

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/10/2012
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NAME OF PROVIDER OR SUPPLIER CHANDLER HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 2879 S LIMA RD KENDALLVILLE, IN46755
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R0000	<p>This visit was for the Investigation of Complaint IN00101827</p> <p>Complaint IN00101827-Substantiated. State residential deficiency related to the allegations cited at R 0052</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: 1/9-10/12</p> <p>Facility number: 004440 Provider number: 004440 AIM number: N/A</p> <p>Survey team: Ellen Ruppel, RN</p> <p>Census bed type: Residential: 26 Total: 26</p> <p>Census payor type: Other: 26 Total: 26</p> <p>Sample: 3</p> <p>These state findings are cited in accordance with 410 IAC 16.2</p> <p>Quality review completed on January 11, 2012, by Bev Faulkner, RN</p>	R0000	<p>Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or, that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who draft or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</p>	

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

TITLE

(X6) DATE

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

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R0052	<p>(v) Residents have the right to be free from:</p> <p>(1) sexual abuse;</p> <p>(2) physical abuse;</p> <p>(3) mental abuse;</p> <p>(4) corporal punishment;</p> <p>(5) neglect; and</p> <p>(6) involuntary seclusion.</p> <p>Based on observation, interviews and record review, the facility failed to prevent the physical and mental abuse of 2 residents in a sample of 3 whose records were reviewed for allegations of abuse. Residents B and C</p> <p>Findings include:</p> <p>1. Review of the clinical record of Resident B, on 1/9/12 at 10:30 a.m., indicated she had been admitted to the facility on 12/19/08. Her diagnoses included, but were not limited to: dementia and post hip fracture of July 2011. The undated aide assignment information, indicated she was at risk for falls. The clinical record indicated she had very poor eyesight.</p> <p>During an interview with Resident B's hospice nurse, on 1/9/12 at 12 noon, she indicated Resident B had significant memory problems and was very confused.</p>	R0052	<p>We respectfully object to this citation. We did not fail to ensure Residents B and C were protected from abuse. After a thorough internal investigation of the incident on 11/29, interviews with current staff members and former LPN#3, we found no concrete basis to suspend or terminate LPN#3. The 12/27 incident was also investigated. LPN#3 was identified, terminated, and report filed. Current residents interviewed for Resident Rights concerns. No other residents were affected. Residents are asked to voice any concerns at our monthly resident council meeting. Families have an open door policy to the RD to voice complaints. Resident Rights education will be re-emphasized as a part of orientation of new employees. This will also be included in the all staff in-service on Resident Rights. Resident Director, Wellness Director and/or designee will re-educate Staff on Resident Rights to ensure staff understand proper procedure and when to report to the State.</p>	02/24/2012			

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	<p>Review of a reportable incident sent to the state regulatory agency was reviewed on 1/9/12 at 1:00 p.m. It was dated as sent on 12/29/11, and indicated "Employee reportedly picked her up from the chair and was pulling her across the dining room floor by rushing her. This resident is blind and unstable in walking. As the employee continued to rush her, resident said 'slow down, slow down, I can't walk that fast' and was stumbling as employee kept pulling her." The report indicated the incident had occurred on 12/29/11 and the employee was LPN #3.</p> <p>Resident B was observed walking alone in the hallway, trying to find her room, on 1/9/12 at 1:25 p.m., and had to have a staff member assist her back to her room.</p> <p>The staff member (Office Staff #4) who had observed the incident between LPN #3 and Resident B was interviewed, on 1/9/12 at 1:10 p.m. Office Staff #4 indicated she had been in the facility, on 12/27/11 after the evening meal and saw LPN #3 "snatch" Resident B out of her chair and heard Resident B calling out "slow down, I can't walk that fast." Office Staff #4 indicated she told the Resident Director on 12/29/11, about the incident and was present when LPN #3 was suspended and subsequently terminated.</p>		<p>Completion: 2/24/12 Education of Resident Rights will be offered to Resident Council at their discretion, emphasizing how to report concerns to staff, and then to escalate concerns if desired. Residence Director will review employee files quarterly for Resident Rights documentation. Regional Director of Operations will review status of documentation on Resident Rights education twice yearly.</p>		

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	<p>On 1/9/12 at 2:30 p.m., the time card record was reviewed and it indicated LPN #3 had worked the entire shift on 12/27/11 and the entire shift on 12/28/11. The record indicated she had "punched in" at 15:00 (3:00 p.m.) on or after 12/29/11.</p> <p>The Resident Director was interviewed on 1/9/12 at 2:45 p.m., and indicated she had met with LPN #3 on 12/29/11 and suspended her on that day. The Resident Director indicated LPN #3 had not worked with residents on 12/29/11.</p> <p>2. The personnel file of LPN #3 was reviewed, on 1/9/12 at 9:15 a.m., and indicated she had been hired on 1/27/10 and terminated on 12/29/11.</p> <p>The file contained a statement from CNA #5, dated 12/1/11, regarding an incident on 11/29/11, which indicated Resident C had expressed concern about the way LPN #3 had treated him. The statement indicated the resident had told CNA #5 about being "pushed" to the floor "3 or 4 days ago" by LPN #3. The statement indicated CNA #5 had told LPN #3 and the Regional Nurse about Resident C's concerns. It also indicated the Resident Director had called her on 12/1/11 and asked her to write a statement. There was no documentation to indicate the state</p>			

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	<p>licensing board had been notified of the allegation of abuse.</p> <p>CNA #5 was interviewed on 1/10/12 at 10:30 a.m., and she indicated she had reported the concerns Resident C had voiced to the Regional Nurse, who was in the building on 11/29/11. She indicated Resident C was fearful of LPN #3.</p> <p>Review of another item on the 12/29/11 document in LPN #3's file, on 1/9/12 at 9:15 a.m., indicated "12/12/11 Another resident (Resident C) came to my office at dinner time and was trembling repeating to me 'keep that lady away from me.' I (Office Staff #4) sat with him and he said how she's mean to him and hurts him. He said 'She is always roughing me up and hurts me at night.' Prior to this evening, (LPN #3) had told (Resident Director's name) (RD) and myself that over the weekend she had to take (Resident C) down to the floor because he was walking without his cane. She was too busy to help him at that very moment so she forced him to the floor. As she demonstrated how she did it to me, it was by gabbing him from the side and buckling his knee with her knee to cause him to lean downward until he reached the floor. She also stated that when she came back for him he was gone. Not sure of dates and times but on daily basis she</p>						

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	<p>speaks very harshly to our residents and staff. Her tone with residents are (sic) argumentative at times. Staff is incredibly alarmed and concerned for the care of our residents."</p> <p>The clinical record of Resident C was reviewed, on 1/9/12 at 2:05 p.m., and indicated the resident had been admitted to the facility on 9/30/11, with diagnoses including, but not limited to: Parkinson's disease, atrial fibrillation, Bipolar disorder and Alzheimer's dementia.</p> <p>Resident C was observed, walking to the noon meal on 1/10/12, using a rolling walker and unsteady in his gait.</p> <p>Review of the information on the undated aide instruction sheets indicated he was a high fall risk due to cognition impairment and Parkinson's disease. It indicated he was to use a cane, walker or wheelchair as needed.</p> <p>Observation of the facility layout, on 1/10/12 at 11:00 a.m., indicated a handrail was present around the entire perimeter of the building, making stabilization of a resident within easy reach and chairs were present between every two to three resident rooms. The chairs were within easy reach to carry to an unstable resident or to assist the resident to sit down until</p>				

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	<p>help could be acquired. There was no explanation for LPN #3's decision to make Resident C sit on the floor, when the rail and chairs were nearby.</p> <p>The facility policy on abuse, dated 1/2006 and updated 2011, was reviewed, on 1/10/12 at 11:10 a.m., and it indicated "Any complaints of abuse, neglect or exploitation should be viewed as very serious and must be reported to the Residence Director and the regional Director of Operations immediately." The policy also indicated "Act quickly to gather pertinent information. If an employee is suspected of the abuse, the employee must be suspended pending the outcome of an investigation, for the employee's protection as well as the protection of the resident.. A staff person suspected or accused of abuse, neglect or exploitation should not have access to any resident until the Residence investigates and takes action to assure resident safety."</p> <p>LPN #3 was not suspended immediately when the allegations were reported and the state licensing agency was not informed within 24 hours of the incidents.</p> <p>This state residential rule relates to Complaint IN00101827</p>						

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R0144	<p>(a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on observation, interviews and record review, the facility failed to ensure the building was in good repair related to the ceiling repair following a water leak in the main hall.</p> <p>Findings include:</p> <p>During the orientation tour, on 1/9/12 at 9:00 a.m., a large area of the ceiling in front of the beauty shop and in the main hall was observed to have the plaster/drywall missing. A sheet of plastic covering insulation was drooping down into the hallway and had been stapled to the ceiling surrounding the open area.</p> <p>During the tour, the Resident Director was queried about the missing ceiling plaster/drywall and she indicated there had been a water pipe leak above the area in early November 2011. She indicated</p>	R0144	Residence Director and/or Maintenance Technician will follow up with contractor to complete repair/replacement of the missing ceiling. Contractor will complete work no later than February 13, 2012. Regional Maintenance Director will assess facility for needed repairs monthly.	02/13/2012	

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	<p>the water leak had been repaired, but the company responsible for the plaster/drywall replacement and repair had not returned to complete the repairs needed.</p> <p>The area was measured, with CNA #5 assisting, on 1/10/12 at 9:30 a.m., and found to be 8 feet 10 inches by 8 feet.</p> <p>Review of the repair requisition, dated 11/9/11, indicated the company authorized for the repair was requesting partial payment prior to doing the work, and had not returned to the facility to complete the repairs.</p>				