1/4/11. It should be noted the lift sling in place for resident 48 is a polyester fabric and not vinyl as stated.<br>2. Any resident has the potential to be affected by the alleged deficient practice. |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |   |
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|--------------------|--|---------------|---|----------------------|
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| F 279 | <p>Continued From page 52</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview and record review, the facility failed to develop a comprehensive care plan, for 1 of 13 sampled residents at risk for pressure sores (#48), in the sample of 21, in that interventions were not inclusive of a pressure reducing device for the wheelchair.</p> <p>Finding includes:</p> <p>During the initial tour, on 12/27/10 at 11:00 a.m., RN #1 was interviewed and indicated Resident #48 was receiving hospice services, required total assistance with activities of daily living, and utilized a seat belt in the high back wheelchair she sat in.</p> <p>Resident #48's clinical record was reviewed on 12/28/10 at 9:40 a.m. The resident's quarterly Minimum Data Set assessment, dated 11/16/10, indicated, under skin and ulcer treatments, the resident was using a pressure reducing device for the chair. The resident's pressure ulcer risk assessment, dated 11/16/10, assessed the resident a score of 14. The assessment indicated a score of 8 or greater indicated the resident was</p> | F 279 | <p>Pressure ulcer risk assessments were performed on all residents in the facility to evaluate the need for additional interventions.</p> <p>3. Those residents triggered to be high risk had care plans initiated and reviewed/revised. All residents at risk for skin breakdown had wheelchair cushion initiated for wheelchairs, if not already in place.</p> <p>4. Nursing administration will perform weekly observations for placement of pressure relieving devices for those noted to be at high risk for developing pressure ulcers. Nursing will monitor for a period of six months and this will be assessed for continued review at the quarterly QA meeting.</p> <p>5. 1/28</p> | 1/28/11 |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
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| F 279   | Continued From page 53<br>at risk for pressure sores.<br><br>Resident #48's care plan for being at risk for pressure ulcers, initiated 6/15/09 and reviewed 11/16/10, included, but was not limited to, an intervention to "provide/monitor effectiveness of pressure relieving or reduction device(s)" and indicated the device of specialty bed/mattress. A chair cushion was not included (as noted by no check mark present) as a current intervention.<br><br>Resident #48 was observed, at the time, to be seated in the wheelchair in the lounge area. No cushion was observed in the chair. The resident was observed on the following dates and times, to be seated in the wheelchair with no cushion in place, just the vinyl sling-type wheelchair seat:<br>12/28/10 9:30 a.m.<br>12/29/10 9:15 a.m., 2:00 p.m.<br>12/30/10 9:45 a.m., 11:25 a.m.<br>1/3/11 10:25 a.m., 12:13 p.m. 1:10 p.m.<br><br>The care plan issue was reviewed with the Director of Nurses and RN #1 on 1/4/11 at 10:15 a.m., and they did not provide a response. | F 279  |  |                      |   |
| F 280<br>SS=D   | 3.1-35(b)(1)<br>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an  | F 280  | F280 Right to Participate in the Planning of Care<br><br>1. Residents involved have had care plans reviewed regarding noted behaviors.<br>2. Any resident has the potential to be affected by the alleged deficient practice. There have been no reports of inappropriate sexual |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

|   |  |  |   |                      |   |
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| F 280   | <p>Continued From page 54</p> <p>interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on interview and record review, the facility failed to revise the care plans to include more proactive interventions to prevent sexual behavior between cognitively impaired residents, for 2 of 2 sampled residents with inappropriate sexual behaviors, in the total sample of 21. (Residents N, O) The residents exhibited behaviors of fondling/manipulating genital areas of each other without adequate intervention to prevent the behavior.</p> <p>Findings include:</p> <p>1. During the initial tour on 12/27/10 at 10:18 a.m., LPN #4, the unit manager, identified Resident N as having dementia and being cognitively impaired.</p> <p>Resident N's clinical record was reviewed on 12/29/10 at 1:30 p.m. The record contained diagnoses that included, but were not limited to, alcoholism, alcoholic cirrhosis, alcohol induced persisting dementia and depression.</p> | F 280  | <p>contact between any residents, and no other behavior monitors initiated on any other residents .</p> <p>3. Behavior policy was reviewed and revised. Ombudsman presented mandatory in-service on 1/13 related to abusive behaviors, particularly sexual abuse. Any instances of inappropriate sexual contact that are observed are to be reported to Director of Nursing as well as social services staff; both will review care plan and determine appropriateness of interventions.</p> <p>4. SS will have charts present at the weekly behavior meetings and will review current care plans at the meeting with the IDT. Interventions and their effectiveness will be discussed and care plans updated as needed at each meeting. This will be an ongoing monitor by SS staff to review behaviors with IDT on a weekly basis.</p> <p>5. 1/28</p> | 1/28/11              |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
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| F 280   | <p>Continued From page 55</p> <p>The Nurses' Notes contained the following entries:</p> <p>"12/25/10 1 pm - Res continues to touch female peers inappropriately. Reach's [sic] &amp; pulls w/c [wheelchair] alarm off bottom of w/c and turns off &amp; attempts to transfer self."</p> <p>" 12/28/10 1:30 p.m. - "Transferred to [room number]-report given to nurse."</p> <p>The Social Service progress notes, dated 12/28/10 [no time] contained the following entry: "Due to unsuccessful interventions I called daughter /POA [power of attorney] [name] for consent to move [resident's name] to a male room available on the South unit..."</p> <p>Next entry dated 12/28/10 [no time] contained the following entry: "I spoke with resident regarding his room change. I explained to resident that the room change was due to his continued behaviors."</p> <p>The Social Service Progress Notes, written before the transfer, were reviewed at that time and contained the following entries related to the inappropriate touching of female residents:</p> <p>"5/28/10 [no time] It was reported to me that resident has inappropriately touched female staff and a resident. I explained to resident that it is inappropriate to touch other people and he need to keep his hands to himself. Resident stated 'but I'm a man...'"</p> <p>Additional notes, dated 6/30/10, 9/13/10, 9/15/10, 11/22/10, and 12/1/10, addressed continued sexually inappropriate touching.</p> | F 280  |   |                      |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 280   | Continued From page 56<br><br>The Monthly Mood and Behavior Monitoring Flowsheet, reviewed at that time, contained the documentation of the number of occurrences of the resident's physically inappropriate touching. June 2010 (4), July (3), August (9), September (18), and October the first through the ninth (8). The record lacked any additional tracking of behaviors for the rest of October, November or December 2010.<br><br>The consulting psychiatrist's Physician Progress Note, dated 11/21/10, included the following history: "staff reports that pt has been rubbing female resident, has been touching her inappropriately and has been putting his hands down her shirt. Pt denies any problem or any concerns when asked about behaviors he said, 'fooling around.' Denied hopelessness or helplessness."<br><br>The treatment plan from the psychiatrist was as follows: "Pt understands that he can't lay his hands on any one. 'no fun' he said upon redirection. Kindly contact me should behavior return. Follow up in 2 months."<br><br>The Nurses' Notes contained entries relating to this resident's inappropriate sexual behaviors of holding another resident's hand, rubbing and patting arms, discussion of sex with female residents, and/or being in a female residents room since 4/28/10.<br><br>The record lacked documentation in the Nurses' Notes of any behaviors from 6/17/10 until 9/13/10. On 9/13/10 at 10:00 a.m., the entry was as follows: "Res making inappropriate touching gestures on female peers. Redirected and told | F 280  |   |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 280   | <p>Continued From page 57</p> <p>res gesture is inappropriate and not acceptable. Occurrence happened X 3. Redirected to room and removed female peers. Female peer initiated invite X 1."</p> <p>9/13/10 10:10 a.m. "SS [social service] notified of touching incidents."</p> <p>On 9/17/10 at 1:45 p.m., the physician was notified of the "sexual behavior problem res is having." The physician's response was "his is a result of his alcoholic dementia. Suggest that we continue to verbally cue him to not touch female residents. Also suggest that he be separated from female resident when verbal cueing does not work. He said that [no] med will help these behaviors, therefore there is no new orders."</p> <p>Resident N's last completed full Minimum Data Set Assessment, dated 6/22/10, indicated the resident had short term and long term memory problems and was moderately impaired in decision making. The assessment indicated the resident exhibited socially inappropriate behaviors 1-3 days in the past 7 days. The Resident Assessment Protocol summary indicated the resident was charted as rubbing a female resident's arm, and was educated as to the inappropriateness of the action.</p> <p>The resident's care plan was reviewed during the record review. The care plans for "socially inappropriate touching of staff and peers due to dementia/ impaired cognition," and "impaired cognitive status of decision making, memory and recall problems" had been updated on 9/13/10.</p> <p>The goal for the inappropriate touching and sexually inappropriate comments related to</p> | F 280  |   |                      |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 280   | <p>Continued From page 58</p> <p>dementia, was to have no episodes of inappropriate touching.</p> <p>The interventions were to assess/record changes in behavior, report to physician significant changes in behavioral status, provide non-confrontational environment for care, anticipate needs and provide them before the resident becomes overly stressed, explain to resident in advance, share with resident other options for dealing with feelings, reinforce positive behavior, intervene during behavioral outbursts to protect the safety of the resident and others by: remove res from scene and redirect, and investigate/monitor the need for psychological/psychiatric support. Provide services if desired by the resident/family and ordered by physician.</p> <p>An additional care plan, dated 10/5/10, identified "Sexually inappropriate AEB [as evidenced by] inappropriate sexual comments, inappropriate touch [sic] of peers." The goal was "will have improvement in behaviors by the decrease of the frequency, intensity, and/or duration of aberrant activity."</p> <p>Interventions included: "Assess/record changes in behavior, report to physician significant changes in behavioral status, provide non-confrontational environment for care, reinforce positive behavior, administer and monitor effectiveness/side effects of medications per order, and investigate/monitor the need for psychological/psychiatric support and provide services if desired by the resident/family and ordered by the physician."</p> <p>Both care plans lacked proactive interventions to</p> | F 280  |   |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155621 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>01/05/2011 |
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| F 280 | <p>Continued From page 59<br/>prevent contact with female peers.</p> <p>On 12/29/10 at 3:10 p.m., LPN #4 was queried about the behaviors and the room change. The LPN indicated that resident N's behaviors had increased after female resident O was transferred to the unit in March 2010, with an escalation in the number of episodes starting in August.</p> <p>LPN #4 indicated it had been reported to her by the evening shift nurse, on two separate occasions, that resident N had been observed in the company of a female resident (Resident O) when resident O had been manipulating his genitals. LPN #4 indicated the female resident involved would occasionally motion with her finger for resident N to come to her.</p> <p>LPN #4 indicated resident N had also been observed rubbing the arm of another female resident and that the female resident didn't like it. LPN #4 indicated the family physician and the psychiatrist had been notified but had issued no orders other than to the watch the residents and keep them away from each other. LPN #4 indicated this was extremely difficult due to the location of the residents' rooms being near each other and out of view unless staff remained in the dining/lounge area of the unit.</p> <p>The facility failed to revise the care plan with specific interventions to keep the residents away from each other to prevent the behaviors.</p> <p>On 1/3/11 at 11:25 a.m. the above information was reviewed with the facility Administrator [ADM], Director of Nursing Service [DNS] and RN #1. All three indicated they were unaware of the extent of the inappropriate behaviors. The DNS</p> | F 280 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

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|---|---|--|---|----------------------|---|
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| F 280   | <p>Continued From page 60</p> <p>stated he was "only aware of hand holding." RN #1 stated, "only hand holding reported to me," and "should document what the inappropriate touching is." They also indicated care plan revisions should have been made, if those behaviors were occurring.</p> <p>2. During the initial tour, on 12/27/10 at 10:21 a.m., resident O was identified, by LPN #4, as having had history of a stroke resulting in right side paralysis. LPN #4 indicated the resident was cognitively impaired.</p> <p>Resident O's clinical record was reviewed on 12/29/10 at 3:15 p.m. The record contained diagnoses that included, but were not limited to, morbid obesity, hemiplegia, anxiety disorder, cerebrovascular disease, and subarachnoid hematoma.</p> <p>Resident O's most recent Minimum Data Set Assessment, an annual assessment, was dated 11/25/2010. The assessment indicated the resident had long term memory deficits, was not oriented to time and also had problems with inattention. The assessment indicated the resident had behaviors; however, it did not indicate the behaviors were directed toward others.</p> <p>The record contained a level II mental health assessment, dated 2/22/10. The narrative description indicated that she had made "sexually inappropriate" remarks to a male aide. She reportedly stated "don't you want to have sex with me?"</p> <p>A review of the Nurses' Notes indicated the following entries:</p> | F 280  |   |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155621   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                 |   | (X3) DATE SURVEY COMPLETED<br><br>C<br>01/05/2011 |
|---|--|--|---|---|
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| F 280   | <p>Continued From page 61</p> <p>9/13/10 10 a.m. "Res asking male peer to come over to her w/c. Male peer inappropriately touching female peer. Redirected and talked [with] res about inappropriate touching to her from male peer. SS notified &amp; res put on behavior charting."</p> <p>9/14/10 3:30 p.m. "Inappropriate inviting of male peer [with] touching x 1."</p> <p>9/29/10 3:25 p.m. "...was hugging another resident in a.m. Separated and told inappropriate."</p> <p>10/25/10 12:30 p.m. "Res in SDR [South dining room] for lunch. Res was moving w/c to side &amp; bumping peer [with] wheelchair. Staff moved res over and she was mumbling to peer then threw some food @ peer..."</p> <p>10/29/10 1:20 p.m. "Res very rude and demanding this shift. Kicking open BR door when peers are in B R..."</p> <p>12/28/10 10 p.m. "Resident noted calling others "asshole." Cursing at staff and other residents..."</p> <p>The Social Service Progress Notes were then reviewed. The notes contained the following entries:</p> <p>9/14/10 [no time] contained the following entry: "Talked with resident about male resident touching her inappropriately. I told resident that she can say no, move away and tell the nurse. Resident stated understanding."</p> <p>The monthly mood/behavior monitoring flowsheet, dated September 2010 identified "requesting</p> | F 280  |   |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

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| F 280   | <p>Continued From page 62</p> <p>touching from male peers" seven times from September 12-30.</p> <p>A care plan was implemented on 10/8/10 by social services for "inappropriately touching of peer" related to "requesting touching from male resident."</p> <p>The interventions were to:<br/>"Assess/record changes in behavior."<br/>"Report to physician significant changes."<br/>"Provide non-confrontational environment for care."<br/>"Investigate/monitor the need for psychological/psychiatric support. Provide services if desired by the resident/family and ordered by physician."</p> <p>The care plan lacked proactive interventions to prevent contact with male peer.</p> <p>LPN #4 indicated it had been reported to her by the evening shift nurse, on two separate occasions, that resident N had been observed in the company of a female resident (O) when resident O had been manipulating his genitals. LPN #4 indicated that the female resident (O) involved would occasionally motion with her finger for resident N to come to her.</p> <p>The care plan had not been revised to include interventions to keep the resident from having access to the male resident to prevent the behaviors.</p> <p>3. On 1/4/11 at 11:30 a.m., the DNS provided a current copy of the facility Behavior Management policy with the revision date of 9/10/10.</p> | F 280  |   |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

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|---|--|--|---|----------------------|---|
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| F 280   | <p>Continued From page 63</p> <p>The policy identified the purpose as: "To provide a procedure for monitoring residents who exhibit inappropriate behavior. This policy will be used as a tool to evaluate the need for interventions, as well as the effectiveness of current interventions."</p> <p>The procedure included: "When an action of a resident is identified as something which has the potential to cause harm to the resident involved, other residents, or staff, a mood behavior monitoring sheet will be initiated. Examples of actions which would warrant this include, but are not exclusive to:<br/>Sexual- suggestive language, exposure not relating to toileting, masturbation in public places, inappropriate touching."</p> <p>"If the resident cannot be removed from the situation, efforts should be taken to keep the other residents away from them. The residents environment should be assessed ad [sic] appropriate safety measures implemented..."</p> <p>Interventions included, but were not limited to:<br/>"Once the immediate risk has been addressed, an entry shall be made in the nurse's notes as to what took place and the interventions that were done. A behavior monitor will be started and the resident put on alert charting."</p> <p>"If this behavior is an ongoing threat, it is the option to initiate a 30 day involuntary discharge notice."</p> <p>"If the behavior is socially inappropriate in a resident who has cognitive impairment: "A care plan will be developed to reflect the interventions, which will be taken when this behavior does occur and address any necessary pharmacological</p> | F 280  |   |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

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|---|---|--|--|---|
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| F 280   | Continued From page 64 interventions."  | F 280  |  |   |
| F 314<br>SS=D   | <p>This federal tag relates to complaint IN00084081.</p> <p>3.1-35(d)(2)(B)<br/>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview and record review, the facility failed to ensure 1 of 13 residents reviewed at risk for pressure sores (#48), in the sample of 21, received the necessary treatment and services to prevent pressure sores, in that the resident's wheelchair failed to have a pressure reducing surface.</p> <p>Finding includes:<br/>During the initial tour, on 12/27/10 at 11:00 a.m., RN #1 indicated Resident #48 was receiving hospice services, required total assistance with activities of daily living, and utilized a seat belt in the high back wheelchair she sat in.<br/>Resident #48 was observed, at the time, to be seated in the wheelchair in the lounge area. No</p> | F 314  | <p>F314 Treatment to Prevent/Heal Pressure Sores</p> <ol style="list-style-type: none"> <li>1. Resident observed has pressure relieving cushion added to wheelchair on 1/4/11. It should be noted that lift sling in place for resident 48 is a polyester fabric and not vinyl as stated.</li> <li>2. Any resident has the potential to be affected by the alleged deficient practice. Pressure ulcer risk assessments were performed on all residents in the facility to evaluate the need for additional interventions.</li> <li>3. Those residents triggered to be high risk had care plans initiated and reviewed/revised. All residents at risk for skin breakdown had wheelchair cushion initiated for wheelchairs, if not already in place.</li> <li>4. Nursing administration will perform weekly observations for placement of pressure relieving devices for those noted to be at high risk for</li> </ol> |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |   |
|--|--|--|---|
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| NAME OF PROVIDER OR SUPPLIER<br><br>PINE HAVEN HEALTH AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3400 STOCKER DR<br>EVANSVILLE, IN 47720 |
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|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

F 314 Continued From page 65  
cushion was observed in the chair. The resident was observed on the following dates and times, to be seated in the wheelchair with no cushion in place, just the vinyl sling-type wheelchair seat:  
12/28/10 9:30 a.m.  
12/29/10 9:15 a.m., 2:00 p.m.  
12/30/10 9:45 a.m., 11:25 a.m.  
1/3/11 10:25 a.m., 12:13 p.m. 1:10 p.m.

At 1:10 p.m. on 1/3/11, CNAs #2 and #3 were observed to transfer Resident #48 from the wheelchair to bed. The resident's buttocks and coccyx area were reddened and there were indentations from the incontinence brief and the seat of the wheelchair. No cushion was in use in the wheelchair.

Resident #48's clinical record was reviewed on 12/28/10 at 9:40 a.m. The resident's quarterly Minimum Data Set assessment, dated 11/16/10, indicated, under skin and ulcer treatments, the resident was using a pressure reducing device for the chair. The resident's pressure ulcer risk assessment, dated 11/16/10, assessed the resident a score of 14. The assessment indicated a score of 8 or greater indicated the resident was at risk for pressure sores. Nurses' notes and physician's orders, dated 12/6/10, indicated the resident had developed an open area on the buttock. That area was healed on 12/20/10, however the resident remained at risk.

Resident #48's care plan for being at risk for pressure ulcers, initiated 6/15/09 and reviewed 11/16/10, included, but was not limited to, an intervention to "provide/monitor effectiveness of pressure relieving or reduction device(s)" and indicated the device of specialty bed/mattress. A chair cushion was not included (as noted by no

F 314  
developing pressure ulcers. Nursing will monitor for a period of six months and this will be assessed for continued review at the quarterly QA meeting.  
5. 1/28

F314 Addendum  
Nursing staff will monitor for placement of pressure relieving cushion every shift and note this on the treatment record. In addition, nursing administration will perform observations on pressure relieving devices on various shifts throughout the week. If a device is noted to be absent, the staff member will receive inservice education regarding the placement of the device; continued failure to provide devices will result in disciplinary action to employee.

1/28/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155621 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br>C<br>01/05/2011 |
|---|--|--|---|----------------------|---|
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| F 314   | Continued From page 66<br>check mark present) as a current intervention.<br><br>The lack of the use of the pressure reduction device in the chair was reviewed with the Director of Nurses and RN #1 on 1/4/11 at 10:15 a.m., and they did not provide a response.   | F 314  |   |                      |   |
| F 323<br>SS=E   | 3.1-40(a)(1)<br>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>A. Based on observation, interview and record review, the facility failed to ensure 2 of 9 residents who required total assistance and/or assistive devices with transfers, in the total sample of 21, were given assistance as needed for safe transfers, in that one resident was transferred with only one assist and was lowered to the floor, and one resident, who was non-weight bearing, was completely lifted from the wheelchair to the bed. (Residents O, #48)<br><br>B. Based on observation, interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible for 2 of 5 nursing units in the facility (Stocker I, Stocker II), in that a supply room and a pantry accessible to both units were | F 323  | F323 Free of Accident Hazards/Supervision/Devices<br><br>1. (A) The employee who failed to follow the care plan and CNA assignment sheet instruction for resident O was terminated on 12/5/10. The employees involved in the physical transfer of Resident 48 were disciplined and in-serviced on proper transfer procedure on 1/6/11.<br>2. Any resident requiring physical assistance or mechanical lift with transfer has the potential to be affected by the alleged deficient practice. The activity orders of residents requiring physical assistance were checked against care plans and CNA assignment sheets to insure they matched.<br>3. An in-service for nursing staff was presented on 1/26 and 1/27 to review lifting policy including mechanical lift procedures. Residents |                      |   |

PRINTED: 01/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

|  |  |  |   |
|--|--|--|---|
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|---|--|

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|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

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| F 323 | <p>Continued From page 67</p> <p>unlocked and unattended, containing hazardous items. This finding had the potential to affect 45 residents.</p> <p>Findings include:</p> <p>A1. During the initial tour, on 12/27/10 at 10:21 a.m., resident O was identified, by LPN #4, as having had a history of a stroke resulting in right side paralysis. The resident was observed seated in a wheelchair participating in a group activity. LPN #4 indicated the resident was cognitively impaired.</p> <p>The clinical record was reviewed on 12/29/10 at 3:15 p.m. The record contained diagnoses that included, but were not limited to, morbid obesity, hemiplegia, anxiety disorder, cerebrovascular disease, and subarachnoid hematoma.</p> <p>The record contained an entry in the Nurse's Notes, dated 5/13/10 9:50 a.m., indicating Resident O's leg buckled and had to be lowered to the floor during a transfer from the toilet to the wheelchair by two staff members.</p> <p>The next entry, on 5/13/10 at 11 a.m., was as follows: "D/T [due to] recent falls [with] transfers, Res is to be transferred X il assist &amp; Sara lift [mechanical lift] to ensure resident safety..."</p> <p>The alteration in mobility care plan, updated 11/16/10, identified the need for two assist for transfer, total lift transfer/non weight bearing with staff utilizing Hoyer lift.</p> <p>The most current physician's order, dated 11/9/10, contained the following order: "Transfer W [with] assist x 2 w/sara lift at all x's."</p> | F 323 | <p>requiring physical assistance or the use of a mechanical lift were reviewed and recommended for screening by therapy if indicated.</p> <p>4. Staff will do a return demonstration of lift use to insure proficiency with mechanical devices. All new employees will be in-serviced on mechanical lift use and do a return demonstration of proper use. Nursing Administration will observe two mechanical lift transfers and two physical assist transfers each week for a period of 6 months and this monitor will be assessed for continued review at the quarterly QA meeting.</p> <p>5. 1/28</p> | 1/28/11 |
|-------|--|-------|---|---------|

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 323 | <p>Continued From page 68</p> <p>On 8/3/10 at 7:30 p.m., the Nurses Notes contained the following entry: "CNA transferring resident onto the toilet. Resident's leg buckled et CNA lowered to the floor. Noted blding [bleeding] to (L) side of forehead. CNA went to get nurse. resident sitting up next to tub. Noted blding to back of head. Applied pressure..."</p> <p>On 8/3/10 at 8 p.m., the resident was sent to the local emergency room. Resident O returned to the facility on 8/4/10 at 1:00 a.m.</p> <p>The Nurse's Notes contained the following entry, on 12/4/10 at 7:30 p.m.: "Res was transferred [without] Sara lift by CNA [with] no gait belt. Res was toileted, dressed, and cleaned. CNA did not put shoes back on resident. Proceeded to transfer resident to w/c [wheelchair]. Resident's legs slipped out from under her. CNA lowered resident to ground and called for help..."</p> <p>On 12/30/10 at 10:30 a.m., LPN #4 was queried about the falls. LPN #4 provided copies of the CNA assignment sheet that identified the needed for the use of the Sara lift and the assist of two for transfers. The words Sara Lift were in bold ink, which she identified as her way of making sure CNAs were aware of the need for the lift.</p> <p>A2. On 12/29/10 at 9:45 a.m., Resident #48 was observed being transferred to bed by RN #4 and CNA #1. The resident's feet were observed to be contracted. A mechanical lift pad was underneath the resident. The CNA applied a gait belt to the resident. The RN and CNA lifted under the resident's arms with some support of the gait belt, moving the resident to the bed. The resident's feet barely touched the floor and appeared to bear no weight. RN #4 was queried and indicated the resident did not bear weight.</p> | F 323 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
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| F 323 | <p>Continued From page 69</p> <p>On 1/3/11 at 1:10 p.m., CNAs #2 and #3 were observed transferring Resident #48 from the wheelchair to the bed. They placed the high backed wheelchair beside the bed and tilted the head back. They attempted to remove the left arm of the wheelchair, but were unable. One CNA held the resident under the arms/upper body and the other CNA held under the knees/lower legs. They proceeded to lift the resident up over the arm of the wheelchair and place her in the bed.</p> <p>Resident #48's clinical record was reviewed on 12/28/10 at 9:40 a.m. The last full Minimum Data Set Assessment was dated 6/8/10. The resident was identified as requiring total assistance of two persons for transfers. The care plan, initiated 6/18/09 and reviewed 11/16/10, indicated the resident required assistance of two for transfers and was partial weight bearing on the right side for transfers. The resident's weight on the assessment was 103 pounds. The quarterly assessment, dated 11/16/10, was unchanged regarding transfers and the weight at that time was 104 pounds.</p> <p>The observations were reviewed with the Director of Nurses (DON) and RN #1 on 1/4/11 at 10:15 a.m. Both indicated the resident was care planned for two person assistance and the transfer with two assistance and the gait belt was appropriate for the resident. The DON indicated it was the facility policy that residents under 120 pounds could be transferred with two persons and did not need a mechanical lift. Both indicated the reason the lift pad was under the resident on 12/29/10 was the Hospice Agency staff had used the lift that morning. The DON indicated he would</p> | F 323 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
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| F 323   | <p>Continued From page 70</p> <p>have Physical Therapy evaluate the resident for safe transfers to be sure.</p> <p>The Physical Therapy evaluation, dated 1/4/11, was provided by the Director of Nurses on 1/5/11 at 9:15 a.m. The Clinical Impression indicated, "Pt. [patient] participated with eval and was transferred per facility policy with gait belt and 2 assist. During eval, this was performed safely and with pt. not displaying any indication of pain. Due to nature of transfer and pt. contractures, pt. may have increased comfort with use of mechanical lift as contractures progress."<br/>"Caregivers were educated in pt. ability to be transferred per facility policy or via mechanical lift if more comfortable for pt." The therapist concluded, "Pt. may be transferred with gait belt and 2 assist or if more comfortable for pt., a mechanical lift." "Precautions: Pt. has multiple joint contractures."</p> <p>Physical Therapist [PT] #1 was interviewed, on 1/5/11 at 10:10 a.m. She indicated she and a CNA had transferred the resident during the evaluation. She indicated the resident's feet were touching the floor, but the resident did not bear weight. She indicated the transfer was done safely. The above transfer, on 1/3/11, was described to her; she indicated she would not recommend the described transfer, i.e. lifting the resident by the upper and lower body over the wheelchair arm. She indicated a mechanical lift might be more comfortable for the resident, but the transfer as done during her evaluation was not determined to be unsafe.</p> <p>The Restricted Lifting Policy, no date, was provided by the Director of Nurses, on 1/4/11 at 11:30 a.m. The policy included, but was not</p> | F 323  |   |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 323 | <p>Continued From page 71</p> <p>limited to, the following:<br/>"The Med Care and InvaCare lifts area available in the facility to aid with transferring and moving of residents. Each resident will be assessed by the nursing staff, with the assistance of PT [Physical Therapy] if necessary, to determine if an assistive device is appropriate for them. The residents will be evaluated for use with the mechanical lifts or gait belts..." "If a resident weighs less than 120 pounds, then that person can be repositioned without a lift. If they weigh over 120 pounds, then the lift should be used for repositioning. It is recommended that there be two people present for repositioning if the lift is not mandatory." "If a resident should start to fall while ambulating, and an aide or nurse is nearby, the resident should be eased to the floor. After the nurse has evaluated the resident and determined it is safe to move them, the mechanical lift should be used to lifting (sic) them from the floor."</p> <p>The Resident Care Protocols for the Nurse Aide Training Program were reviewed on 1/7/11 at 11:50 a.m. and indicated the following procedure for a two-person transfer:</p> <p>"Do initial steps.<br/>2. Place chair at bedside. Brace it firmly against side of bed. Lock wheels of wheelchair or geriatric chair.<br/>3. Assist resident to sit on edge of bed (according to procedure #7).<br/>4. Reach around resident's back and grasp other assistant's forearm above wrist. Have resident place arms around your shoulders (not your neck).<br/>5. Each NA should reach under resident's knees and grasp other assistant's forearm above wrist.</p> | F 323 |  |  |
|-------|---|-------|--|--|

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 323 | <p>Continued From page 72</p> <p>6. On the count of three lift resident. Allows you to work together, and allows weight to be distributed evenly to prevent injury to resident or staff.</p> <p>8. Align resident in chair.</p> <p>9. Do final steps."</p> <p>B1. On 12/27/10 at 12:12 p.m., a quart spray bottle of "Oasis 499" was observed stored in an unlocked cabinet on a shelf, approximately 4 feet from the floor, in the nourishment pantry for the Stocker I and Stocker II units.</p> <p>Interview of the Administrator and Director of Nursing [DON], at the time, indicated the chemical should not be stored in an unlocked cabinet.</p> <p>Review of the Material Safety Data Sheet, provided by the DON on 12/27/10 at 1:50 p.m., indicated the following:<br/>"DANGER! causes respiratory tract, eye and skin burns. Harmful if absorbed through skin or if swallowed.</p> <p>First aid measures:<br/>Eye contact--In case of contact, immediately flush eyes with cool running water. Remove contact lenses and continue flushing with plenty of water for at least 15 minutes. Get medical attention immediately.<br/>Skin contact--In case of contact, immediately flush skin with plenty of water for at least 15 minutes while removing contaminated clothing and shoes. Wash clothing before reuse. Thoroughly clean shoes before reuse. Get medical attention immediately.<br/>Inhalation--If inhaled, remove to fresh air. If not breathing, give artificial respiration. If breathing is difficult, give oxygen. Get medical attention</p> | F 323 | <ol style="list-style-type: none"> <li>(B) All cabinets in the Stocker areas were checked for presence of chemicals/harmful substances. All doors in the facility that have a keypad entry mechanism also had a mechanism on the opposite side of the door which allowed the locking mechanism to be disarmed; these mechanisms have been disabled on all the keypad entry locks so that they cannot be left unlocked.</li> <li>Any mobile resident has the potential to be affected by the alleged deficient practice. Storage closets/cabinets on all units were reviewed for presence of chemicals or unlocked doors to storage areas.</li> <li>Housekeeping staff to document daily on the monthly log that they have checked closets and pantry areas to insure the absence of any harmful substance or chemical in those areas that might be accessible to residents.</li> </ol> |  |
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 323 | <p>Continued From page 73 immediately.<br/>Ingestion—Rinse mouth; then drink one or two large glasses of water. Do not induce vomiting. Never give anything by mouth to an unconscious person. Get medical attention immediately."</p> <p>B2. The "Supply Room" on the Stocker I unit was observed unlocked and unattended on 12/27/10 at 3:00 p.m. Unlocked drawers and cabinets contained the following: 8 containers of McKesson Deodorant labeled "Warning If swallowed, get medical help or contact a Poison control center," 3 tubes of McKesson tooth paste labeled "Warning If you accidentally swallow more than used for brushing get medical help or contact a poison control center immediately", and three containers of Instant Hand Sanitizer.</p> <p>Review of the Material Safety Data Sheet for the Hand Sanitizer, provided by the Director of Nursing on 1/4/11 at 11:30 a.m., indicated, "First aid measures Eyes: Flush with clear water for 15 minutes. Inhaled: Remove to fresh air. Swallowed: If patient is conscious and alert, dilute by drinking large quantities of water. Allow vomiting to occur then get medical attention. Always get medical attention when product is swallowed or when signs and/or symptoms of significant or persist."</p> <p>Also observed were eight - 4 packs of denture cleanser labeled, "In case of accidental ingestion, seek professional assistance or contact the poison control center immediately," 31 nail clippers, and a spray bottle of Antimicrobial skin cleanser labeled, "If swallowed get medical help or call poison control center."</p> <p>Upon interview of the administrator, at the time of</p> | F 323 | <p>4. Log sheets will be reviewed by Housekeeping supervisor weekly and submitted to Administrator monthly. Forms and procedure will be reviewed for six months and this monitor will be assessed for continued review at quarterly QA meetings.</p> <p>5. 1/28</p> | 1/28/11 |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 323   | Continued From page 74<br>the observation, she indicated the supply room should not have been unlocked.  | F 323  |  |   |
| F 364<br>SS=E   | 3.1-45(a)(1)<br>3.1-45(a)(2)<br>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP<br><br>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to ensure palatable food, at the proper temperature, was served to 1 of 1 sampled resident who received her lunch later in the afternoon (#101), in the sample of 21, in that the lunch tray had been stored on the counter in the pantry without refrigeration. The facility also failed to ensure palatable food, at the proper temperature, was served to 3 of 5 sampled interviewable residents (#111, #110, #116) in the group interviews and 6 of 11 supplemental sample interviewable residents in the group interviews (#107, #117, #118, #119, #121, #123), in that there were complaints of cold food. One of two meals observed indicated the food was cool upon service. (Lunch meal 1/3/11)<br><br>Findings include:<br><br>1. On 12/28/10 at 2:45 p.m., CNA #1 was observed retrieving a lunch tray from the 100 unit pantry. She indicated the resident had not | F 364  | F364 Nutritive Value / Appearance, Palatable / Pref. temperature<br><br>1. Managerial staff is now assigned to meal pass for all three meals to provide assistance in getting trays passed more promptly so they are in an acceptable temperature range. Trays are no longer to be held between meals if a resident refuses or is out of the facility.<br><br>2. Any resident has the potential to be affected by the alleged deficient practice. When the resident requests a tray other than meal time, a meal tray will be sent at that time.<br><br>3. Dietary was in-serviced on acceptable temperature ranges on 1/25. The dietary meal manager will monitor food temperatures twice during meal service. The food temperatures will be recorded prior to the trays leaving the kitchen. A "test tray" will be prepared and placed on the food cart. |   |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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|--------------------|---|---------------|---|----------------------|
| F 364              | <p>Continued From page 75</p> <p>wanted the lunch meal when it was delivered and it had been on the counter in the pantry room. CNA #1 set the tray in front of Resident #101, on an overbed table in the lounge. CNA #1 then carried the plate of food from the tray to the employee break room and placed it in the microwave oven. Chopped meat in red sauce, potatoes, and peas were observed on the plate.</p> <p>CNA #1 indicated she was heating up the food so she could serve it to the resident, since it had been on the counter since lunch.</p> <p>Also observed on the lunch tray, in front of the resident, was a bowl of cottage cheese. It had been setting on the counter as well.</p> <p>LPN #5 was interviewed and indicated lunch had been served at around 11:45 a.m.</p> <p>Resident #101's clinical record was reviewed on 12/28/10 at 2:05 p.m. The initial Minimum Data Set assessment, dated 12/14/10, indicated she was cognitively impaired with limited communication abilities.</p> <p>2. On 12/29/10 at 10:00 a.m., a group interview was held on the Stocker Unit. Eight (8) of 16 residents present were identified as interviewable, according to the Resident Roster provided by the Director of Nursing on 12/27/10 at 1:50 p.m. One of two sampled interviewable residents indicated they received cold food (Resident #116). Five of six supplemental sample interviewable residents indicated they received cold food. (Residents #117, #118, #119, #121, #123)</p> <p>On 12/29/10 at 11:00 a.m., a group interview was held on the South Unit. Eight (8) of thirteen</p> | F 364         | <p>After the last resident tray is served from that cart, temperatures on the "test tray" will then be documented to ascertain that food temperature is still in the acceptable range.</p> <p>4. Temperature monitoring will be done for all meals throughout the week alternating meals to assure all items are checked for proper temperatures. Temperatures will be checked each meal before trays leave the kitchen and again on a "test tray" three to five times a week to insure temperature is maintained. Copies of temperature logs will be submitted to the administrator at the quarterly QA meeting for review for 6 months; monitor will be assessed for continued review at the quarterly QA meeting.</p> <p>5. 1/28</p> | 1/28/11              |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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|--------------------|--|---------------|---|----------------------|
| F 364              | <p>Continued From page 76</p> <p>residents present were identified as interviewable, according to the Resident Roster provided by the Director of Nursing on 12/27/10 at 1:50 p.m. Two of three sampled interviewable residents indicated they received cold food (Residents #111, #110). One of five supplemental sample interviewable residents indicated they received cold food.</p> <p>3. On 1/3/11 at 11:48 a.m., the Harmony Unit tray cart was observed in the dining room. LPN #5 was observed passing the meal trays to the residents. At 11:58 a.m., two CNAs arrived to help pass the trays. At 12:14 p.m., the last tray was served. A tray that had been refused was available for temperature testing. The meat was 110 degrees Fahrenheit. The mashed potatoes were 112 degrees. The vegetables were 104 degrees. The tapioca pudding was 54 degrees. A single serving of ice cream was opened and the top half of the ice cream was soft.</p> | F 364         |   |                      |
| F 368<br>SS=E      | <p>3.1-21(a)(2)<br/>483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME</p> <p>Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.</p> <p>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial</p>   | F 368         | <p>F368 Frequency of Meals/Snacks at Bedtime</p> <ol style="list-style-type: none"> <li>1. Dietary is providing HS snacks to each unit to offer the residents at bedtime.</li> <li>2. Any resident has the potential to be affected by the alleged deficient practice. Nursing staff is now signing a form provided by Dietary to indicate they have received the HS snacks. Dietary will label special snacks requested or required for specific residents with their</li> </ol> |                      |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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|--------------------|---|---------------|--|----------------------|
| F 368              | <p>Continued From page 77</p> <p>evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on record review and interview, the facility failed to offer snacks at bedtime daily, for 4 of 5 sampled residents in group interviews, and 7 of 11 supplemental sample residents in group interviews, who were identified as alert and oriented/interviewable. (Residents #108, #110, #107, #114, #115, #117, #118, #119, #120, #121, #122)</p> <p>Finding includes:</p> <p>On 12/27/10 at 3:20 p.m., the resident council minutes for the past one year were reviewed. During the following months' meetings, residents expressed concerns about not getting bedtime snacks: 8/23/10, 9/20/10, 10/20/10, 12/22/10.</p> <p>On 12/29/10 at 10:00 a.m., a group interview was held on the Stocker Unit. Eight of sixteen residents present were identified as interviewable on the Resident Roster, provided by the Director of Nurses on 12/27/10 at 1:50 p.m. One (1) of 2 sampled interviewable residents present (#120) indicated the resident was not offered a bedtime snack. Five of 6 supplemental sample interviewable residents present indicated they were not offered bedtime snacks (#117, #118, #119, #121, #122).</p> <p>On 12/29/10 at 11:00 a.m., a group interview was held on the South Unit. Eight of 13 residents</p> | F 368         | <p>names. Nursing will document on the meal consumption log the percentage of the HS snack the resident consumed.</p> <p>3. Nursing staff will sign that they have received the snacks provided by Dietary. Nursing staff is responsible for passing the provided snacks and documenting the percentage of the snack consumed. In-service was presented on 1/26 and 1/27 to review this process with staff on procedure for distributing snacks and recording consumption of snack.</p> <p>4. The Clinical Dietary supervisor will interview the interviewable residents at least once per week to insure they have received the bedtime snack as noted on the consumption sheet. The responses will be shared with nursing each week in order to follow up on any issues in regard to this process. This will be monitored for six months and will be assessed for continued review at the quarterly QA meeting.</p> <p>5. 1/28</p> | 1/28/11              |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
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OMB NO. 0938-0391

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| F 368         | <p>Continued From page 78</p> <p>present were identified as interviewable on the Resident Roster, provided by the Director of Nurses on 12/27/10 at 1:50 p.m. Three of 3 sampled interviewable residents present indicated they were not offered a bedtime snack (Residents #108, #110, #115). Two of 5 supplemental sample interviewable residents indicated they were not offered a bedtime snack (Residents #107, #114).</p> <p>The policy and procedure for Nourishments, dated 10/08, was provided by the Director of Nurses [DON] on 1/4/11 at 11:30 a.m. The procedure included, but was not limited to, the following: "Bedtime nourishments will be offered to all residents. Dietary will provide special nourishments and bulk nourishments." The DON indicated the staff should be offering bedtime snacks.</p> | F 368 |   |  |
| F 441<br>SS=E | <p>3.1-21(e)<br/>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program<br/>The facility must establish an Infection Control Program under which it -<br/>(1) Investigates, controls, and prevents infections in the facility;<br/>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br/>(3) Maintains a record of incidents and corrective actions related to infections.</p>   | F 441 | <p>F 441 Infection Control, Prevent Spread, Linens</p> <ol style="list-style-type: none"> <li>1. Policy and procedure reviewed and revised. Staff in-serviced on 1/13 on proper procedure for sanitation of glucometer.</li> <li>2. Any resident who has orders to have blood glucose monitoring done could be affected by this alleged deficient practice. Staff members have received the in-service information as noted above and will follow this with any new resident</li> </ol> |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
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OMB NO. 0938-0391

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| F 441 | <p>Continued From page 79</p> <p>(b) Preventing Spread of Infection<br/>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br/>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br/>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens<br/>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview, and record review, the facility failed to sanitize the glucometers according to manufacturer's instructions, for 2 of 2 residents observed for glucometer testing (#39, #124), on 2 of 5 nursing units [Stocker I and Stocker II units], in that only alcohol prep pad wipes were used to clean the exterior of the glucometer prior to and/or after use for the multi-resident use glucometer. This had the potential to affect 11 of 11 residents receiving glucometer testing on the units.</p> <p>Findings include:</p> | F 441 | <p>receiving orders for blood glucose monitoring.</p> <p>3. Policy and procedure for sanitation of glucometer implemented with staff training and post test.</p> <p>4. Nursing administration will observe five random med passes a week and record observations with sanitation of glucometer and record if proper sanitation procedure was followed. This monitor will continue for a minimum of six months and will be assessed for continued review at the quarterly QA meeting.</p> <p>5. 1/28</p> <p>F 441 Addendum<br/>The policy on Glucometer testing includes a section on "Cleaning the Glucometer" which states the device will be sanitized "...with a disposable Super Sani-Cloth in between uses".</p> | 1/28/11 |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
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| F 441 | <p>Continued From page 80</p> <p>1. The medication pass was observed on Stocker One nursing unit<br/>Resident #39 was observed, on 12/30/10 at 11:25 a.m., to have a glucometer test for blood sugar levels. LPN #2 was observed to remove the glucometer from the med cart drawer. She then checked the resident's blood sugar level. The exterior of the glucometer machine was cleaned with alcohol prep pad following the test. The pad indicated 70 % alcohol content.</p> <p>2. The medication pass was observed on Stocker Two nursing unit<br/>Resident #124 was observed, on 1/3/11 at 11:45 a.m., to have a glucometer test for blood sugar levels. LPN # 2 was observed to wipe the exterior of surface of the Bayer brand Contour glucometer with an alcohol prep pad. At the completion of the test, LPN #2 again wiped the exterior of the glucometer machine with an alcohol prep pad prior to storage.</p> <p>LPN #2 indicated, at the time, that the same machine was used for multiple residents on the unit.</p> <p>3. The current facility policy for Glucometer testing was provided, on 1/4/11 at 11:30 a.m., by the Director of Nurses. The policy was dated 10/08; the cleaning/disinfecting directions were as follows:<br/>"Glucometer machine will be cleaned and disinfected immediately after use. Machine will be wiped clean utilizing an alcohol pad and allowed to air dry."</p> <p>The user guide for the Bayer Contour machine was reviewed on 1/4/11 at 1:55 p.m., provided by the Administrator. "Caring for the System" listed</p> | F 441 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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|--------------------|--|---------------|--|----------------------|
| F 441              | Continued From page 81<br>the following:<br>"The exterior of the meter can be cleaned using a moist [not wet] lint-free tissue with a mild detergent or disinfectant solution, such as 1 [one] part bleach mixed with 9 [nine] parts water. Wipe dry with lint-free tissue after cleaning."<br><br>4. Review of the Medication Administration Records, on 1/5/11 at 1:50 p.m., for Stocker I and Stocker II units, indicated 11 residents received routine glucometer testing.   | F 441         |  |                      |
| F 498<br>SS=D      | 3.1-18(b)(1)<br>483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS<br><br>The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure 2 of 9 residents requiring assistance with transfers, in the sample of 21, had the transfers performed by nurse aides competent to provide the transfers safely and in accordance with the plans of care, in that a resident was transferred with one assist without a mechanical lift, and a resident was transferred by being totally lifted from the wheelchair to the bed. (Resident O, Resident #48)<br><br>Findings include:<br><br>1. During the initial tour, on 12/27/10 at 10:21 | F 498         | F 498 Nurse Aide Competency / Care Needs<br><br>1. The employee who failed to follow the care plan and CNA assignment sheet instruction for resident O was terminated on 12/5/10. The employees involved in the physical transfer of Resident 48 were disciplined and in-serviced on proper transfer procedure on 1/6/11.<br><br>2. Any resident requiring physical assistance or mechanical lift with transfer has the potential to be affected by the alleged deficient practice. The activity orders of residents requiring physical assistance were checked against care plans and CNA assignment sheets to insure they matched.<br><br>3. An in-service for nursing staff was presented on 1/26 and |                      |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2011  
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|  |  |  |   |
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|--------------------|---|---------------|--|----------------------|
| F 498              | <p>Continued From page 82</p> <p>a.m., resident O was identified, by LPN #4, as having had a history of a stroke resulting in right side paralysis. LPN #4 indicated the resident was cognitively impaired.</p> <p>The clinical record was reviewed on 12/29/10 at 3:15 p.m. The record contained diagnoses that included, but were not limited to, morbid obesity, hemiplegia, anxiety disorder, cerebrovascular disease, and subarachnoid hematoma.</p> <p>The record contained an entry in the Nurse's Notes, dated 5/13/10 9:50 a.m., indicating Resident O's leg buckled and had to be lowered to the floor during a transfer from the toilet to the wheelchair by two staff members.</p> <p>The next entry, on 5/13/10 at 11 a.m., was as follows: "D/T [due to] recent falls [with] transfers, Res is to be transferred X ii assist &amp; Sara lift to ensure resident safety..."</p> <p>The alteration in mobility care plan, updated 11/16/10, identified the need for two assist for transfer, total lift transfer/non weight bearing with staff utilizing Hoyer lift.</p> <p>The most current physician's order, dated 11/9/10, contained the following order: "Transfer W [with] assist x 2 w/sara lift at all x's."</p> <p>On 8/3/10 at 7:30 p.m., the Nurses Notes contained the following entry: "CNA transferring resident onto the toilet. Resident's leg buckled et CNA lowered to the floor. Noted biding [bleeding] to (L) side of forehead. CNA went to get nurse. resident sitting up next to tub. Noted biding to back of head. Applied pressure..."</p> | F 498         | <p>1/27 to review lifting policy including mechanical lift procedures. Residents requiring physical assistance or the use of a mechanical lift were reviewed and recommended for screening by therapy if indicated.</p> <p>4. Staff will do a return demonstration of lift use to insure proficiency with mechanical devices. All new employees will be in-serviced on mechanical lift use and do a return demonstration of proper use. Nursing Administration will observe two mechanical lift transfers and two physical assist transfers each week for a period of 6 months. This will be assessed for continued review at the quarterly QA meeting.</p> <p>5. 1/28</p> | 1/28/11              |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
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| F 498   | <p>Continued From page 83</p> <p>On 8/3/10 at 8 p.m., the resident was sent to the local emergency room. Resident O returned to the facility on 8/4/10 at 1:00 a.m.</p> <p>The Nurse's Notes contained the following entry, on 12/4/10 at 7:30 p.m.: "Res was transferred [without] Sara lift by CNA [with] no gait belt. Res was toileted, dressed, and cleaned. CNA did not put shoes back on resident. Proceeded to transfer resident to w/c [wheelchair]. Resident's legs slipped out from under her. CNA lowered resident to ground and called for help..."</p> <p>On 12/30/10 at 10:30 a.m., LPN #4 was queried about the falls. LPN #4 provided copies of the CNA assignment sheet that identified the needed for the use of the Sara lift and the assist of two for transfers. The words Sara Lift were in bold ink, which she identified as her way of making sure CNAs were aware of the need for the lift.</p> <p>2. On 12/29/10 at 9:45 a.m., Resident #48 was observed being transferred to bed by RN #4 and CNA #1. The resident's feet were observed to be contracted. A mechanical lift pad was underneath the resident. The CNA applied a gait belt to the resident. The RN and CNA lifted under the resident's arms with some support of the gait belt, moving the resident to the bed. The resident's feet barely touched the floor and appeared to bear no weight. RN #4 was queried and indicated the resident did not bear weight.</p> <p>On 1/3/11 at 1:10 p.m., CNAs #2 and #3 were observed transferring Resident #48 from the wheelchair to the bed. They placed the high backed wheelchair beside the bed and tilted the head back. They attempted to remove the left arm of the wheelchair, but were unable. One</p> | F 498  |   |                      |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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|  |  |  |   |
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| F 498 | <p>Continued From page 84</p> <p>CNA held the resident under the arms/upper body and the other CNA held under the knees/lower legs. They proceeded to lift the resident up over the arm of the wheelchair and place her in the bed.</p> <p>Resident #48's clinical record was reviewed on 12/28/10 at 9:40 a.m. The last full Minimum Data Set Assessment was dated 6/8/10. The resident was identified as requiring total assistance of two persons for transfers. The care plan, initiated 8/18/09 and reviewed 11/16/10, indicated the resident required assistance of two for transfers and was partial weight bearing on the right side for transfers. The resident's weight on the assessment was 103 pounds. The quarterly assessment, dated 11/16/10, was unchanged regarding transfers and the weight at that time was 104 pounds.</p> <p>The observations were reviewed with the Director of Nurses (DON) and RN #1 on 1/4/11 at 10:15 a.m. Both indicated the resident was care planned for two person assistance and the transfer with two assistance and the gait belt was appropriate for the resident. The DON indicated it was the facility policy that residents under 120 pounds could be transferred with two persons and did not need a mechanical lift. Both indicated the reason the lift pad was under the resident on 12/29/10 was the Hospice Agency staff had used the lift that morning. The DON indicated he would have Physical Therapy evaluate the resident for safe transfers to be sure.</p> <p>The Physical Therapy evaluation, dated 1/4/11, was provided by the Director of Nurses on 1/5/11 at 9:15 a.m. The Clinical Impression indicated, "Pt [patient] participated with eval and was</p> | F 498 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
| F 498              | <p>Continued From page 85</p> <p>transferred per facility policy with gait belt and 2 assist. During eval, this was performed safely and with pt. not displaying any indication of pain. Due to nature of transfer and pt. contractures, pt. may have increased comfort with use of mechanical lift as contractures progress." "Caregivers were educated in pt. ability to be transferred per facility policy or via mechanical lift if more comfortable for pt." The therapist concluded, "Pt. may be transferred with gait belt and 2 assist or if more comfortable for pt., a mechanical lift." "Precautions: Pt. has multiple joint contractures."</p> <p>Physical Therapist [PT] #1 was interviewed, on 1/5/11 at 10:10 a.m. She indicated she and a CNA had transferred the resident during the evaluation. She indicated the resident's feet were touching the floor, but the resident did not bear weight. She indicated the transfer was done safely. The above transfer, on 1/3/11, was described to her; she indicated she would not recommend the described transfer, i.e. lifting the resident from the upper and lower body over the wheelchair arm to the bed. She indicated a mechanical lift might be more comfortable for the resident, but the transfer as done during her evaluation was not determined to be unsafe.</p> <p>The Resident Care Protocols for the Nurse Aide Training Program were reviewed on 1/7/11 at 11:50 a.m. and indicated the following procedure for a two-person transfer:</p> <p>"Do initial steps.<br/>2. Place chair at bedside. Brace it firmly against side of bed. Lock wheels of wheelchair or geriatric chair.<br/>3. Assist resident to sit on edge of bed</p> | F 498         |   |                      |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155621 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>01/05/2011 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>PINE HAVEN HEALTH AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3400 STOCKER DR<br>EVANSVILLE, IN 47720 |
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|--------------------|---|---------------|---|----------------------|
| F 498              | <p>Continued From page 86 (according to procedure #7).</p> <p>4. Reach around resident's back and grasp other assistant's forearm above wrist. Have resident place arms around your shoulders (not your neck).</p> <p>5. Each NA should reach under resident's knees and grasp other assistant's forearm above wrist.</p> <p>6. On the count of three lift resident. Allows you to work together, and allows weight to be distributed evenly to prevent injury to resident or staff.</p> <p>8. Align resident in chair.</p> <p>9. Do final steps."</p> <p>3.1-14(i)</p> | F 498         |   |                      |