

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155680	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/17/2013
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NAME OF PROVIDER OR SUPPLIER  HOMEWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2494 N LEBANON ST LEBANON, IN 46052
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F0000	<p>This visit was for the Investigation of Complaint IN00121285.</p> <p>Complaint IN00121285 substantiated, Federal/state deficiencies related to the allegation are cited at F225 and F226.</p> <p>Survey dates: January 16 &amp; 17, 2013</p> <p>Facility number: 002703 Provider number: 155680 AIM number: 200309250</p> <p>Survey team: Joyce Hofmann, RN, TL Brenda Nunan, RN</p> <p>Census bed type: SNF: 9 SNF/NF: 39 Residential: 34 Total: 82</p> <p>Census payor type: Medicare: 11 Medicaid: 21 Other: 50 Total: 82</p> <p>Sample: 3</p> <p>These deficiencies also reflect state</p>	F0000	<p><b>Submission of this plan of correction does not constitute an admission by Homewood Health Campus of any wrong-doing or failure to comply with the Federal or State Regulations.</b></p> <p><b>Homewood Heath Campussubmits this plan of currection as its letter of credible allegation and is <u>requesting a desk review</u>. All corrective actions will be completed by February 01, 2013.</b></p>	

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

TITLE

(X6) DATE

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

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	findings in accordance with 410 IAC 16.2.  Quality Review completed on 01/24/2013 by Brenda Nunan, RN.			

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record</p>	F0225	F 225 Homewood Health	02/01/2013			

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	<p>review, the facility failed to report an allegation of abuse to officials in accordance with State law for 1 of 3 residents reviewed for allegations of abuse/neglect in a sample of 3 [Resident B].</p> <p>Findings include:</p> <p>Resident B's clinical record was reviewed on 01/16/13 at 1:50 p.m. and indicated the resident had diagnoses which included, but were not limited to, dementia, congestive heart failure, hypertension, anxiety, and hypothyroidism.</p> <p>Resident B's most recent quarterly Minimum Data Set [MDS] assessment, dated 11/06/12, indicated the resident was cognitively impaired with a BIMS [shows cognitive patterns and mental status] score of "5." Resident B needed extensive assist of 1 person with bed mobility, transfers, dressing, toileting, and hygiene. Resident B needed limited assist with ambulation and used a walker and wheelchair. Resident B had alarms and a bed sensor to alert staff of unassisted transfer attempts. Resident B was also noted to be a Hospice resident.</p> <p>A police report, dated 10/12/12,</p>		<p><b>Campus, under Trilogy Health Services, has developed and implemented processes which strive to ensure the prevention of suspected or alleged resident abuse and neglect. Homewood has implemented processes in an effort to provide a comfortable and safe environment. The Executive Director and Director of Health Service has reviewed the implementation, ongoing monitoring of abuse standards, procedures to accommodate all the residents and the reporting with the investigation of incidents, accidents and abuse to officials in accordance with State law through established procedures that was affected by the alleged deficient practice. Abuse and Neglect Procedural Training is provided for all new employees through orientation and with yearly ongoing training programs which includes immediately notifying the Executive Director or their designee in their absence of any abuse, neglect and misappropriation of resident property. The Executive Director/designee investigate and report all alleged violations involving mistreatment, neglect, or abuse, including injuries of</b></p>		

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	<p>indicated a CRCA [Certified Resident Care Aide] went into Resident B's room after her call light came on. The report indicated CRCA #1 entered Resident B 's room and observed Resident B's husband hitting and pushing her left arm.</p> <p>Social Service Progress Notes, dated 10/15/12, indicated, "Writer was contacted by CSR [Clinical Service Representative/Marketing Representative] on 10/12/12 at 4:40 p.m. and notified that 2 CRCA's reported being witness to [Resident B's] husband's spouse], "hitting" her on the arm and tugging on the same arm to try to get [Resident B] to get out of her recliner...CSR reported to writer that both CRCA's had given a statement to the police, that police had interviewed [Resident B] alone and that they state her report is consistent c [with] what the aids [sic] report witnessing...."</p> <p>Interview with CRCA #1 on 01/13/12 at 5:05 p.m., indicated she was in Resident B's room taking care of her roommate. CRCA #1 indicated she pulled the privacy curtain back and saw Resident B's spouse pushing on her arm trying to wake her for dinner. CRCA #1 indicated Resident B kept her eyes closed and her head down.</p>		<p><b>unknown source and misappropriation of resident property to other officials in accordance with State law through established procedures to ensure the deficient practice will not recur. The following measures will be put into place to ensure that the deficient practice does not recur. All report and investigations of alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property will be reviewed by the IDT each morning during morning meetings to ensure compliance in reporting timely to ISDH. All results will be reported each month to QA committee for six months for review and changes to ensure the deficient practice will not recur. Date of Compliance: 02.01.13</b></p>		

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	<p>CRCA #1 indicated Resident B's spouse used an open hand, then a closed fist to hit Resident B's arm. CRCA #1 indicated Resident B had no reaction and indicated she told Resident B's spouse, "We don't do that here." CRCA #1 indicated Resident B's spouse said, "If you think this is bad, you should of seen what it was like at home." CRCA #1 indicated she took Resident B out of the room and took her to the charge nurse.</p> <p>During an interview on 01/16/13 at 11:40 a.m., the Director of Nursing Services [DNS] indicated the facility did not have any reportable incidents during October 2012. The DNS indicated she verified with the Executive Director [ED] there were no incidents reported.</p> <p>Interview with the ED and DNS on 01/16/13 at 2:30 p.m., indicated the facility did not obtain a copy of the police report and did not report the allegation of abuse reported by the CRCA to State agency. The ED indicated she did not report the allegation because she did not consider it abuse.</p> <p>Interview with the charge nurse, RN #2, on 01/16/13 at 5:12 p.m.,</p>			

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	<p>indicated she heard CRCA #1 tell Resident B's spouse "Don't do that." RN #2 indicated CRCA #1 indicated Resident B's spouse pushed his wife.</p> <p>Interview with the ED and DNS on 01/17/12 at 10 a.m. indicated the police was called to get Resident B's spouse out the facility. The ED and DNS indicated they had never seen him demonstrate any violence toward Resident B, and indicated Resident B did not cry out or complain of being hurt. The ED indicated she did not consider this incident as abuse.</p> <p>The ED and DNS presented an incident report indicating an incident that occurred 10/12/12 at 4:40 p.m. CRCA #1 was named as the only witness and RN #2 was named as the person reported to. The description of what happened is as follows: "[CRCA #1] witnessed [Resident B's spouse] (husband) pushing on res. [resident] shoulder. [CRCA #1] informed [Resident B's spouse] that we do not treat [Resident B] like that here. [Resident B's spouse] had smurck on face, made fist c [with] hand et [and] started pushing her shoulder. [CRCA #1] states she told [Resident B's spouse] again that we don't treat [Resident B] that way here, [CRCA #1] then removed [Resident</p>			

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	<p>B] from room et [and] reported situation to nurse. As [CRCA #1] was taking res [resident] out of room, husband stated "If you think that was bad then you should have seen what I did to her @ [at] home." No abuse founded, - unsubstantiated. Will monitor husband visit. Measures that were taken to prevent this from happening again were "Husband asked to leave - took awhile to get husband to leave. Police where [sic] called, came to get statement from resident c daughter [Resident B's daughter] present. APS [Adult Protective Services] was notified. Ombudsman was notified."</p> <p>The facility's Accident and Incident Reporting Guidelines, dated 11/2000, was presented by the Administrator on 01/17/13 at 10 a.m. and indicated, "...Reporting of incident, accidents and abuse to state and federal agencies shall be in compliance in accordance with agency guidelines..."</p> <p>The facility's Abuse and Neglect Procedural Guidelines with revised date of 9/16/2011, indicated, "...The Executive Director is accountable for investigating and reporting...Any staff member, resident, visitor or responsible party may report known or suspected abuse, neglect, or</p>			

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	<p>misappropriation to local or state agencies...Immediately and not more than 24 hours complete an initial report to applicable state agencies...A written report of the investigation outcome, including resident response and/or condition, final conclusion and actions taken to prevent reoccurrence, will be submitted to the applicable State agencies within five days...The Elder Justice Act requires that if the event that caused the suspected abuse/neglect resulted in serious bodily injury, the Executive Director or designee is required to report the suspicion to the police department immediately but not later than 2 hours. If the event does not result in bodily injury, it must be reported no later than 24 hours...The investigation folder and Episodic Event forms should be completed for all state reportable occurrences."</p> <p>This federal tag is related to Complaint IN00121285.</p> <p>3.1-28(c) 3.1-28(e)</p>				

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview, and record review, the facility failed to implement their policy and procedures for an alleged allegation of abuse for 1 of 3 residents reviewed for abuse in a sample of 3 [Resident B].</p> <p>Findings include:</p> <p>Resident B's clinical record was reviewed on 01/16/13 at 1:50 p.m. and indicated the resident had diagnoses which included, but were not limited to, dementia, congestive heart failure, hypertension, anxiety, and hypothyroidism.</p> <p>Resident B's most recent quarterly Minimum Data Set [MDS] assessment, dated 11/06/12, indicated the resident was cognitively impaired with a BIMS [shows cognitive patterns and mental status] score of "5." Resident B needed extensive assist of 1 person with bed mobility, transfers, dressing, toileting, and hygiene. Resident B needed limited assist with ambulation and</p>	F0226	<p><b>F 226 Homewood Health Campus, under Trilogy Health Services, has developed and implemented processes which strive to ensure the prevention of suspected or alleged resident abuse and neglect. Homewood has implemented processes in an effort to provide a comfortable and safe environment. The Executive Director and Director of Health Service has reviewed the implementation, ongoing monitoring of abuse standards, procedures to accommodate all the residents and the reporting with the investigation of incidents, accidents and abuse to officials in accordance with State law through established procedures that was affected by the alleged deficient practice. Abuse and Neglect Procedural Training is provided for all new employees through orientation and with yearly ongoing training programs which includes immediately notifying the Executive Director or their designee in their absence of</b></p>	02/01/2013			

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	<p>used a walker and wheelchair. Resident B had alarms and a bed sensor to alert staff of unassisted transfer attempts. Resident B was also noted to be a Hospice resident.</p> <p>A police report, dated 10/12/12, indicated a CRCA [Certified Resident Care Aide] went into Resident B's room after her call light came on. The report indicated CRCA #1 entered Resident B 's room and observed Resident B's husband hitting and pushing her left arm.</p> <p>Social Service Progress Notes, dated 10/15/12, indicated, "Writer was contacted by CSR [Clinical Service Representative/Marketing Representative] on 10/12/12 at 4:40 p.m. and notified that 2 CRCA's reported being witness to [Resident B's] husband's spouse, "hitting" her on the arm and tugging on the same arm to try to get [Resident B] to get out of her recliner...CSR reported to writer that both CRCA's had given a statement to the police, that police had interviewed [Resident B] alone and that they state her report is consistent c [with] what the aids [sic] report witnessing...."</p> <p>Interview with CRCA #1 on 01/13/12 at 5:05 p.m., indicated she was in</p>		<p><b>any abuse, neglect and misappropriation of resident property. The Executive Director/designee investigate and report all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property to other officials in accordance with State law through established procedures to ensure the deficient practice will not recur. The following measures will be put into place to ensure that the deficient practice does not recur. All report and investigations of alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property will be reviewed by the IDT each morning during morning meetings to ensure compliance in reporting timely to ISDH. All results will be reported each month to QA committee for six months for review and changes to ensure the deficient practice will not recur. Date of Compliance: 02.01.13</b></p>		

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	<p>Resident B's room taking care of her roommate. CRCA #1 indicated she pulled the privacy curtain back and saw Resident B's spouse pushing on her arm trying to wake her for dinner. CRCA #1 indicated Resident B kept her eyes closed and her head down. CRCA #1 indicated Resident B's spouse used an open hand, then a closed fist to hit Resident B's arm. CRCA #1 indicated Resident B had no reaction and indicated she told Resident B's spouse, "We don't do that here." CRCA #1 indicated Resident B's spouse said, "If you think this is bad, you should of seen what it was like at home." CRCA #1 indicated she took Resident B out of the room and took her to the charge nurse.</p> <p>During an interview on 01/16/13 at 11:40 a.m., the Director of Nursing Services [DNS] indicated the facility did not have any reportable incidents during October 2012. The DNS indicated she verified with the Executive Director [ED] there were no incidents reported.</p> <p>Interview with the ED and DNS on 01/16/13 at 2:30 p.m., indicated the facility did not obtain a copy of the police report and did not report the allegation of abuse reported by the</p>				

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	<p>CRCA to State agency. The ED indicated she did not report the allegation because she did not consider it abuse.</p> <p>Interview with the charge nurse, RN #2, on 01/16/13 at 5:12 p.m., indicated she heard CRCA #1 tell Resident B's spouse "Don't do that." RN #2 indicated CRCA #1 indicated Resident B's spouse pushed his wife.</p> <p>Interview with the ED and DNS on 01/17/12 at 10 a.m. indicated the police was called to get Resident B's spouse out the facility. The ED and DNS indicated they had never seen him demonstrate any violence toward Resident B, and indicated Resident B did not cry out or complain of being hurt. The ED indicated she did not consider this incident as abuse.</p> <p>The ED and DNS presented an incident report indicating an incident that occurred 10/12/12 at 4:40 p.m. CRCA #1 was named as the only witness and RN #2 was named as the person reported to. The description of what happened is as follows: "[CRCA #1] witnessed [Resident B's spouse] (husband) pushing on res. [resident] shoulder. [CRCA #1] informed [Resident B's spouse] that we do not treat [Resident B] like that</p>				

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	<p>here. [Resident B's spouse] had smurck on face, made fist c [with] hand et [and] started pushing her shoulder. [CRCA #1] states she told [Resident B's spouse] again that we don't treat [Resident B] that way here, [CRCA #1] then removed [Resident B] from room et [and] reported situation to nurse. As [CRCA #1] was taking res [resident] out of room, husband stated "If you think that was bad then you should have seen what I did to her @ [at] home." No abuse founded, - unsubstantiated. Will monitor husband visit. Measures that were taken to prevent this from happening again were "Husband asked to leave - took awhile to get husband to leave. Police where [sic] called, came to get statement from resident c daughter [Resident B's daughter] present. APS [Adult Protective Services] was notified. Ombudsman was notified."</p> <p>The facility's Accident and Incident Reporting Guidelines, dated 11/2000, was presented by the Administrator on 01/17/13 at 10 a.m. and indicated, "...Reporting of incident, accidents and abuse to state and federal agencies shall be in compliance in accordance with agency guidelines..."</p> <p>The facility's Abuse and Neglect</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155680	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/17/2013
NAME OF PROVIDER OR SUPPLIER  HOMEWOOD HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2494 N LEBANON ST LEBANON, IN 46052		
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	<p>Procedural Guidelines with revised date of 9/16/2011, indicated, "...The Executive Director is accountable for investigating and reporting...Any staff member, resident, visitor or responsible party may report known or suspected abuse, neglect, or misappropriation to local or state agencies...Immediately and not more than 24 hours complete an initial report to applicable state agencies...A written report of the investigation outcome, including resident response and/or condition, final conclusion and actions taken to prevent reoccurrence, will be submitted to the applicable State agencies within five days...The Elder Justice Act requires that if the event that caused the suspected abuse/neglect resulted in serious bodily injury, the Executive Director or designee is required to report the suspicion to the police department immediately but not later than 2 hours. If the event does not result in bodily injury, it must be reported no later than 24 hours...The investigation folder and Episodic Event forms should be completed for all state reportable occurrences."</p> <p>This federal tag is related to Complaint IN00121285.</p> <p>3.1-28(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155680	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/17/2013
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