

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025
--	--

(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
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for the Investigation of Complaint IN00146118.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00142655.</p> <p>Complaint IN00146118 - Substantiated. Federal/state deficiencies related to the allegation are cited at F159, F224, F225, F226, and F514.</p> <p>Survey dates: March 31 and April 1, 2014</p> <p>Facility number: 000022 Provider number: 155061 AIM number: 100274510</p> <p>Survey team: Diana Sidell RN, TC Penny Marlatt RN</p> <p>Census bed type: SNF/NF: 44 Total: 44</p> <p>Census payor type: Medicare: 5 Medicaid: 37</p>	F000000	<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.</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/01/2014
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025		
(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	
	<p>Other: 2 Total: 44</p> <p>Sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on April 7, 2014, by Brenda Meredith, R.N.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/01/2014
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025		
(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	
F000159 SS=D	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025
--	--

(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
--------------------	--	---------------	---	----------------------

	<p>receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on record review and interview, the facility failed to ensure a resident had a complete accounting of their personal funds in that receipts were missing for some funds that had been withdrawn. This affected 1 of 3 residents reviewed for personal funds accounts in a sample of 3. (Resident #O)</p> <p>Findings include:</p> <p>Resident #O's record was reviewed on 3/31/14 at 10:10 a.m. The record indicated Resident #O was admitted with diagnoses that included, but were not limited to, heart murmur, curvature of the spine, mental retardation, inability to speak, and bilateral hip abnormalities.</p> <p>On 4/1/14, at 9:08 a.m., the Administrator provided Resident #O's personal funds statements. The statements included a check deposit dated 2/8/14 in the amount of \$3256.88. The reason listed for the</p>	F000159	<p>F0159 requires that upon written authorization of a resident the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility. 1. A complete audit of Resident #O's Resident Trust account was completed in February. Funds were reimbursed to the Resident Trust account for all transactions for which receipts could not be located. 2. All residents have the potential to be affected, thus, the following corrective action shall be taken: A complete audit of all Resident Trust accounts was completed by the Corporate Director of Accounts Receivable with no concerns noted. 3. Resident Trust Accounting policies and procedures were reviewed with no changes noted. Staff members with the ability to sign checks from the Resident Trust account has been revised and reduced to the facility Administrator, Director of Nursing and Regional Director of Operations. The facility Business Office Manager has been educated on the Resident Trust Accounting policies and</p>	04/02/2014
--	---	---------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/01/2014	
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025			
(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			
	<p>check deposit was "Resident trust."</p> <p>On 4/1/14 at 9:10 a.m., the Administrator indicated the \$3456.88 was reimbursed because the receipts could not be found in all the files. She said the term "spend down" listed on the ledger was used incorrectly, and said: "to me, Medicaid spend down means Medicaid provides information of what a resident is told to pay us, I then wanted to see if there really was a spend down." The Administrator also indicated she was not sure if any of the items purchased without receipts have [Resident #O's] name on them to identify them.</p> <p>On 4/1/14 at 12:25 p.m., the Administrator indicated the therapy bean bag was the only thing she knew that had been purchased for Resident #O. She said it was unknown; that kids had come and gone, and they couldn't find all the receipts. She wasn't sure what the company had bought and she didn't know what else was Resident #O's. Her corporation had said to reimburse Resident #O for all of it. She indicated it was hard to tell what was Resident #O's and there was no one left to ask that still worked here.</p>		<p>procedures (See Attachment A)</p> <p>4. The Administrator or Designee will utilize the Resident Trust Monitoring Tool and review all Resident Trust transactions daily, on scheduled days of work, times four weeks, then weekly times four weeks, then every two weeks times two months, then monthly ongoing to ensure continued compliance and accuracy with all Resident Trust accounting (See Attachment B). The audits and any concerns/corrective actions taken will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly, if warranted</p> <p>5. The above corrective action will be completed on or before April 2, 2014.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025
--	--

(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
--------------------	--	---------------	---	----------------------

	<p>A policy and procedure for "Resident Trust Deposit Procedures," with a last review date of 1/1/5/14, was provided by the Administrator on 4/1/14 at 12:40 p.m. The policy indicated, but was not limited to, "...5. Copy all checks and deposit ticket (or keep yellow copy of deposit ticket) with copies of checks and cash receipts. 6. Be sure to keep copies of cash receipts with deposit copies...."</p> <p>This Federal tag relates to Complaint IN00146118.</p> <p>3.1-6(b) 3.1-6(e)</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/01/2014	
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025			
(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			
F000224 SS=D	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION</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 review and interview, the facility failed to ensure a resident was free from misappropriation of her personal funds and from utilization of a therapeutic bean bag by other residents. This affected 1 of 3 residents reviewed for misappropriation of resident property in a sample of 3. (Resident #O)</p> <p>Findings include:</p> <p>Resident #O's record was reviewed on 3/31/14 at 10:10 a.m. The record indicated Resident #O was admitted with diagnoses that included, but were not limited to, heart murmur, curvature of the spine, mental retardation, inability to speak, and bilateral hip abnormalities.</p> <p>On 3/31/14 at 2:50 p.m., a family member indicated there was money stolen from Resident #O's account, and she had gotten the money back by getting the Ombudsman involved.</p>	F000224	F0224 Requires the facility to develop and implement written policies and procedures that prohibit misappropriation of resident property. 1. A complete audit of Resident #O's Resident Trust account was completed in February. Funds were reimbursed to the Resident Trust account for all transactions for which receipts could not be located or it was determined that the items had been placed in areas for use by other residents. 2. All residents have the potential to be affected, thus, the following correcting actions shall be taken: A complete audit of all Resident Trust accounts was completed by the Corporate Director of Accounts Receivable with no concerns noted. A complete audit of all inventory sheets was completed with updates made, as warranted. 3. Resident Trust Accounting policies and procedures were reviewed with no changes noted. Staff members with the ability to sign checks from the Resident Trust account has been revised and reduced to the facility Administrator, Director of	04/02/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/01/2014	
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025			
(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			
	<p>She indicated approximately #3,500.00 was taken from the resident's account in January, and the facility had put the money back. She indicated Resident #O had Medicaid spend downs on her account and she wasn't eligible for them.</p> <p>An "Incident Report Form," with a date of occurrence of 2/11/14 at 10:00 a.m., which was reported to the Indiana State Department of Health on 3/14/14, was provided by the Administrator on 4/1/14 at 9:08 a.m. The incident indicated: "...Brief description of incident: Items purchased was placed in common area without consent from family. We became aware of the concern when the family stated there was a discrepancy in the resident trust account. It was determined that some of the items purchased for the resident were in a common area being utilized by other residents. Type of injury/injuries: None. Immediate action taken: A full investigation conducted through [Corporate name] on all resident trust funds. No other resident funds were affected, and the funds were reimbursed to resident trust fund account immediately after investigation complete. It is</p>		<p>Nursing, and Regional Director of Operations. The facility Business Office Manager has been educated on the Resident Trust Accounting policies and procedures (See Attachment A). The Inventory Sheet policy and procedure was reviewed with no changes noted. The Social Service Staff has been educated on the Inventory Sheet policy (See Attachment C) 4. The Administrator or Designee will utilize the Resident Trust Monitoring tool and review all Resident Trust transactions daily, on scheduled days of work, times four weeks, then weekly times four weeks, then every two weeks times two months, then monthly ongoing to ensure no concerns of misappropriation of resident's personal funds exists (See Attachment B). All new admits will have their inventory sheets completed within 24 hours of admission and inventory sheets will be reviewed quarterly thereafter to ensure the inventory sheets are accurately completed. The Social Service Director or designee will utilize the Social Service Monitoring tool daily, on scheduled days of work, times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained to ensure prompt and accurate completion of the inventory sheets (See Attachment D). The</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/01/2014	
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025			
(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			
	<p>understood that this allegation should have been reported immediately. The reason for the delay in this incident is the change in recent Administrators and that the investigation was completed at the corporate level by the corporate office to determine if funds were actually misappropriated and to ensure no other accounts were affected. Preventive measures taken: Administrator and Business Office Manager no longer employed at this facility. Signatures on resident trust fund account have been changed to include new Administrator, Regional Director, and Director of Nursing only. Two signatures are required on each check with receipts attached. All signers have been educated on documentation necessary to verify that the funds are being dispersed appropriately. Current Administrator reviews resident trust reconciliation on a monthly basis to ensure no concerns exist."</p> <p>The investigation of the missing funds and items used by other residents included a document signed by the Administrator: "RE: Reporting of Unusual Occurrences as Per ISDH Guidance...On or about January 30/31, [2014] question was raised as to whether items had been purchased</p>		<p>audits and any concerns identified/corrective actions taken will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly, if warranted 5. The above corrective actions will be completed on or before April 2, 2014.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025
--	--

(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
	<p>with individual funds which were now in community use. Resident account was refunded on 2/8/14 when items purchased with resident account were confirmed to be in community use; it was uncertain as to whether items had been individual use initially and then moved into common areas for community...."</p> <p>On 4/1/14, at 9:08 a.m., the Administrator provided Resident #O's personal funds statements. The statements included a check deposit dated 2/8/14 in the amount of \$3256.88. The reason listed for the check deposit was "Resident trust."</p> <p>On 4/1/14 at 9:10 a.m., the Administrator indicated the \$3456.88 was reimbursed because the receipts could not be found in all the files. She indicated the term "spend down" listed on the ledger was used incorrectly, and said: "To me, Medicaid spend down means Medicaid provides information of what a resident is told to pay us, I then wanted to see if there really was a spend down." The Administrator also indicated she was not sure if any of the items purchased without receipts have Resident #O's name on them to identify them.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025
--	--

(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
--------------------	--	---------------	---	----------------------

	<p>On 4/1/14 at 12:25 p.m., the Administrator indicated the therapy bean bag was the only thing she knew that had been purchased for Resident #O. She said it was unknown, that kids had come and gone, and they couldn't find all the receipts. She wasn't sure what the company had bought and she didn't know what else was Resident #O's. Her corporation had said to reimburse Resident #O for all of it. She indicated it was hard to tell what was Resident #O's and there was no one left to ask that still worked here.</p> <p>A policy titled "Abuse Prohibition, Reporting and Investigation Policy and Procedure," with a last review date of 1/15/14, was provided by the Corporate Nurse Consultant on 3/31/14 at 10:45 a.m. The policy indicated, but was not limited to: "It is the policy of this facility that reports of abuse will be communicated to, and thoroughly investigated by, the correct authority. 1. This facility will not permit residents to be subjected to abuse by anyone, including employees, other residents, consultants, volunteers, staff or personnel of other agencies serving the resident, family members, legal guardians, sponsors, friends or other individuals. 2. This facility will</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025
--	--

(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
--------------------	--	---------------	---	----------------------

	<p>ensure that all alleged violations, including mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility. Violations of the aforementioned will be reported to other officials in accordance with state law through established procedures (including to the state survey and certification agency) as outlined in paragraph #3. 3. This facility will report all unusual occurrences, which includes abuse, within 24 hours of discovery, to the Long Term Care Division of the Indiana State Department of Health. The reporting procedure is outlined in the Nursing Policy and Procedure Manual, "Unusual Occurrence Reporting Policy and Procedure". Upon completion of the investigation, which must occur within 5 days of the reporting of an incident, a report of the investigation must be forwarded to the Long Term Care Division of the Indiana State Department of Health.</p> <p>4. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, anguish or deprivation of an individual of goods or services that are necessary to attain or</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025
--	--

(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
--------------------	--	---------------	---	----------------------

	<p>maintain physical, mental or psychosocial well-being...Misappropriation of Resident Property - The deliberate misplacement, exploitation or the wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent...."</p> <p>This Federal tag relates to Complaint IN00146118.</p> <p>3.1-28(a)</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/01/2014	
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025			
(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			
F000225 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 and</p>	F000225	F0225 Requires the facility to	04/02/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/01/2014
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025		
(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	
	<p>interview, the facility failed to ensure an allegation of misappropriation of a resident's personal funds and property was reported immediately to the State agency and other officials. This affected 1 of 3 residents reviewed for misappropriation in a sample of 3. (Resident #O)</p> <p>Findings include:</p> <p>Resident #O's record was reviewed on 3/31/14 at 10:10 a.m. The record indicated Resident #O was admitted with diagnoses that included, but were not limited to, heart murmur, curvature of the spine, mental retardation, inability to speak, and bilateral hip abnormalities.</p> <p>On 3/31/14 at 2:50 p.m., a family member indicated there was money stolen from Resident #O's account, and she got the money back by getting the Ombudsman involved. The family member indicated approximately \$3,500.00 was taken from her account in January and "the facility had put the money back." She indicated Resident #O had Medicaid spend downs on her account and she wasn't eligible for them.</p> <p>An "Incident Report Form," with a date of occurrence of 2/11/14 at</p>		<p>immediately report any allegations of misappropriation of resident property 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>1. The allegation of misappropriation affecting Resident #O has been reported to the State agency and other officials and a full investigation completed. 2. All residents have the potential to be affected, thus, the following corrective actions shall be taken: A complete audit of all Resident Trust accounts was completed by the Corporate Director of Accounts Receivable to identify any other potential misappropriation concerns with no concerns noted. 3. Abuse Prohibition policies and procedures were reviewed with no changes noted. Administrative staff was educated on the aforementioned policies with emphasis on the requirement to report all allegations immediately to the State agency and other officials (See Attachment E) 4. The Administrator or Designee will utilize the Resident Trust Monitoring tool and review all Resident Trust transactions daily, on scheduled days of work, times four weeks, then weekly times four weeks, then every two weeks times two months, then monthly ongoing to ensure no concerns of misappropriation of</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/01/2014	
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025			
(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			
	<p>10:00 a.m., which was reported to the Indiana State Department of Health on 3/14/14, was provided by the Administrator on 4/1/14 at 9:08 a.m. The incident indicated: "...Brief description of incident: Items purchased was placed in common area without consent from family. We became aware of the concern when the family stated there was a discrepancy in the resident trust account. It was determined that some of the items purchased for the resident were in a common area being utilized by other residents. Type of injury/injuries: None. Immediate action taken: A full investigation conducted through [Corporate name] on all resident trust funds. No other resident funds were affected, and the funds were reimbursed to resident trust fund account immediately after investigation complete. It is understood that this allegation should have been reported immediately. The reason for the delay in this incident is the change in recent Administrator's and that the investigation was completed at the corporate level by the corporate office to determine if funds were actually misappropriated and to ensure no other accounts were affected. Preventive measures taken:</p>		<p>resident's personal funds exists (See Attachment B). The audits and any concerns/corrective actions taken will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective actions will be completed on or before April 2, 2014.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/01/2014	
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025			
(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			
	<p>Administrator and Business Office Manager no longer employed at this facility. Signatures on resident trust fund account have been changed to include new Administrator, Regional Director, and Director of Nursing only. Two signatures are required on each check with receipts attached. All signers have been educated on documentation necessary to verify that the funds are being dispersed appropriately. Current Administrator reviews resident trust reconciliation on a monthly basis to ensure no concerns exist."</p> <p>The investigation of the missing funds and items used by other residents included a document signed by the Administrator and indicated: "RE: Reporting of Unusual Occurrences as Per ISDH Guidance...On or about January 30/31[2014], question was raised as to whether items had been purchased with individual funds which were now in community use. Resident account was refunded on 2/8/14 when items purchased with resident account were confirmed to be in community use; it was uncertain as to whether items had been individual use initially and then moved into common areas for community..."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025
--	--

(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
--------------------	--	---------------	---	----------------------

	<p>On 4/1/14, at 9:08 a.m., the Administrator provided Resident #O's personal funds statements. The statements included a check deposit dated 2/8/14 in the amount of \$3256.88. The reason listed for the check deposit was "Resident trust."</p> <p>On 4/1/14 at 9:10 a.m., the Administrator indicated the \$3456.88 was reimbursed because the receipts could not be found in all the files. She said the term "spend down" listed on the ledger was used incorrectly, and said: "to me, Medicaid spend down means Medicaid provides information of what a resident is told to pay us, I then wanted to see if there really was a spend down." The Administrator also indicated she was not sure if any of the items purchased without receipts have Resident #O's name on them to identify them.</p> <p>On 4/1/14 at 12:25 p.m., the Administrator indicated the therapy bean bag was the only thing she knew that had been purchased for Resident #O. She said it was unknown, that kids had come and gone, and they couldn't find all the receipts. She wasn't sure what the company had bought and she didn't know what else was Resident #O's.</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025
--	--

(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
--------------------	--	---------------	---	----------------------

	<p>Her corporation had said to reimburse her for all of it. She indicated it was hard to tell what was Resident #O's and there was no one left to ask that still worked here.</p> <p>A policy titled "Abuse Prohibition, Reporting and Investigation Policy and Procedure," with a last review date of 1/15/14, was provided by the Corporate Nurse Consultant on 3/31/14 at 10:45 a.m. The policy indicated, but was not limited to: "It is the policy of this facility that reports of abuse will be communicated to, and thoroughly investigated by, the correct authority. 1. This facility will not permit residents to be subjected to abuse by anyone, including employees, other residents, consultants, volunteers, staff or personnel of other agencies serving the resident, family members, legal guardians, sponsors, friends or other individuals. 2. This facility will ensure that all alleged violations, including mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility. Violations of the aforementioned will be reported to other officials in accordance with state law through established</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025
--	--

(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
--------------------	--	---------------	---	----------------------

	<p>procedures (including to the state survey and certification agency) as outlined in paragraph #3. 3. This facility will report all unusual occurrences, which includes abuse, within 24 hours of discovery, to the Long Term Care Division of the Indiana State Department of Health. The reporting procedure is outlined in the Nursing Policy and Procedure Manual, "Unusual Occurrence Reporting Policy and Procedure". Upon completion of the investigation, which must occur within 5 days of the reporting of an incident, a report of the investigation must be forwarded to the Long Term Care Division of the Indiana State Department of Health.</p> <p>4. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, anguish or deprivation of an individual of goods or services that are necessary to attain or maintain physical, mental or psychosocial well-being...Misappropriation of Resident Property - The deliberate misplacement, exploitation or the wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent...."</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025
--	--

(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
--------------------	--	---------------	---	----------------------

	<p>This Federal tag relates to Complaint IN00146118.</p> <p>3.1-28(c) 3.1-28(e)</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/01/2014	
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025			
(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			
F000226 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 review and interview, the facility failed to follow their policy and procedure related to reporting an allegation of misappropriation of a resident's personal funds and property immediately to the State agency and other officials. This affected 1 of 3 residents reviewed for misappropriation in a sample of 3. (Resident #O)</p> <p>Findings include:</p> <p>Resident #O's record was reviewed on 3/31/14 at 10:10 a.m. The record indicated Resident #O was admitted with diagnoses that included, but were not limited to, heart murmur, curvature of the spine, mental retardation, inability to speak, and bilateral hip abnormalities.</p> <p>On 3/31/14 at 2:50 p.m., a family member indicated there was money stolen from Resident #O's account, and she got the money back by getting the Ombudsman involved.</p>	F000226	F0226 Requires the facility to develop and implement written policies and procedures that prohibit misappropriation of resident property. 1. The allegation of misappropriation affecting Resident #O has been reported to the State agency and other officials and a full investigation completed. 2. All residents have the potential to be affected, thus, the folowing corrective actions shall be taken: A complete audit of all Resident Trust accounts was completed by the Corporate Director of Accounts Receivable to identify any other potential misappropriation concerns with no concerns noted. 3. Abuse Prohibition policies and procedures were reviewed with no changes noted. Administrative staff was educated on the aforementioned policies with emphasis on the requirement to report all allegations immediately to the State agency and other officials (See Attachment E). 4. The Administrator or Designee will utilize the Resident Trust Monitoring tool and review all Resident Trust transactions daily, on scheduled days of work,	04/02/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/01/2014
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025		
(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	
	<p>The family member indicated approximately \$3,500.00 was taken from her account in January and "the facility had put the money back." She indicated Resident #O had Medicaid spend downs on her account and she wasn't eligible for them.</p> <p>An "Incident Report Form," with a date of occurrence of 2/11/14 at 10:00 a.m., which was reported to the Indiana State Department of Health on 3/14/14, was provided by the Administrator on 4/1/14 at 9:08 a.m. The incident indicated: "...Brief description of incident: Items purchased was placed in common area without consent from family. We became aware of the concern when the family stated there was a discrepancy in the resident trust account. It was determined that some of the items purchased for the resident were in a common area being utilized by other residents. Type of injury/injuries: None. Immediate action taken: A full investigation conducted through [Corporate name] on all resident trust funds. No other resident funds were affected, and the funds were reimbursed to resident trust fund account immediately after investigation complete. It is understood that this allegation should</p>		<p>times four weeks, then weekly times four weeks, then every two weeks times two months, then monthly ongoing to ensure no concerns of misappropriation of resident's personal funds exists (See Attachment B). The audits and any concerns/corrective actions taken will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly, if warranted 5. The above corrective actions will be completed on or before April 2, 2014.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025
--	--

(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
--------------------	--	---------------	---	----------------------

	<p>have been reported immediately. The reason for the delay in this incident is the change in recent Administrator's and that the investigation was completed at the corporate level by the corporate office to determine if funds were actually misappropriated and to ensure no other accounts were affected. Preventive measures taken: Administrator and Business Office Manager no longer employed at this facility. Signatures on resident trust fund account have been changed to include new Administrator, Regional Director, and Director of Nursing only. Two signatures are required on each check with receipts attached. All signers have been educated on documentation necessary to verify that the funds are being dispersed appropriately. Current Administrator reviews resident trust reconciliation on a monthly basis to ensure no concerns exist."</p> <p>The investigation of the missing funds and items used by other residents included a document signed by the Administrator and indicated: "RE: Reporting of Unusual Occurrences as Per ISDH Guidance...On or about January 30/31, [2014] question was raised as to whether items had been purchased with individual funds which</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025
--	--

(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
--------------------	--	---------------	---	----------------------

	<p>were now in community use. Resident account was refunded on 2/8/14 when items purchased with resident account were confirmed to be in community use; it was uncertain as to whether items had been individual use initially and then moved into common areas for community...."</p> <p>On 4/1/14 at 12:25 p.m., the Administrator indicated the therapy bean bag was the only thing she knew that had been purchased for Resident #O. She said it was unknown, that kids had come and gone, and they couldn't find all the receipts. She wasn't sure what the company had bought and she didn't know what else was Resident #O's. Her corporation had said to reimburse her for all of it. She indicated it was hard to tell what was Resident #O's and there was no one left to ask that still worked here.</p> <p>A policy titled "Abuse Prohibition, Reporting and Investigation Policy and Procedure," with a last review date of 1/15/14, was provided by the Corporate Nurse Consultant on 3/31/14 at 10:45 a.m. The policy indicated, but was not limited to: "It is the policy of this facility that reports of abuse will be communicated to, and</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025
--	--

(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
--------------------	--	---------------	---	----------------------

	<p>thoroughly investigated by, the correct authority. 1. This facility will not permit residents to be subjected to abuse by anyone, including employees, other residents, consultants, volunteers, staff or personnel of other agencies serving the resident, family members, legal guardians, sponsors, friends or other individuals. 2. This facility will ensure that all alleged violations, including mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility. Violations of the aforementioned will be reported to other officials in accordance with state law through established procedures (including to the state survey and certification agency) as outlined in paragraph #3. 3. This facility will report all unusual occurrences, which includes abuse, within 24 hours of discovery, to the Long Term Care Division of the Indiana State Department of Health. The reporting procedure is outlined in the Nursing Policy and Procedure Manual, "Unusual Occurrence Reporting Policy and Procedure". Upon completion of the investigation, which must occur within 5 days of the reporting of an incident, a report of</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/01/2014
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025		
(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	
	<p>the investigation must be forwarded to the Long Term Care Division of the Indiana State Department of Health.</p> <p>4. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, anguish or deprivation of an individual of goods or services that are necessary to attain or maintain physical, mental or psychosocial well-being...Misappropriation of Resident Property - The deliberate misplacement, exploitation or the wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent...."</p> <p>This Federal tag relates to Complaint IN00146118.</p> <p>3.1-28(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/01/2014	
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025			
(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			
F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to maintain complete and accurate clinical records, in that 2 inventory sheets were not signed or dated, and resident's personal items were not listed on the inventory sheets. This affected 2 of 3 residents reviewed for complete and accurate inventory sheets in a sample of 3. (Residents #O and Q)</p> <p>Findings include:</p> <p>1. Resident #O's record was reviewed on 3/31/14 at 10:10 a.m. The record indicated Resident #O was admitted with diagnoses that included, but were not limited to, heart murmur, curvature of the spine, mental retardation, inability to speak,</p>	F000514	F0514 Requires the facility maintain complete and accurate clinical records. 1. Resident#O and #Q inventory sheets were reviewed and updated. 2. All residents have the potential to be affected. No negative outcomes were noted and the following corrective actions shall be taken: A complete audit of all inventory sheets was completed. All inventory sheets were updated at this time, as warranted. 3 The Inventory sheet policy and procedure was reviewed with no changes made. The Social Service staff was inserviced on the above procedure (See Attachment C). The facility will remind legal responsible party in the monthly newsletter to update the inventory sheet when bringing in items or removing items. 4. All new admits will have their inventory sheets completed within	04/02/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/01/2014
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025		
(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	
	<p>and bilateral hip abnormalities.</p> <p>Resident #O's record included three inventory sheets. One inventory sheet was dated 10/9/12 and had not been signed by the resident or family member, nor signed by the staff member. One inventory sheet was dated 10/25/12 and had additional clothing listed. The third inventory sheet had no date or signatures and had undershirts and 3 balls listed on it.</p> <p>On 4/1/14 at 10:00 a.m., the Administrator indicated the inventory had been updated by the resident's mother and the date was unknown. Resident #O's room was observed at this time, with the Administrator, Director of Nurses, and Corporate Administrator. The following items were observed in the resident's room, closet, or entryway: a disco ball with colored lights, a small keyboard, a large keyboard, a plastic toy box full of clothing, and a wall mounted television. None of these items were listed on any of the three inventory sheets for Resident #O.</p> <p>During an interview, on 4/1/14 at 11:42 a.m., the Assistant Director of Nursing and LPN #1 indicated the television in Resident #O's room did</p>		<p>24 hours of admission and inventory sheets will be reviewed quarterly thereafter to ensure that the inventory sheets are accurately completed. The Social Service Director or his designee will utilize the Social Service monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained to ensure prompt and accurate completion of the inventory sheets. (See Attachment D) The audits and any concerns/corrective actions taken will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly, if warranted 5. The above corrective measures will be completed on or before April 2, 2014.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/01/2014
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025		
(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	
	<p>not belong to the facility, so the family would have brought it in.</p> <p>During an observation on 4/1/14, at 12:05 p.m., with the Medical Records Director, Resident #O's therapeutic bean bag was checked for a resident name or identifier. The therapeutic bean bag was located in a small room connected to the therapy department. There was no name/identifier located on the bean bag.</p> <p>2. Resident #Q's record was reviewed on 3/31/14 at 11:23 a.m. The record indicated Resident #Q was admitted with diagnosis that included, but were not limited to, curvature of the spine, cerebral palsy with developmental delay, difficulty swallowing, inability to speak, and epilepsy.</p> <p>Resident #Q's record included one inventory sheet. A flat screen television, larger than 19 inches was observed in the resident's room but was not listed on the inventory sheet.</p> <p>During an interview, on 4/1/14 at 11:42 a.m., the Assistant Director of Nursing and LPN #1 indicated the television in Resident #O's room did</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025
--	--

(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
--------------------	--	---------------	---	----------------------

	<p>not belong to the facility, so the family would have brought it in.</p> <p>A policy and procedure for "Resident's Personal Inventory Procedure" was provided by the Administrator on 4/1/14 at 12:25 p.m. The policy indicated, but was not limited to: "Purpose: To provide identification for the resident's personal property. Equipment: 1. Personal Inventory Form. Procedure: Explain purpose to resident and/or family. 2. Inform resident and family upon admission that clothing must be marked. 3. Check all clothing and possessions for legible markings. Label with name if not already done. 4. Record all items on resident's Personal Inventory Form...6. Items which cannot be stored in resident's room are to be sent home with family. Complete Inventory form and have resident or family member sign. 7. Staff member is to sign form as witness. 8. Personal Inventory must be updated when: a) Additional clothing or property is brought in. b) Any time clothes are discarded or sent home. c) Property is obtained from storage. d) Property sent for storage. e) Annually the resident/responsible party is encouraged to inventory property and update the record...10. Resident,</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025
--	--

(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
--------------------	--	---------------	---	----------------------

	<p>relative, or sponsor is responsible for signing back of Personal Inventory Form for personal property that is removed from facility...."</p> <p>This Federal tag relates to Complaint IN00146118.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			
--	---	--	--	--