

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155705	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/02/2011
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NAME OF PROVIDER OR SUPPLIER HERITAGE POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 801 N HUNTINGTON AVE WARREN, IN46792
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F0000	<p>This visit was for the Investigation of Complaint IN00100230.</p> <p>Complaint IN00100230 - Substantiated. Federal/state deficiencies related to the allegation are cited at F-223, F-225, and F-226.</p> <p>Survey date: December 2, 2011</p> <p>Facility number: 000542 Provider number: 155705 AIM Number: 100267380</p> <p>Survey team: DeAnn Mankell, R.N.</p> <p>Census bed type: SNF: 13 SNF/NF: 135 Residential: 170 Total: 318</p> <p>Census payor type: Medicare: 13 Medicaid: 67 Other: 238 Total: 318</p> <p>Sample: 3</p> <p>These deficiencies also reflect state</p>	F0000		

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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F0223 SS=D	<p>findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 12/06/11 by Suzanne Williams, RN</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 record review and interview, the facility failed to ensure verbal abuse did not occur to 2 of 3 residents in a sample of 3 residents reviewed for allegations of verbal abuse. (Residents A and B) .</p> <p>Findings include:</p> <p>1. During the review of abuse allegation reports provided by the Administrator on 12/2/2011, an allegation of abuse was reviewed related to Resident A.</p> <p>The abuse allegation included a "Report of Concern" completed on 11/13/11 8:15 A.M., with the following information, "(Resident A) was in the dining room. (Name of Employee #1) was talking to another res in the dining room about the other res. going to the beauty shop today. (Name of Employee #1) told the other res maybe you could take (Name of Resident</p>	F0223	<p>F223 1.This tag is being disputed through IDR. <u>Identification:</u> Residents throughout the facility were interviewed to see if Employee #1 had ever been rude to them. <u>Corrective action:</u> Employee #1 was given a formal written warning and suspended pending the results of the facility investigation. Employee #1 was to be in-serviced prior to returning to work; however, she resigned her position with the facility and did not return to work. <u>Measures to prevent recurrence:</u> Staff and resident interviews will be conducted to coincide with resident care plans to ensure facility abuse policies and procedures are understood and being implemented. <u>Q.A.:</u> All data from resident, family, and staff interviews will be analyzed for trends and problems. All findings from interviews will be investigated and reported to the Q.A. Committee for review and recommendations.F223 2.This</p>	12/23/2011	

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	<p>A) with you." The witness statement was "Spoke with... (Employee #2 and Employee #3) report that (Resident A) was very upset and crying." The follow-up action was "(Employee #1) suspended d/t (due to) res. mental anguish et tearfulness. Beauty Shop Appt. scheduled and completed."</p> <p>The investigation of the allegation of abuse indicated the same information as the report of concern with additional information of "This was very upsetting to (Resident A) causing her to cry most of the morning."</p> <p>The summary of the investigation indicated "(Employee #1) was aware that she had hurt (Resident A's) feelings. She was very apologetic et says sometimes she is too blunt. Social Services spoke c (with) (Resident A). She stated another res. told her hair looked messy. Unit staff get her a beauty shop appointment. Res felt better after appointment."</p> <p>The summary indicated the abuse was unsubstantiated.</p> <p>Resolution of investigation addressed with involved resident/responsible party indicated, "11/18/11 3:37 P.M. Spoke c (with) res daughter (name). Stated 'I can't believe (Name of Employee #1) said that.'</p>		<p>tag is being disputed through IDR. <u>Identification:</u> All residents residing on Unit 2B were identified to be potentially affected. Interview-able residents on the Unit were questioned to see if any other residents had been treated rudely by CNA #5. In addition, family interviews were conducted with families that visit often and may have had contact with CNA #5. <u>Corrective action:</u> CNAs #4 and #5 as well as the charge nurse involved were in-serviced on resident abuse policies and procedures. In addition, all were given formal write-ups. <u>Measures to prevent recurrence:</u> Staff, family and resident interviews will be conducted to coincide with the facility Care Plan schedules to ensure all staff know how to report abuse and to ensure all reports of abuse are thoroughly investigated. <u>Q.A.:</u> All data from the staff and resident interviews will be reviewed for concerns and trends. All findings will be investigated and reported to the Q.A. Committee for review and recommendations.</p>		

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	<p>Also said her mom is very soft hearted and her feelings get hurt easily."</p> <p>Employee #1 resigned on 11/28/11.</p> <p>Resident A's clinical record was reviewed on 12/02/2011 at 4:10 P.M.</p> <p>Resident A's diagnoses included, but were not limited to, dementia, hypertension, GERD (gastroesophageal reflux disease), and PVD (peripheral vascular disease).</p> <p>Review of the progress notes for Resident A indicated on 11/18/2011 at 8:15 A.M., "Reported to this nurse that res was in the dining room for breakfast. (Employee #1) was speaking to another res about her beauty shop appointment. (Employee #1) then told the other res maybe you could take (Resident A) with you. This was very upsetting to her and she was very tearful...."</p> <p>Review of the progress notes for Resident A indicated on 11/18/2011 at 12:00 P.M., "Res has remained tearful regarding comment about the beauty shop. Nurse offered res a beauty shop appointment. Res agreeable scheduled for 1:30 P.M."</p> <p>Review of the progress notes for Resident A, written by Social Services, indicated on 11/18/2011 at 3:30 P.M., "Met with</p>			

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	<p>resident recently. Writer commented on her hair and how nice it looked after she got it done at the beauty shop. Resident indicated 'well good, because I was told by another resident that it looked 'all a mess' today at the table in front of everyone.' Resident indicated that it did hurt her feelings and she will get over it eventually.... Resident was very pleasant, no tearfulness of anxiety noted."</p> <p>Resident A's annual MDS dated 9/14/2011 indicated she was cognitively intact and was able to independently make decisions.</p> <p>Resident A was interviewed on 12/02/2011 at 4:30 P.M. She indicated she was OK now and that "I just took it the wrong way. I'm sure she didn't mean to hurt me." She indicated she got her feelings easily hurt.</p> <p>2. During an interview with CNA #4 on 12/02/2011 at 2:15 P.M., she indicated CNA #5 had spoken rudely and harshly to Resident B one evening last week. She indicated she had reported this to her nurse and the nurse had interviewed Resident B, but nothing else had been done. She indicated she had not told anyone else in the building.</p> <p>During an interview with the</p>				

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	<p>Administrator on 12/02/2011 at 2:30 P.M., she indicated Resident B likes CNA #5 and would ask for her to take care of her. She was unaware of any allegation of abuse related to Resident B.</p> <p>During an interview with Resident B on 12/2/2011 at 2:35 P.M., she indicated some of the staff were OK and some were not. She indicated some of them have a temper and some make her wait for care. She said "(CNA #5), I get along with great." She indicated she had no trouble with CNA #4.</p> <p>Review of the "Abuse Prevention/Intervention" dated 2011 and provided by the Administrator on 12/02/2011 at 12:30 P.M., indicated "It is the policy of Heritage Pointe to provide a living and working environment that prohibits abuse, neglect, involuntary seclusion and misappropriation of resident property. Therefore Heritage Pointe will provide/promote the following practices to promoted quality of care and quality of life for its residents and staff..."</p> <p>This federal tag relates to complaint IN00100230.</p> <p>3.1-27(a)(1) 3.1-27(a)(3) 3.1-27(b)</p>				

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F0225 SS=D	<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 interview, the facility failed to ensure all allegations of verbal abuse were reported to the administrator immediately for 1 of 3 allegations of verbal abuse reviewed for 1</p>	F0225	F225 1.This tag is being disputed through IDR. <u>Identification:</u> All residents residing on Unit 2B were identified to be potentially affected. Interview-able residents on the Unit were questioned to	12/23/2011	

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	<p>of 3 residents in a sample of 3 residents. (Resident B)</p> <p>Findings include:</p> <p>1. During an interview with CNA #4 on 12/02/2011 at 2:15 P.M., she indicated CNA #5 had spoken rudely and harshly to Resident B one evening last week. She indicated she had reported this to her nurse and the nurse had interviewed Resident B, but nothing else had been done. She indicated she had not told anyone else in the building.</p> <p>During an interview with the Administrator on 12/02/2011 at 2:30 P.M., she indicated Resident B likes CNA #5 and would ask for her to take care of her. She was unaware of any allegation of abuse related to Resident B, but she would look into it.</p> <p>During an interview with Resident B on 12/2/2011 at 2:35 P.M., she indicated some of the staff were OK and some were not. She indicated some of them have a temper and some make her wait for care. She said "(CNA #5), I get along with great." She indicated she had no trouble with CNA #4.</p> <p>Review of the "Abuse Prevention/Intervention" dated 2011 and</p>		<p>see if any other residents had been treated rudely by CNA #5. In addition, family interviews were conducted with families that visit often and may have had contact with CNA #5. <u>Corrective action:</u> CNAs #4 and #5 as well as the charge nurse involved were in-serviced on resident abuse policies and procedures. In addition, all were given formal write-ups. <u>Measures to prevent recurrence:</u> Staff, family and resident interviews will be conducted to coincide with the facility Care Plan schedules to ensure all staff know how to report abuse and to ensure all reports of abuse are thoroughly investigated. <u>Q.A.:</u> All data from the staff and resident interviews will be reviewed for concerns and trends. All findings will be investigated and reported to the Q.A. Committee for review and recommendations.</p>		

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F0226 SS=D	<p>provided by the Administrator on 12/02/2011 at 12:30 P.M., indicated "...Suspicious of, or reports of any alleged abuse or questionable behavior will be reported immediately to the Administrator/CEO and thoroughly investigated. Any substantiated report shall be cause for disciplinary action up to and including immediate discharge."</p> <p>This federal tag relates to complaint IN00100230.</p> <p>3.1-28(c)</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. Based on record review and interview, the facility failed to implement written policies and procedures to ensure verbal abuse did not occur and allegations were immediately reported and investigated, for 2 of 3 residents reviewed for allegations of verbal abuse in a sample of 3 residents. (Residents A and B) .</p> <p>Findings include:</p> <p>1. During the review of abuse allegation reports provided by the Administrator on 12/2/2011, an allegation of abuse was reviewed related to Resident A.</p>	F0226	<p>F226 1.This tag is being disputed through IDR. <u>Identification:</u> Residents throughout the facility were interviewed to see if Employee #1 had ever been rude to them. <u>Corrective action:</u> Employee #1 was given a formal written warning and suspended pending the results of the facility investigation. Employee #1 was to be in-serviced prior to returning to work; however, she resigned her position with the facility and did not return to work. <u>Measures to prevent recurrence:</u> Staff and resident interviews will be conducted to coincide with resident care plans to ensure</p>	12/23/2011

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	<p>The abuse allegation included a "Report of Concern" completed on 11/13/11 8:15 A.M., with the following information, "(Resident A) was in the dining room. (Name of Employee #1) was talking to another res in the dining room about the other res. going to the beauty shop today. (Name of Employee #1) told the other res maybe you could take (Name of Resident A) with you." The witness statement was "Spoke with... (Employee #2 and Employee #3) report that (Resident A) was very upset and crying." The follow-up action was "(Employee #1) suspended d/t (due to) res. mental anguish et tearfulness. Beauty Shop Appt. scheduled and completed."</p> <p>The investigation of the allegation of abuse indicated the same information as the report of concern with additional information of "This was very upsetting to (Resident A) causing her to cry most of the morning."</p> <p>The summary of the investigation indicated "(Employee #1) was aware that she had hurt (Resident A's) feelings. She was very apologetic et says sometimes she is too blunt. Social Services spoke c (with) (Resident A). She stated another res. told her hair looked messy. Unit staff get her a beauty shop appointment. Res</p>		<p>facility abuse policies and procedures are understood and being implemented. <u>Q.A.</u>: All data from resident, family, and staff interviews will be analyzed for trends and problems. All findings from interviews will be investigated and reported to the Q.A. Committee for review and recommendations.F226 2.This tag is being disputed through IDR. <u>Identification</u>: All residents residing on Unit 2B were identified to be potentially affected. Interview-able residents on the Unit were questioned to see if any other residents had been treated rudely by CNA #5. In addition, family interviews were conducted with families that visit often and may have had contact with CNA #5. <u>Corrective action</u>: CNAs #4 and #5 as well as the charge nurse involved were in-serviced on resident abuse policies and procedures. In addition, all were given formal write-ups. <u>Measures to prevent recurrence</u>: Staff, family and resident interviews will be conducted to coincide with the facility Care Plan schedules to ensure all staff know how to report abuse and to ensure all reports of abuse are thoroughly investigated. <u>Q.A.</u>: All data from the staff and resident interviews will be reviewed for concerns and trends. All findings will be investigated and reported to the Q.A. Committee for review and recommendations.</p>	

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	<p>felt better after appointment."</p> <p>The summary indicated the abuse was unsubstantiated.</p> <p>Resolution of investigation addressed with involved resident/responsible party indicated, "11/18/11 3:37 P.M. Spoke c (with) res daughter (name). Stated 'I can't believe (Name of Employee #1) said that.' Also said her mom is very soft hearted and her feelings get hurt easily."</p> <p>Employee #1 resigned on 11/28/11.</p> <p>Resident A's clinical record was reviewed on 12/02/2011 at 4:10 P.M.</p> <p>Resident A's diagnoses included, but were not limited to, dementia, hypertension, GERD (gastroesophageal reflux disease), and PVD (peripheral vascular disease).</p> <p>Review of the progress notes for Resident A indicated on 11/18/2011 at 8:15 A.M., "Reported to this nurse that res was in the dining room for breakfast. (Employee #1) was speaking to another res about her beauty shop appointment. (Employee #1) then told the other res maybe you could take (Resident A) with you. This was very upsetting to her and she was very tearful...."</p>						

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	<p>Review of the progress notes for Resident A indicated on 11/18/2011 at 12:00 P.M., "Res has remained tearful regarding comment about the beauty shop. Nurse offered res a beauty shop appointment. Res agreeable scheduled for 1:30 P.M."</p> <p>Review of the progress notes for Resident A, written by Social Services, indicated on 11/18/2011 at 3:30 P.M., "Met with resident recently. Writer commented on her hair and how nice it looked after she got it done at the beauty shop. Resident indicated 'well good, because I was told by another resident that it looked 'all a mess' today at the table in front of everyone.' Resident indicated that it did hurt her feelings and she will get over it eventually.... Resident was very pleasant, no tearfulness of anxiety noted."</p> <p>Resident A's annual MDS dated 9/14/2011 indicated she was cognitively intact and was able to independently make decisions.</p> <p>Resident A was interviewed on 12/02/2011 at 4:30 P.M. She indicated she was OK now and that "I just took it the wrong way. I'm sure she didn't mean to hurt me." She indicated she got her feelings easily hurt.</p> <p>2. During an interview with CNA #4 on</p>				

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	<p>12/02/2011 at 2:15 P.M., she indicated CNA #5 had spoken rudely and harshly to Resident B one evening last week. She indicated she had reported this to her nurse and the nurse had interviewed Resident B, but nothing else had been done. She indicated she had not told anyone else in the building.</p> <p>During an interview with the Administrator on 12/02/2011 at 2:30 P.M., she indicated Resident B likes CNA #5 and would ask for her to take care of her. She was unaware of any allegation of abuse related to Resident B.</p> <p>During an interview with Resident B on 12/2/2011 at 2:35 P.M., she indicated some of the staff were OK and some were not. She indicated some of them have a temper and some make her wait for care. She said "(CNA #5), I get along with great." She indicated she had no trouble with CNA #4.</p> <p>Review of the "Abuse Prevention/Intervention" dated 2011 and provided by the Administrator on 12/02/2011 at 12:30 P.M., indicated "It is the policy of Heritage Pointe to provide a living and working environment that prohibits abuse, neglect, involuntary seclusion and misappropriation of resident property. Therefore Heritage Pointe will</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155705	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/02/2011
NAME OF PROVIDER OR SUPPLIER HERITAGE POINTE			STREET ADDRESS, CITY, STATE, ZIP CODE 801 N HUNTINGTON AVE WARREN, IN46792		
(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>provide/promote the following practices to promoted quality of care and quality of life for its residents and staff....Suspicious of, or reports of any alleged abuse or questionable behavior will be reported immediately to the Administrator/CEO and thoroughly investigated. Any substantiated report shall be cause for disciplinary action up to and including immediate discharge."</p> <p>This federal tag relates to complaint IN00100230.</p> <p>3.1-28(a)</p>				