

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155329	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/11/2013
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NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00137731 and Complaint IN00137931. This resulted in a Past Non- Compliance Immediate Jeopardy.</p> <p>Complaint IN00137731 -- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00137931 -- Substantiated. Federal/state deficiencies related to the allegations are cited at F221, F225 and F226.</p> <p>Survey dates: October 9, 10 and 11, 2013</p> <p>Facility number: 000222 Provider number: 155329 AIM number: 100274950</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF: 10 SNF/NF: 141 Total: 151</p> <p>Census payor type: Medicare: 43</p>	F 0000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after October 29, 2013. Facility also requests face to face IDR for F225 and F226.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0221 SS=D Bldg. 00	<p>Medicaid: 82 Other: 26 Total: 151</p> <p>Sample: 6</p> <p>These deficiencies reflect state finding in accordance with 410 IAC 16.2.</p> <p>Quality review completed on October 19, 2013, by Janelyn Kulik, RN.</p> <p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on interview and record review, the facility failed to ensure a resident was not physically restrained by the tying of his gown to his wheelchair which prevented him from rising from his wheelchair for 1 of 1 residents reviewed for restraints in a sample of 6. (Resident #D)</p> <p>Findings include:</p> <p>The clinical record of Resident #D was reviewed on 10-10-13 at 2:22 p.m. His diagnoses included, but were not limited to cerebral thrombosis with infarct, high</p>	F 0221	F221 Right to be free from physical restraint It is the practice of this provider to ensure that all alleged violations involving the right to be free from physical restraints are provided in accordance with State and Federal law through established procedures. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? The resident D no longer resides in the facility. The employee responsible for securing resident D's gown was suspended and terminated. Social services provided follow up	10/29/2013

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	<p>blood pressure, dysphagia, aphasia, senile dementia, chronic kidney disease, and gastrostomy.</p> <p>Review of Resident #D's Minimum Data Set (MDS) admission assessment, dated 9-17-13, indicated he was cognitively intact. This had declined by the 30 day MDS reassessment, dated 10-6-13, to severely cognitively impaired. Both MDS assessments's indicated he required extensive assistance of 1 or more persons with transfers, bed mobility, ambulation, dressing, hygiene and toileting. Both indicated he received gastrostomy tube feedings with his weight being stable. Both MDS assessments indicated he had falls with no injuries and that no restraints were utilized for this resident.</p> <p>In an interview with the Executive Director (ED) on 10-10-13 at 3:50 p.m., he indicated there had been an issue on the evening of 10-1-13 in which a CNA had tied Resident #D's gown to his wheelchair. He indicated the facility was restraint-free. In interview with the ED on 10-11-13 at 1:45 p.m., he indicated, the incident was not reported to the Director of Nursing (DON) until the following morning on 10-2-13 and did not get reported to him until 10-4-13. In interview with the ED on 10-11-13 at 1:25 p.m., he indicated "somehow the</p>		<p>to resident D who showed no negative psychosocial effects related to the incident. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who reside in the facility have the potential to be affected by the alleged deficient practice. All facility staff will be re-educated on the facilities restraint policy and appropriate fall interventions by the SDC on designee on or before 10/29/13. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? All facility staff will be re-educated on the facilities restraint policy and appropriate fall interventions by the SDC on designee on or before 10/29/13. The facility department heads will complete daily rounds monitoring for inappropriate restraint use Monday thru Friday excluding holidays and report any findings immediately to ED, DNS, or designee. The weekend supervisor will complete rounds on Saturday and Sunday and report any findings immediately to ED, DNS, or designee How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A restraint monitoring audit tool will be reviewed monthly by the CQI</p>	

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	<p>ball got dropped," in regard to the timely reporting to the ED. He indicated after he received the report of the incident on 10-4-13, video surveillance tapes were reviewed. He indicated in reviewing the video surveillance tape, it indicated CNA #2 was seen "manipulating [name of Resident #D]'s gown and wheelchair." He indicated CNA #2 was suspended that same day, 10-4-13. He indicated CNA #3 was seen on the video surveillance tape and "was aware of it [the restraint]" and was also suspended on the same date. He indicated Resident #D did not appear injured in any manner.</p> <p>In an interview with LPN #1 on 10-11-13 at 2:50 p.m., he indicated he had been working on Resident #D's hall on 10-1-13. He indicated the resident had been very restless, agitated and confused. He indicated he was aware of the resident attempting to stand from a seated position in the wheelchair. He indicated the resident frequently attempted to stand while seated in the wheelchair. He indicated he had not noticed the resident adjusting his gown. He indicated the resident was seated in his wheelchair at the nurse's station in order for the staff to supervise him closely. He indicated he had been documenting information into the electronic records while he was at the nurse's station. He indicated near the end</p>		<p>Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 100% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of Compliance 10/29/13.</p>	

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	<p>of his shift, CNA #1, a night shift staff, had gone to get some ice when she noticed Resident #D's gown was tied to the wheelchair on the left side of the chair. He indicated it was tied behind the resident and difficult to see. He indicated, "Everyone seemed to ask who did this, but no one said they did or had seen anything earlier." He indicated he passed this information to the next shift. He indicated he provided a written statement to the Director of Nursing (DON) when requested to do so later in the week. He did not indicate he had immediately informed the ED or the DON of the event.</p> <p>In an interview with CNA #4 on 10-11-13 at 3:05 p.m., she indicated she had worked with Resident #D on the evening of 10-1-13. She indicated he had a history of falls, as well as attempting to arise from his wheelchair unassisted. She indicated because of these issues, the resident was placed at the nurse's station in order to "have someone right there with him." She indicated the nurse had indicated the resident was very agitated that evening. She indicated she and the nurse had discussed lying him down in his bed, but elected to keep him near the staff at the nurse's station, "because he might try to get up by himself." She indicated she did not learn of the resident</p>			

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F 0225	<p>being restrained until the following evening. She indicated she had been told a night shift staff member had found the resident "tied by the gown to the wheelchair with a sheet over the top of it." She indicated she had not seen anything on the evening of 10-1-13 regarding any type of restraint.</p> <p>On 10-10-13 at 2:05 p.m., the ED provided a written statement which indicated the facility currently had no residents with restraints.</p> <p>On 10-11-13 at 1:20 p.m., the ED provided a copy of a policy entitled, "Restrictive Devices." This policy indicated, "It is policy of [name of the corporation] to prohibit the use of restrictive devices...for the purpose of discipline or convenience. Restrictive device use will be considered only after less restrictive measures have failed, and the interdisciplinary team determines that they are needed to treat resident(s) medical symptoms."</p> <p>This Federal tag relates to Complaint IN00137931.</p> <p>3.1-3(w)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4)</p>			

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SS=D Bldg. 00	<p>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 interview and record review, the facility failed to ensure timely</p>	F 0225	Past noncompliance: No POC required.	10/08/2013
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	<p>reporting of an allegation of abuse related to a resident's gown being tied to his wheelchair which prevented him from arising from his wheelchair. Due to the delayed reporting of the allegation of abuse to the Executive Director (ED), this in turn delayed timely investigation of the incident and exposed the resident to continued potential abuse from the accused staff member as the accused staff member continued to work in the facility for 3 more days. (Resident #D, CNA #1, CNA #2, CNA #3, LPN #1)</p> <p>This deficient practice resulted in an Immediate Jeopardy (IJ). The IJ began on 10-1-13 when Resident #D was observed by facility staff to have his gown tied to his wheelchair which prevented him from arising from his wheelchair. The IJ was identified on 10-11-13. The Executive Director was notified of the IJ on 10-11-13 at 3:45 p.m. The IJ was removed and the deficient practice corrected on 10/8/13 prior to the start of the survey and was therefore Past Non-Compliance.</p> <p>Findings include:</p> <p>The clinical record of Resident #D was reviewed on 10-10-13 at 2:22 p.m. His diagnoses included, but were not limited to cerebral thrombosis with infarct, high</p>			

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	<p>blood pressure, dysphagia, aphasia, senile dementia, chronic kidney disease, and gastrostomy.</p> <p>Review of Resident #D's Minimum Data Set (MDS) admission assessment, dated 9-17-13, indicated he was cognitively intact. This had declined by the 30 day MDS reassessment, dated 10-6-13, to severely cognitively impaired. Both MDS assessments's indicated he required extensive assistance of 1 or more persons with transfers, bed mobility, ambulation, dressing, hygiene and toileting. Both indicated he received gastrostomy tube feedings with his weight being stable. Both MDS assessments indicated he had falls with no injuries and that no restraints were utilized for this resident.</p> <p>In an interview with the Executive Director (ED) on 10-10-13 at 3:50 p.m., he indicated there had been an issue on the evening of 10-1-13 in which a CNA had tied Resident #D's gown to his wheelchair. He indicated the facility was restraint-free. In interview with the ED on 10-11-13 at 1:45 p.m., he indicated, the incident was not reported to the Director of Nursing (DON) until the following morning on 10-2-13 and did not get reported to him until 10-4-13. In interview with the ED on 10-11-13 at 1:25 p.m., he indicated "somehow the</p>			

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	<p>ball got dropped," in regard to the timely reporting to the ED. He indicated after he received the report of the incident on 10-4-13, video surveillance tapes were reviewed. He indicated in reviewing the video surveillance tape, it indicated CNA #2 was seen "manipulating [name of Resident #D]'s gown and wheelchair." He indicated CNA #2 was suspended that same day, 10-4-13. He indicated CNA #3 was seen on the video surveillance tape and "was aware of it [the restraint]" and was also suspended on the same date. He indicated Resident #D did not appear injured in any manner.</p> <p>The ED provided a copy of the facility's written documentation of the investigation. It indicated the initial report of the incident was submitted via fax to the Indiana State Department of Health (ISDH) on 10-4-13 at 4:18 p.m. This was 3 days after the report should have been received by ISDH. A 5-day follow up report was submitted to ISDH via fax on 10-7-13 at 4:44 p.m., which was approximately 1 day after the report should have been received by ISDH.</p> <p>The reports to ISDH indicated on 10-1-13 at 10:00 p.m., Resident #D was found by CNA #1 to be tied by his gown to his wheelchair in a manner that prevented him from standing and the gown was</p>			

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	<p>untied by CNA #1. The report indicated upon review of the surveillance video, CNA #2 was observed to manipulate the resident's gown and wheelchair and it indicated CNA #3 had witnessed this. It indicated LPN #1 and LPN #2 were observed in the area, but did not witness the event. It indicated CNA #2 and CNA #3 were indicated to have been terminated. All staff were inserviced on abuse and reporting on 10-7-13.</p> <p>On 10-11-13 at 1:50 p.m., the ED provided a copy of CNA #2's timecard for 10-1-13 through 10-5-13. It indicated CNA #2 worked in the facility on 10-1-13 from 1:54 p.m. to 9:58 p.m.; on 10-2-13 from 1:59 p.m. until 9:59 p.m.; on 10-3-13 from 1:57 p.m. until 10:07 p.m. and on 10-4-13 from 1:58 p.m. until 4:33 p.m.</p> <p>In an interview with the ED on 10-11-13 at 1:45 p.m., he indicated the DON did receive counseling. The ED provided a counseling form, dated 10-8-13, which indicated, "...any findings of abuse or violation of resident rights must be report [sic] immediately to the Executive Director...Educate your department of the sense of urgency in reporting any resident concerns." Additionally, he provided a counseling form, dated 10-9-13 for LPN #1. This document indicated, "...any</p>			

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	<p>findings of abuse or violation of resident rights must be report [sic] immediately to the Executive Director...Supervise and impart to the CNA's that report to you (and co-workers) during your shift a sense of urgency in reporting any resident concerns..." In interview with LPN #1 on 10-11-13 at 2:50 p.m., he indicated he recalled the DON and ED talking to him about the events of 10-1-13 and thought this occurred on/about 10-2-13. He indicated at that time, he provided a written statement regarding his view of the events of 10-1-13 and received one on one counseling as well as education on reporting of abuse at this time. A copy of his written statement indicated the date as 10-4-13.</p> <p>In an interview with LPN #1 on 10-11-13 at 2:50 p.m., he indicated he had been working on Resident #D's hall on 10-1-13. He indicated the resident had been very restless, agitated and confused. He indicated he was aware of the resident attempting to stand from a seated position in the wheelchair. He indicated the resident frequently attempted to stand while seated in the wheelchair. He indicated he had not noticed the resident adjusting his gown. He indicated the resident was seated in his wheelchair at the nurse's station in order for the staff to supervise him closely. He indicated he</p>			

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	<p>had been documenting information into the electronic records while he was at the nurse's station. He indicated near the end of his shift, CNA #1, a night shift staff, had gone to get some ice when she noticed Resident #D's gown was tied to the wheelchair on the left side of the chair. He indicated it was tied behind the resident and difficult to see. He indicated, "Everyone seemed to ask who did this, but no one said they did or had seen anything earlier." He indicated he passed this information to the next shift. He indicated he provided a written statement to the Director of Nursing (DON) when requested to do so later in the week. He did not indicate he had immediately informed the ED or the DON of the event. LPN #1 indicated he was later counseled by the ED and a one on one abuse inservice was conducted with him on the topics of abuse and reporting abuse. He indicated at the time of the occurrence, he did not think the event was abuse as the resident had been under the supervision of staff. He indicated now he understands that this could be a form of physical abuse. He indicated he now would ensure the resident's safety and then immediately inform the DON and ED of the event.</p> <p>In an interview with CNA #4 on 10-11-13 at 3:05 p.m., she indicated she</p>			

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	<p>had worked with Resident #D on the evening of 10-1-13. She indicated he had a history of falls, as well as attempting to arise from his wheelchair unassisted. She indicated because of these issues, the resident was placed at the nurse's station in order to "have someone right there with him." She indicated the nurse had indicated the resident was very agitated that evening. She indicated she and the nurse had discussed lying him down in his bed, but elected to keep him near the staff at the nurse's station, "because he might try to get up by himself." She indicated she did not learn of the resident being restrained until the following evening. She indicated she had been told a night shift staff member had found the resident "tied by the gown to the wheelchair with a sheet over the top of it." She indicated she had not seen anything on the evening of 10-1-13 regarding any type of restraint. She indicated after this event, the facility held an inservice on abuse issues. She indicated the topic of abuse is generally addressed at almost every inservice offering.</p> <p>On 10-10-13 at 2:05 p.m., the ED provided a written statement which indicated the facility currently had no residents with restraints.</p>			

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	<p>On 10-11-13 at 1:20 p.m., the ED provided a copy of a policy entitled, "Restrictive Devices." This policy indicated, "It is policy of [name of the corporation] to prohibit the use of restrictive devices...for the purpose of discipline or convenience. Restrictive device use will be considered only after less restrictive measures have failed, and the interdisciplinary team determines that they are needed to treat resident(s) medical symptoms."</p> <p>On 10-9-13 at 12:10 p.m., the ED provided a copy of a policy entitled, "Abuse Prohibition, Reporting, and Investigation." This policy indicated, "It is the policy of [corporate name] to protect residents from abuse...All abuse allegations/abuse must be reported to the Executive Director immediately...Failure to report will result in disciplinary action, up to and including immediate termination...It is the responsibility of every employee of [name of corporation] to not only report abuse situations, but also suspicion of abuse and unusual circumstances to his/her immediate supervisor...If resident abuse is identified or suspected, the following guidelines will be followed: The resident(s) involved in the incident will be protected and/or removed from the situation immediately. Any individual who</p>			

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	<p>witnesses abuse, or has suspicion of, shall immediately notify the charge nurse of the unit, which the resident resides. Any staff member implicated in the alleged abuse will be removed from the facility at once and will remain suspended until an investigation is completed...."</p> <p>On 10-9-13 at 12:10 p.m., the ED provided a copy of a policy entitled, "Resident Event Investigation." This policy indicated, "Upon the occurrence of any of the above items [unusual occurrences], the Executive Director or his/her designee is to be informed immediately...It is [name of corporation] policy that any allegation of abuse or neglect results in an immediate suspension of the individual accused of the abuse/neglect pending the investigation outcome...Initial Reports are to be made within 24 hours of the occurrence...5 Day Follow-up should occur within 5 days of the occurrence date..."</p> <p>The Immediate Jeopardy that began on 10-1-13 was removed and corrected on 10-8-13 upon completion of inservice education on abuse identification and abuse reporting, completion of abuse allegation investigation, completion of abuse allegation reporting, completion of</p>			

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F 0226 SS=D Bldg. 00	<p>staff terminations after investigation and staff counselings.</p> <p>This Federal tag relates to Complaint IN00137931.</p> <p>3.1-28(a) 3.1-28(d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 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 interview and record review, the facility failed to ensure timely reporting of an allegation of abuse related to a resident's gown being tied to his wheelchair which prevented him from arising from his wheelchair. Due to the delayed reporting of the allegation of abuse to the Executive Director (ED), this in turn delayed timely investigation of the incident and exposed the resident to continued potential abuse from the accused staff member as the accused staff member continued to work in the facility for 3 more days. (Resident #D, CNA #1, CNA #2, CNA #3, LPN #1)</p>	F 0226	Past noncompliance: No POC required.	10/08/2013

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	<p>This deficient practice resulted in an Immediate Jeopardy (IJ). The IJ began on 10-1-13 when Resident #D was observed by facility staff to have his gown tied to his wheelchair which prevented him from arising from his wheelchair. The IJ was identified on 10-11-13. The Executive Director was notified of the IJ on 10-11-13 at 3:45 p.m. The IJ was removed and the deficient practice corrected on 10/8/13 prior to the start of the survey and was therefore Past Non-Compliance.</p> <p>Findings include:</p> <p>The clinical record of Resident #D was reviewed on 10-10-13 at 2:22 p.m. His diagnoses included, but were not limited to cerebral thrombosis with infarct, high blood pressure, dysphagia, aphasia, senile dementia, chronic kidney disease, and gastrostomy.</p> <p>Review of Resident #D's Minimum Data Set (MDS) admission assessment, dated 9-17-13, indicated he was cognitively intact. This had declined by the 30 day MDS reassessment, dated 10-6-13, to severely cognitively impaired. Both MDS assessments's indicated he required extensive assistance of 1 or more persons</p>			

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	<p>with transfers, bed mobility, ambulation, dressing, hygiene and toileting. Both indicated he received gastrostomy tube feedings with his weight being stable. Both MDS assessments indicated he had falls with no injuries and that no restraints were utilized for this resident.</p> <p>In an interview with the Executive Director (ED) on 10-10-13 at 3:50 p.m., he indicated there had been an issue on the evening of 10-1-13 in which a CNA had tied Resident #D's gown to his wheelchair. He indicated the facility was restraint-free. In interview with the ED on 10-11-13 at 1:45 p.m., he indicated, the incident was not reported to the Director of Nursing (DON) until the following morning on 10-2-13 and did not get reported to him until 10-4-13. In interview with the ED on 10-11-13 at 1:25 p.m., he indicated "somehow the ball got dropped," in regard to the timely reporting to the ED. He indicated after he received the report of the incident on 10-4-13, video surveillance tapes were reviewed. He indicated in reviewing the video surveillance tape, it indicated CNA #2 was seen "manipulating [name of Resident #D]'s gown and wheelchair." He indicated CNA #2 was suspended that same day, 10-4-13. He indicated CNA #3 was seen on the video surveillance tape and "was aware of it [the restraint]"</p>			

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	<p>and was also suspended on the same date. He indicated Resident #D did not appear injured in any manner.</p> <p>The ED provided a copy of the facility's written documentation of the investigation. It indicated the initial report of the incident was submitted via fax to the Indiana State Department of Health (ISDH) on 10-4-13 at 4:18 p.m. This was 3 days after the report should have been received by ISDH. A 5-day follow up report was submitted to ISDH via fax on 10-7-13 at 4:44 p.m., which was approximately 1 day after the report should have been received by ISDH.</p> <p>The reports to ISDH indicated on 10-1-13 at 10:00 p.m., Resident #D was found by CNA #1 to be tied by his gown to his wheelchair in a manner that prevented him from standing and the gown was untied by CNA #1. The report indicated upon review of the surveillance video, CNA #2 was observed to manipulate the resident's gown and wheelchair and it indicated CNA #3 had witnessed this. It indicated LPN #1 and LPN #2 were observed in the area, but did not witness the event. It indicated CNA #2 and CNA #3 were indicated to have been terminated. All staff were inserviced on abuse and reporting on 10-7-13.</p>			

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	<p>On 10-11-13 at 1:50 p.m., the ED provided a copy of CNA #2's timecard for 10-1-13 through 10-5-13. It indicated CNA #2 worked in the facility on 10-1-13 from 1:54 p.m. to 9:58 p.m.; on 10-2-13 from 1:59 p.m. until 9:59 p.m.; on 10-3-13 from 1:57 p.m. until 10:07 p.m. and on 10-4-13 from 1:58 p.m. until 4:33 p.m.</p> <p>In an interview with the ED on 10-11-13 at 1:45 p.m., he indicated the DON did receive counseling. The ED provided a counseling form, dated 10-8-13, which indicated, "...any findings of abuse or violation of resident rights must be report [sic] immediately to the Executive Director...Educate your department of the sense of urgency in reporting any resident concerns." Additionally, he provided a counseling form, dated 10-9-13 for LPN #1. This document indicated, "...any findings of abuse or violation of resident rights must be report [sic] immediately to the Executive Director...Supervise and impart to the CNA's that report to you (and co-workers) during your shift a sense of urgency in reporting any resident concerns..." In interview with LPN #1 on 10-11-13 at 2:50 p.m., he indicated he recalled the DON and ED talking to him about the events of 10-1-13 and thought this occurred on/about 10-2-13. He indicated at that time, he provided a</p>			

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	<p>written statement regarding his view of the events of 10-1-13 and received one on one counseling as well as education on reporting of abuse at this time. A copy of his written statement indicated the date as 10-4-13.</p> <p>In interview with LPN #1 on 10-11-13 at 2:50 p.m., he indicated he had been working on Resident #D's hall on 10-1-13. He indicated the resident had been very restless, agitated and confused. He indicated he was aware of the resident attempting to stand from a seated position in the wheelchair. He indicated the resident frequently attempted to stand while seated in the wheelchair. He indicated he had not noticed the resident adjusting his gown. He indicated the resident was seated in his wheelchair at the nurse's station in order for the staff to supervise him closely. He indicated he had been documenting information into the electronic records while he was at the nurse's station. He indicated near the end of his shift, CNA #1, a night shift staff, had gone to get some ice when she noticed Resident #D's gown was tied to the wheelchair on the left side of the chair. He indicated it was tied behind the resident and difficult to see. He indicated, "Everyone seemed to ask who did this, but no one said they did or had seen anything earlier." He indicated he</p>			

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	<p>passed this information to the next shift. He indicated he provided a written statement to the Director of Nursing (DON) when requested to do so later in the week. He did not indicate he had immediately informed the ED or the DON of the event. LPN #1 indicated he was later counseled by the ED and a one on one abuse inservice was conducted with him on the topics of abuse and reporting abuse. He indicated at the time of the occurrence, he did not think the event was abuse as the resident had been under the supervision of staff. He indicated now he understands that this could be a form of physical abuse. He indicated he now would ensure the resident's safety and then immediately inform the DON and ED of the event.</p> <p>In interview with CNA #4 on 10-11-13 at 3:05 p.m., she indicated she had worked with Resident #D on the evening of 10-1-13. She indicated he had a history of falls, as well as attempting to arise from his wheelchair unassisted. She indicated because of these issues, the resident was placed at the nurse's station in order to "have someone right there with him." She indicated the nurse had indicated the resident was very agitated that evening. She indicated she and the nurse had discussed lying him down in his bed, but elected to keep him near the</p>			

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	<p>staff in the nurse's station, "because he might try to get up by himself." She indicated she did not learn of the resident being restrained until the following evening. She indicated she had been told a night shift staff member had found the resident "tied by the gown to the wheelchair with a sheet over the top of it." She indicated she had not seen anything on the evening of 10-1-13 regarding any type of restraint. She indicated after this event, the facility held an inservice on abuse issues. She indicated the topic of abuse is generally addressed at almost every inservice offering.</p> <p>On 10-10-13 at 2:05 p.m., the ED provided a written statement which indicated the facility currently had no residents with restraints.</p> <p>On 10-11-13 at 1:20 p.m., the ED provided a copy of a policy entitled, "Restrictive Devices." This policy indicated, "It is policy of [name of the corporation] to prohibit the use of restrictive devices...for the purpose of discipline or convenience. Restrictive device use will be considered only after less restrictive measures have failed, and the interdisciplinary team determines that they are needed to treat resident(s) medical symptoms."</p>			

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	<p>policy indicated, "Upon the occurrence of any of the above items [unusual occurrences], the Executive Director or his/her designee is to be informed immediately...It is [name of corporation] policy that any allegation of abuse or neglect results in an immediate suspension of the individual accused of the abuse/neglect pending the investigation outcome...Initial Reports are to be made within 24 hours of the occurrence...5 Day Follow-up should occur within 5 days of the occurrence date..."</p> <p>The Immediate Jeopardy that began on 10-1-13 was removed and corrected on 10-8-13 upon completion of inservice education on abuse identification and abuse reporting, completion of abuse allegation investigation, completion of abuse allegation reporting, completion of staff terminations after investigation and staff counselings.</p> <p>This Federal tag relates to Complaint IN00137931.</p> <p>3.1-28(a) 3.1-28(d)</p>			