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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 11/15/2012 |
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| NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526 |
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| F0000 | <p>This visit was for the Investigation of Complaint IN00119154 and IN00119373.</p> <p>Complaint IN00119154 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00119373 - Substantiated. Federal/state deficiencies related to the allegations are cited at F225 and F226.</p> <p>Survey dates: November 13-15, 2012</p> <p>Facility number: 000091 Provider number: 155689 AIM number: 100290080</p> <p>Survey team: Honey Kuhn, RN</p> <p>Census bed type: SNF: 37 SNF/NF: 129 Total: 166</p> <p>Census payor type: Medicare: 19 Medicaid: 103 Other: 44 Total: 166</p> <p>Sample: 4</p> | F0000 | <p>Please accept this Plan of Correction as our facility's Credible Allegation of Compliance for our Complaint Survey of November 15, 2012. Submission of this Plan of Correction is not an admission by Courtyard Healthcare Center that the deficiencies alleged in the survey are accurate or that they depict the quality of nursing care and services provided to the residents of our facility. This Plan of Correction is being submitted solely because doing solely because it is required by State and Federal law. Considering the volume, scope, and severity of the alleged deficient practices noted in the CMS-2567, Courtyard Healthcare Center respectfully requests a desk review for this survey. If approved, we would be willing to provide and all documentation requested including, but not limited to: education records, policies and procedures, checklists, and forms that have been completed, revised, or implemented as a part of this Plan of Correction.</p> | |
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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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| | <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on November 19, 2012 by Bev Faulkner, RN</p> | | | |

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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 record review, observation, and</p> | F0225 | F225 INVESTIGATE/REPORT | 12/15/2012 | | | |

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| | <p>interview, the facility failed to ensure allegations of verbal abuse and physical abuse between a resident and spouse were investigated and reported to the ISDH (Indiana State Department of Health) for 1 of 4 residents reviewed. (Resident "E")</p> <p>Finding includes:</p> <p>During the initial tour with LPN Unit Manager "C", between 9:30 a.m. and 10:20 a.m., Resident "E" was identified as non-interviewable and as requiring extensive assistance with ADL's (Activities of Daily Living.) The Unit Manager indicated the resident's spouse is present at all meals and very involved in the resident's care.</p> <p>The record of Resident "E" was reviewed on 11/13/12 at 10:45 a.m. Resident "E" was admitted to the facility on 04/30/12 with diagnoses including, but not limited to, aphasia, diabetes, cognitive deficits, muscle weakness, Alzheimer's disease, depression, and legally blind. Review of the most recent MDS (Minimum Data Set: a tool to assess care needs of residents), dated 11/06/12, indicated Resident "E" was "Severely impaired: never/rarely made decisions" for "Daily Decision Making" and displayed a "Memory problem" for both "Short-term Memory" and</p> | | <p>ALLEGATIONS/INDIVIDUALS Facility will continue to ensure that allegations of verbal abuse and physical abuse between a resident and spouse are investigated and reported to the ISDH (Indiana State Department of Health). Corrective Actions: Facility initiated an investigation with respect to Resident "E" and her spouse during the survey. That investigation has since been completed. A parallel investigation was conducted by ISDH personnel and is detailed in the 2567. In both cases, abuse was unsubstantiated. To date, with respect to Resident E, there have been no allegations of mistreatment, neglect, or abuse, including injuries of unknown source and/or misappropriation of resident property as per F225.</p> <p>How Others Identified: All residents have the potential to be affected by this alleged deficient practice. Preventative Measures: Before December 15 th , staff will undergo another round of Abuse Training. As the 11 staff members who underwent confidential interviews during the survey have not been made known to facility staff, corrective action cannot be taken regarding those who did not report allegations. Monitoring: Management staff will interview 5 staff members each week for the next four weeks; then 3 staff members a week for four weeks; then 2 staff members a week for</p> | | | | |

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| | <p>"Long-term Memory.) The MDS indicated the resident required "Extensive assistance" for bed mobility, transfers, toileting, and hygiene. The resident was "Total dependence" for dressing and bathing. Resident "E" had "Impairment on both sides" related to the upper and lower extremities.</p> <p>Resident "E" was observed in bed on 11/13/12, 11/14/12, and 11/15/12. An attempt to interview Resident "E" on 11/14/12 at 12:30 p.m., elicited no verbal response. An attempt to interview Resident "E" on 11/15/12 resulted in lack of meaningful responses, including "yes" and "no" questions.</p> <p>Review of "Progress Notes", indicated:</p> <p>"10/01/12 14:19 (2:19 p.m.) Resident's spouse came to the nurses station and stated resident was unable to breath (sic). Writer assisted resident to lie on her side and ...Nurse assessed resident lungs and administered a prn (as needed) br (breathing) tx (treatment). While nurse was in the room spouse again came to the nurses station and voiced concern about residents lungs... He stated 'The question is are we going to let her lie there and suffer or give her a shot to stop her heart..'..Social services, DON (Director of Nursing) and physician notified...."</p> | | <p>the next four weeks and 1 staff member a week for the following three months to determine if their concerns are being addressed appropriately. Interviews will take place on all shifts and include all departments. The findings of these interviews will be forwarded to the facility's QAPI Committee for follow-up. Date of Completion: December 15, 2012</p> | | | | |

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| | <p>"10/13/12 18:32 (6:32 p.m.) While attempting to administer resident's medication, resident's husband insisted on administering them himself. This nurse stayed to observe medication administration and resident refused, clenching her teeth together. After some persistence by resident's husband, this nurse suggested reapproching (sic) at a later time. Residents husband then stated 'No, because shell (sic) just try these antics later.' Resident's husband then became impatient and stated to resident '(name) take your medicine damn it!' At this time he began to force the plastic spoon with the crushed medication into resident's mouth. This nurse reported situation to staff nurse who talked with resident's husband and retrieved unadministered medication."</p> <p>Eleven (11) confidential employee interviews were conducted during the survey, between 11/13/12 and 11/15/12, which included staff employed as LPN's, CNA's (Certified Nursing Assistants), Social Services, and Physical/Occupational Therapy's. Seven (7) employee interviews indicated concerns regarding interactions between Resident "E" and her spouse of either a verbal or physical nature. Four (4) employees indicated concerns were</p> | | | | |

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| | <p>verbally reported to either Social Services or the DNS (Director Nursing Services).</p> <p>Confidential Interview 1 (CI-1) indicated Resident "E" was cognitively impaired and the resident's spouse was controlling. CI-1 indicated staff can tell if Resident "E" does not want something (to move, eat, etc.). CI-1 indicated the spouse is in the facility for every meal and assists with toileting the resident. The spouse was reported to become easily frustrated with the resident. The CI-1 indicated being knowledgeable of Resident "E"'s spouse indicated would "help that along" in regards of the need for a bowel movement and a staff member had indicated the spouse had given the resident an enema.</p> <p>Confidential Interview 2 (CI-2) indicated being told by the spouse of Resident "E" to not do any more care and the spouse said, "...I inspected the anal cavity and flushed it out." The spouse indicated using a syringe. CI-2 indicated the comment was reported to the Unit Manager. CI-2 indicated the resident is severely cognitively impaired. CI-2 was told by another staff member a sexual act was observed between the resident and spouse after which the resident displayed tenseness and fear when peri-care was attempted by the other staff member. CI-2 indicated the incident was reported</p> | | | | | | |

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| | <p>to the Social Services Manager (SSM). When CI-2 inquired of the SSM regarding an investigation, the SSM it was the resident's right to have spousal privileges. CI-2 indicated Resident "E" was observed to become more anxious when the spouse is near.</p> <p>The Administrator and the DNS were interviewed on 11/15/12 at 11:30 a.m., and indicated no formal allegations were made in regards to Resident "E". The DNS indicated a possible situation between Resident "E" and the resident's spouse was based on second hand knowledge and not observed by the person reporting to the DNS. The DNS indicated Resident "E", at times, could express her needs. The DNS and Administrator indicated due to Resident Rights and Spousal Rights no investigation was initiated or reported to ISDH (Indiana State Department of Health).</p> <p>Review of the facility's Policy and Procedure, provided by the DNS on 11/14/12 at 10:00 a.m., titled, "Abuse and Neglect - Clinical Protocol: 2007", indicated: "Policy Statement: It is the responsibility of our employees, facility consultants, Attending Physicians, family members, visitors etc., to promptly report any</p> | | | |

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| | <p>incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management.</p> <p>Policy Interpretation and Implementation: 1. Our facility will not condone resident abuse by anyone, including staff members, physicians, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals.... 4. If mistreatment, neglect, injuries of unknown source, or abuse is reported, the facility Administrator, or his/her designee, he Administrator must be immediately notified of suspected abuse or incidents of abuse.... 5. When an alleged or suspect case of mistreatment, neglect, injuries of unknown source, or abuse is reported, the facility Administrator, or his/her designee, will immediately (within twenty-four hours of the alleged incident) notify the following persons or agencies of such incident: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local State Ombudsman; c. The Resident's Representative (Sponsor) of Record;</p> | | | |

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| | <p>d. Adult Protective Services e. Law Enforcement Official; f. The Resident's Attending Physician; and g. The Facility Medical Director...</p> <p>11. A completed copy of the "Potential Resident abuse Report Form" and written statements from witnesses, if any, must be provided to the Administrator within ____ (blank) hours of the occurrence of such incident. An immediate investigation will be made..."</p> <p>This Federal tag relates to Complaint IN00119373.</p> <p>3.1-28(c) 3.1-28(d) 3.1-28(e)</p> | | | | | | |

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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 record reviews, observations, and interviews, the facility failed to implement the facility policy and procedure in regards to thoroughly investigating an allegation of verbal abuse and physical abuse between a resident and family member. (Resident "E")</p> <p>Finding includes:</p> <p>1. During the initial tour with LPN Unit Manager "C", between 9:30 a.m. and 10:20 a.m., Resident "E" was identified as non-interviewable and as requiring extensive assistance with ADL's (Activities of Daily Living.) The Unit Manager indicated the resident's spouse is present at all meals and very involved in the resident's care.</p> <p>The record of Resident "E" was reviewed on 11/13/12 at 10:45 a.m. Resident "E" was admitted to the facility on 04/30/12 with diagnoses including, but not limited to, aphasia, diabetes, cognitive deficits, muscle weakness, Alzheimer's disease, depression, and legally blind. Review of</p> | F0226 | <p>F226 DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES Facility has developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Those policies and procedures have been consistently followed as evidenced by the fact that the facility has reported 60 Unusual Occurrences thus far in 2012, many of them allegations of mistreatment, neglect, and abuse of residents or misappropriation of resident property. Three such investigations were reviewed by ISDH personnel during the survey and were noted to be thorough, accurate, and "impressive".</p> <p>Corrective Actions: Facility initiated an investigation with respect to Resident "E" and her spouse during the survey. That investigation has since been completed. A parallel investigation was conducted by ISDH personnel and is detailed in the 2567. In both cases, abuse was unsubstantiated. To date, there have been allegations, with respect to Resident E, of mistreatment, neglect, or abuse,</p> | 12/15/2012 | |

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| | <p>the most recent MDS (Minimum Data Set: a tool to assess care needs of residents), dated 11/06/12, indicated Resident "E" was "Severely impaired: never/rarely made decisions" for "Daily Decision Making" and displayed a "Memory problem" for both "Short-term Memory" and "Long-term Memory.) The MDS indicated the resident required "Extensive assistance" for bed mobility, transfers, toileting, and hygiene. The resident was "Total dependence" for dressing and bathing. Resident "E" had "Impairment on both sides" related to the upper and lower extremities.</p> <p>Resident "E" was observed in bed on 11/13/12, 11/14/12, and 11/15/12. An attempt to interview Resident "E" on 11/14/12 at 12:30 p.m., elicited no verbal response. An attempt to interview Resident "E" on 11/15/12 resulted in lack of meaningful responses, including "yes" and "no" questions.</p> <p>Review of "Progress Notes", indicated: "10/01/12 14:19 (2:19 p.m.) Nurses note: Resident's spouse came to the nurses station and stated resident was unable to breath (sic). Writer assisted resident to lie on her side and ...Nurse assessed resident lungs and administered a prn (as needed) br (breathing) tx (treatment). While nurse</p> | | <p>including injuries of unknown source and/or misappropriation of resident property as per F226. How Others Identified: All residents have the potential to be affected by this alleged deficient practice. Preventative Measures: Before December 15 th , staff will undergo another round of Abuse Training. As the 11 staff members who underwent confidential interviews during the survey have not been made known to facility staff, corrective action cannot be taken regarding those who did not report allegations as per facility policy. Monitoring: Management staff will interview 5 staff members each week for the next four weeks; then 3 staff members a week for four weeks; then 2 staff members a week for the next four weeks and 1 staff member a week for the following three months to determine if their concerns are being addressed appropriately. Interviews will take place on all shifts and include all departments. The findings of these interviews will be forwarded to the facility's QAPI Committee for follow-up. Date of Completion: December 15, 2012</p> | | | | |

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| | <p>was in the room spouse again came to the nurses station and voiced concern about residents lungs... He stated 'The question is are we going to let her lie there and suffer or give her a shot to stop her heart.' ...Social services, DON (Director of Nursing) and physician notified...."</p> <p>"10/13/12 18:32 (6:32 p.m.) Nurses note: While attempting to administer resident's medication, resident's husband insisted on administering them himself. This nurse stayed to observe medication administration and resident refused, clenching her teeth together. After some persistence by resident's husband, this nurse suggested reproaching (sic) at a later time. Resident's husband then stated 'No, because shell (sic) just try these antics later.' Resident's husband then became impatient and stated to resident '(name) take your medicine damn it!' At this time he began to force the plastic spoon with the crushed medication into resident's mouth. This nurse reported situation to staff nurse who talked with resident's husband and retrieved unadministered medication."</p> <p>"11/06/12 12:36 (p.m.) Social Service Progress Note: ...saw resident in the hallways, she did not speak or open her eyes when I spoke to her....She has no memory recall ability and she makes poor</p> | | | |

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| | <p>decisions. All of her needs are meet (sic) by staff and or husband. He is here all day long and for all 3 meals. He feed (sic) her the meals and also will help with some ADL skills....she has little interest in doing things, appears depressed and has little energy nearly every day...."</p> <p>2. Eleven (11) confidential employee interviews were conducted during the survey, between 11/13/12 and 11/15/12, which included staff employed as LPN's, CNA's (Certified Nursing Assistants), Social Services, and Physical/Occupational Therapy's. Seven (7) employee interviews indicated concerns regarding interactions between Resident "E" and spouse of either a verbal or physical nature. Four (4) employees indicated concerns were verbally reported to either Social Services or the DNS (Director Nursing Services).</p> <p>Confidential Interview 1 (CI-1) indicated Resident "E" was cognitively impaired and the resident's spouse was controlling. CI-1 indicated staff can tell if Resident "E" does not want something (to move, eat, etc.). CI-1 indicated the spouse is in the facility for every meal and assists with toileting the resident. The spouse was reported to become easily frustrated with the resident. The CI-1 indicated being knowledgeable of Resident "E"'s spouse</p> | | | |

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| | <p>indicated would "help that along" in regards of the need for a bowel movement and a staff member had indicated the spouse had given the resident an enema.</p> <p>Confidential Interview 2 (CI-2) indicated being told by the spouse of Resident "E" to not do any more care and the spouse said, "...I inspected the anal cavity and flushed it out." The spouse indicated using a syringe. CI-2 indicated the comment was reported to the Unit Manager. CI-2 indicated the resident is severely cognitively impaired. CI-2 was told by another staff member a sexual act was observed between the resident and spouse after which the resident displayed tenseness and fear when peri-care was attempted by the other staff member. CI-2 indicated the incident was reported to the Social Services Manager (SSM). When CI-2 inquired of the SSM regarding an investigation, the SSM it was the resident's right to have spousal privileges. CI-2 indicated Resident "E" was observed to become more anxious when the spouse is near.</p> <p>Confidential Interview 3 (CI-3) indicated staff knocks on the door before entering Resident "E"'s room and the spouse will often tell the staff to wait several minutes before allowing them to enter. Resident "E" is noted to be anxious or rigid when</p> | | | |

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| | <p>staff provides care. CI-3 indicated this does not occur when the spouse has not been alone in the room with the resident prior to care.</p> <p>Confidential Interview 4 (CI-4) indicated Resident "E" often appears frightened, "rigid" and "resistive" to peri-care. CI-4 indicated staff always explain what they are going to do before initiating care. CI-4 indicated Resident "E" appears more resistant following being alone with her spouse.</p> <p>Confidential Interview 5 (CI-5) indicated staff knocks before entering room of all residents. CI-5 indicated the spouse will be agitated towards staff. CI-5 indicated the spouse is controlling and will at times insist on directing care.</p> <p>The Administrator and the DNS were interviewed on 11/15/12 at 11:30 a.m., and indicated no formal allegations were made in regards to Resident "E". The DNS indicated a possible situation between Resident "E" and the resident's spouse was based on second hand knowledge and not observed by the person reporting to the DNS. The DNS and Administrator indicated due to Resident Rights and Spousal Rights no investigation was initiated or reported to ISDH (Indiana State Department of</p> | | | |

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| | <p>Health). The DNS indicated Resident "E" had voiced no concerns regarding her spouse. The Administrator indicated the facility had offered a private room to Resident "E" in regards to Spousal rights but the spouse had declined. There was no documentation to indicate the issue had been addressed.</p> <p>3. Review of the facility's Policy and Procedure, provided by the DNS on 11/14/12 at 10:00 a.m., titled, "Abuse and Neglect - Clinical Protocol: 2007", indicated: "Policy Statement: It is the responsibility of our employees, facility consultants, Attending Physicians, family members, visitors etc., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management.</p> <p>Policy Interpretation and Implementation: 1. Our facility will not condone resident abuse by anyone, including staff members, physicians, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals.... 4. If mistreatment, neglect, injuries of unknown source, or abuse is reported, the</p> | | | | | | |

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| | <p>facility Administrator, or his/her designee, he Administrator must be immediately notified of suspected abuse or incidents of abuse....</p> <p>5. When an alleged or suspect case of mistreatment, neglect, injuries of unknown source, or abuse is reported, the facility Administrator, or his/her designee, will immediately (within twenty-four hours of the alleged incident) notify the following persons or agencies of such incident:</p> <ul style="list-style-type: none"> a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local State Ombudsman; c. The Resident's Representative (Sponsor) of Record; d. Adult Protective Services e. Law Enforcement Official; f. The Resident's Attending Physician; <p>and</p> <ul style="list-style-type: none"> g. The Facility Medical Director... <p>11. A completed copy of the "Potential Resident abuse Report Form" and written statements from witnesses, if any, must be provided to the Administrator within ____ (blank) hours of the occurrence of such incident. An immediate investigation will be made..."</p> <p>"Abuse Investigations...Policy Interpretation and Implementation:</p> <ul style="list-style-type: none"> 1. Should an incident or suspected | | | | |

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| | <p>incident of resident abuse, mistreatment, neglect or injury of unknown source be reported, the Administrator, or his/her designee, will appoint a member of management to investigate the alleged incident...</p> <p>3. The individual conducting the investigation will, as a minimum:</p> <p>a. Review the completed "Potential Resident Abuse Report Form"; ...</p> <p>c. Interview the person(s) reporting the incident;</p> <p>d. Interview any witnesses to the incident;</p> <p>e. Interview the resident (as medically appropriate);</p> <p>f. Interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition;</p> <p>g. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident;..."</p> <p>This Federal tag relates to Complaint IN00119373.</p> <p>3.1-28(a)</p> | | | |