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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155385 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 06/17/2016 |
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| NAME OF PROVIDER OR SUPPLIER CAMELOT CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 1555 COMMERCE ST LOGANSPORT, IN 46947 |
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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 0000 Bldg. 00 | <p>This visit was for the Investigation of Complaint IN00197384.</p> <p>Complaint IN00197384 - Substantiated. Federal/State deficiencies related to the allegations are cited at F223.</p> <p>Survey dates: June 17, 2016</p> <p>Facility number: 000466 Provider number: 155385 AIM number: 100289810</p> <p>Census bed type: SNF/NF: 6 NF: 62 Total: 68</p> <p>Census payor type: Medicaid: 68 Total: 68</p> <p>Sample: 1</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by 21662 on June 22, 2016.</p> | F 0000 | <p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.</p> | |
| F 0223 | 483.13(b), 483.13(c)(1)(i) | | | |

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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| SS=D Bldg. 00 | <p>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>Based on interview and record review, the facility failed to ensure a resident was free from sexual abuse for 1 of 1 residents reviewed for abuse (Resident B).</p> <p>Findings include:</p> <p>A record review of the facility investigation of the abuse allegation was completed on 06/17/16 at 10:18 a.m.</p> <p>A written statement from Housekeeper #2, dated 04/05/16, indicated she was in the middle hallway between 5:30 a.m. and 6:00 a.m. by the housekeeping closet. A CNA brought Resident B around the corner and set her by the dietary supervisor's door. CNA #1 then came around the corner, bent over, kissed Resident B on the lips and said "...well, I have to go home now, darling, I will see you tomorrow."</p> <p>During an interview on 06/17/16 at 11:00 a.m., the Administrator indicated it was</p> | F 0223 | <p>F223 Requires the facility to ensure a resident is free from sexual abuse.</p> <ol style="list-style-type: none"> 1. Resident B was removed from the situation. Staff immediately reported the concern 2. All residents have the potential to be affected. CNA #1 was suspended from work per policy and an investigation completed. Resident was removed from the situation. No further concerns were noted. See below for corrective measures. 3. The abuse policy and procedure was reviewed with no changes made. (See attachment A) The staff was inserviced on the above procedure. 4. The Administrator or her designee will conduct rounds ensuring staff are conducting themselves in an appropriate manner while care for the residents. The Administrator will also conduct 2 staff interviews ensuring no inappropriate behavior is occurring to the residents daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter | 06/28/2016 |

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| | <p>not uncommon for staff to show affection towards residents in an appropriate manner. She indicated CNA #1 had a prior incident approximately one year ago in which he placed his arm around a female resident. Although he did nothing wrong, staff members indicated it made them uncomfortable. Therefore boundaries were addressed with CNA #1. The administrator indicated CNA #1 denied the allegations regarding Resident B. Resident B was a minor with profound intellectual disabilities. CNA #1 was terminated due to the seriousness of the incident, as Resident B was non-verbal with a developmental disability and unable to speak for herself.</p> <p>A current facility policy, dated January 2015 , provided by the Administrator on 06/17/16 at 10:35 a.m., indicated "...1. This facility will not permit residents to be subjected to abuse by anyone, including employees...."</p> <p>. This Federal tag relates to complaint IN00197384.</p> <p>3.1-27(a)(1)</p> | | <p>until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly.</p> <p>5. The above corrective measures will be completed on or before June 28, 2016.</p> | |