

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155355	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2012
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NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619
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F0000	<p>This visit was for the Investigation of Complaint IN00104958.</p> <p>Complaint IN00104958 substantiated, Federal/State Deficiencies related to the allegations are cited at F 226.</p> <p>Survey dates: March 5 and 6, 2012</p> <p>Facility number: 000246 Provider number: 155355 AIM number: 100275420</p> <p>Survey team: Janelyn Kulik, RN</p> <p>Census bed type: SNF/NF: 88 Total: 88</p> <p>Census payor type: Medicare:7 Medicaid: 69 Other: 12 Total: 88</p> <p>Sample: 4</p> <p>This deficiency also reflects State findings cited in accordance with 410 IAC 16.2.</p>	F0000	The creation and submission of this Plan or Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Complince.	

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

TITLE

(X6) DATE

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

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	Quality review completed 3/7/12 Cathy Emswiller RN			

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on observation, record review, and interview, the facility failed to follow their abuse prevention policy for 1 of 4 resident reviewed for allegations of abuse in a sample of 4 related to the nurse not immediately reporting and ensuring the resident was safe after suspecting possible abuse. (Resident #E and LPN #1)</p> <p>Findings include:</p> <p>The record for Resident #E was reviewed on 3/5/12 at 3:52 p.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbances, chronic kidney disease, schizophrenia, paranoid, hypertension, incontinence, confusion, and osteoporosis.</p> <p>On 3/5/12 at 3:00 p.m. during the initial tour, the Staff Development Director identified Resident #E. The resident was observed at that time sitting in the lounge area by the nursing station in her wheelchair with an activity aide and another resident. During interview at that time, the Staff Development Director</p>	F0226	<p>F 226The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. It is the practice of this provider to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident E – physician and family were notified. DNS and ED immediately reported to the building. Authorities were contacted and an investigation was initiated. The visitor in the suspected abuse case is not authorized to return to the building. Resident was sent to ER for evaluation and treatment. Upon return to the facility resident was placed in observation and the plan of care was adjusted. How other residents having the potential to be affected by the same deficient</p>	04/05/2012

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	<p>indicated Resident #E had a male care giver who was no longer allowed in the facility.</p> <p>A quarterly Minimum Data Set Assessment dated 2/3/12, indicated the resident usually makes self understood and usually understands others. The resident scored a 99 on the Brief Interview for Mental Status which indicated the resident was unable to complete the assessment. She had short and long term memory problems. She was moderately impaired cognitively which indicated she made poor decisions, cueing and supervision was needed for decision making.</p> <p>A progress note dated 3/1/12 at 8:12 p.m., indicated upon taking care of resident's roommate, a visitor was observed laying in resident's [Resident E's] bed. The visitor was asked to leave the facility at this time. Authorities were notified and the resident was sent to the emergency room for evaluation and treatment.</p> <p>A reportable incident provided by the facility on 3/5/12 and reviewed at 4:30 p.m., indicated the reportable incident was an unusual occurrence/incident. A letter was attached dated 3/2/12. "Please accept this as an initial and final report of an incident that occurred on March 2,</p>		<p>practice will be identified and what corrective action(s) will be taken: All residents are at risk to be affected by this finding. A whole house inspection was immediately completed to ensure all residents were safe and no visitors were in the building and that the facility was secure. Resident and family interviews were conducted per CQI Abuse Questionnaire devised by CMS with no findings. All staff in-services will be conducted by 4/5/12 on Abuse Prohibition, Reporting and Investigation and Elder Justice Act. The ED, DNS/designee will be responsible for conducting this in-service. A new procedure for visitation will also be initiated. This procedure will include requesting all visitors to sign in at the front office and/or nurse's station. Nursing will monitor visitors who sign in by routinely checking sign in logs and monitor visitor/resident interactions. All residents, families/responsible parties will be notified of this new visitation procedure. The facility is secured from 8pm – 6 am therefore all visitors must ring and nursing to allow entrance to facility. Visitors will still be required to sign in and out after hours. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Resident and family interviews were conducted per CQI Abuse</p>				

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	<p>2012 involving resident (Resident #E's name) and long time acquaintance (Visitor's name). (Resident #E's name) is a (age) female with diagnosis of dementia, HTN (hypertension), CAD (coronary artery disease), osteoporosis, hypothyroidism, and chronic back pain. On March 2, 2012 while going into room (room number of Resident #F) to provide evening medications nurse noted visitor in room with (room number of Resident #E) (Resident #E's name). Visitor announced himself by saying "hello" to nurse. This startled nurse as she was not aware (Visitor's name) was in the room. Nurse looked around curtain noting visitor lying in bed with resident. Resident was in hospital gown under blankets and visitor was reportedly lying on top of blankets next to resident. Nurse noted visitor to have left hand on resident's genital area and right hand on residents face. Nurse immediately returned to building summon other nurse on duty and aide to room (room number of Resident #E) and asked visitor to leave building. Upon rising from bed staff witnessed visitor's jeans to be unzipped and genital area exposed. Visitor covered himself with t-shirt before zipping pants back up. Nurse directed nurse to call 911 and escorted visitor from building. Resident (Resident #E's name) exhibited no signs of fear or distress before or after</p>		<p>Questionnaire devised by CMS with no findings. All staff in-services will be conducted by 4/5/12 on Abuse Prohibition, Reporting and Investigation and Elder Justice Act. The facility policy regarding Abuse Prohibition, Reporting and Investigation and Elder Justice Act will also be reviewed with all new hires during the orientation process. The ED, DNS/designee will be responsible for conducting this in-service. A new procedure for visitation will also be initiated. This procedure will include requesting all visitors to sign in at the front office and/or nurse's station. Nursing will monitor visitors who sign in and monitor visitor/resident interactions. All residents, families/responsible parties will be notified of this new visitation procedure. Facility tours and interviews with staff regarding Abuse Prohibition, Reporting and Investigation will be conducted at random times on random shifts. The ED, DNS/designee will be responsible for conducting random facility tours (including after hours and on weekends) and interviews with staff regarding Abuse Prohibition, Reporting and Investigation with an emphasis to ensure protection of resident. Once the resident is protected then report immediately to Supervisor and ED, DNS/designee. ED, DNS/designee are assigned after hours and routinely on weekends</p>	

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	<p>the incident. Police arrived within minutes to building and directed investigation. Physician notified of incident. Family unable to be reached by facility however police able to locate and notify son later that evening. Resident sent to Emergency Room where rape kit was completed. At approximately 2:30 a.m. resident returned to facility with new order for 250 mg (milligrams) Zithromax (antibiotic) to be given 4 tabs p.o. (by mouth) x (times) 1 on 3/2/12 upon rising prophylactic. ER (emergency room) nurse verbally reported to facility nurse that there had been "no evidence of trauma." Head to toe assessment completed. Resident was alert however did not respond verbally. No fearfulness, tearfulness or distress noted. Immediate action was taken and preventative measures were taken. Local police department were summoned and arrived within minutes of incident being identified by staff. Staff completed facility wide checks to ensure all residents were safely accounted. No visitors were identified in building, only staff and residents. A head to toe assessment was completed on roommate to ensure safety with no concerns. Upon return to facility 15-minute checks were initiated by nursing as well as follow up assessments every shift until resident is stable. Social Services have also been notified to</p>		<p>to interview staff regarding abuse policy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The ED, DNS/designee will be responsible for completion of the CQI Audit tool titled, "Abuse Prohibition, Reporting and Investigation" weekly x4 weeks then monthly for 6 months to monitor for ongoing compliance of this corrective action. If threshold of 100% is not met, an action plan will be initiated. Any trends or findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance date = 4/5/12.</p>				

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	<p>provide further assessment and supportive intervention.</p> <p>Executive Director and Director Nursing Services were notified immediately and immediately reported to the facility. Staff interviews were conducted by local authorizes (authorities) as well as ED (Executive Director) and DSN (Director Nursing Services) ED met with evening and midnight shifts at shift change to initiate further review of Abuse and Neglect Policy and Procedure. Facility wide inservicing on Abuse & Neglect Policy and Procedure as well as the Elder Care Act is currently in progress. Further interviews with residents and staff are ongoing and investigations in progress.</p> <p>One-on-One meeting with son, (Resident E's son's name), 3/2/12 indicates there has been an ongoing relationship with (Visitor's name) and (Resident #E's name) for many years now and is believed to be consensual. Executive Director expressed a need for meeting with son and (Visitor) would be required prior to future visit. Son expressed understanding and agreement. The local police department has been notified of this meeting and past relationship."</p> <p>A written statement provided by the Executive Director on 3/5/12 at 6:00 p.m. and reviewed at that time, indicated LPN #1 made rounds to give medications. She</p>			

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	<p>heard a man say "hello" and she looked around corner and he was laying in bed with her. He reported he always leaves by 8:30 p.m. LPN #1 walked around to window and observed the visitors left hand on her genital area and right hand on her face. When he stood up blanket was covering private area. His penis was exposed and zipper was open with penis outside of pants. The visitor exited through the front door and walked to the back parking lot. The visitor indicated "we are in love. We have been lovers for four year."</p> <p>Interview with RN #1 on 3/5/12 at 4:50 p.m., indicated he was working the night the incident took place with Resident #E. He indicated LPN #1 come out of the Resident #E's room and indicated concerns with the visitor and Resident #E. He told her to have the visitor leave if she had concerns. He then indicated LPN#1 went back to the Resident #E's room. She informed RN #1 the visitor indicated he would leave at 8:30 p.m. RN #1 then indicated LPN #1 still did not feel good about the situation so she was going to go outside and look in the window. She returned to the building and RN #1 went to the Resident #E's room at which time the visitor was in bed with the resident. When he got up his genitals were exposed. RN #1 further indicated LPN #</p>			

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	<p>I had not indicated anything that had made him concerned, however, she was not comfortable with the situation and had continued to go back to the resident's room. He indicated the visitor was not in bed with the resident when the LPN came to him the first two times. He also indicated if he had any concerns he would have had the visitor leave immediately. He also indicated Resident #E was not cognitively able to make a consensual decision.</p> <p>Interview with the Executive Director on 3/5/12 at 5:15 p.m., indicated LPN #1 saw the visitor lying in bed with the resident, she did not have the visitor leave at this time, she went outside and saw the resident under the covers and the visitor on top of the covers with one hand on over her genitals and the other hand on her face. She returned to the building and with another nurse they asked the visitor to leave and at that time his genitals were exposed and he zipped his pants.</p> <p>Interview with the Executive Director and the Director of Nursing Services on 3/6/12 at 5:10 p.m., indicated LPN #1 was suspicious of what was going on between the visitor and Resident #E. She did not have the visitor leave at the time of her initial suspicious, she left the room and went outside and looked it the</p>			

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	<p>window. She then returned with the RN and asked the visitor to leave the facility.</p> <p>The facility Abuse Prohibition, Reporting, and Investigation Policy and Procedure was provided on 3/5/12 and reviewed at 4:35 p.m. The policy indicated, "It is the policy of (name of company) to protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or funds.</p> <p>Resident Abuse-Staff member, volunteer, or visitor: "Policy: It is the policy of (name of company) to assure appropriate interventions are in place and followed to assure safety of the resident (s) is maintained if abuse is identified or suspected.</p> <p>Procedure: if resident abuse is identified or suspected, the following guidelines will be followed:</p> <ol style="list-style-type: none"> 1. Any individual who witnesses abuse or has the suspicion of, shall immediately notify the charge nurse of the unit, which the resident resides. 2. The resident (s) involved in the incident will be removed from the situation immediately. 3. Any staff member implicated in alleged abuse will be removed from the facility at once and will remain suspended 						

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	<p>until an investigation is completed. Any volunteer implicated in the alleged abuse will be removed from the facility immediately. Any visitor implicated in the alleged abuse will be removed from the facility immediately. ect..."</p> <p>This federal tag relates to complaint IN00104958.</p> <p>3.1-28(a)</p>			