

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
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NAME OF PROVIDER OR SUPPLIER LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH ST CONNERSVILLE, IN 47331
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F000000	<p>This visit for the Investigation of Complaint IN00127519.</p> <p>Complaint IN00127519 -- Substantiated. Federal/State deficiencies related to the allegations are cited at F223, F225 and F226.</p> <p>Unrelated deficiency is cited.</p> <p>Survey dates: April 23, 24 and 25, 2013</p> <p>Facility number: 000316 Provider number: 155491 AIM number: 100286370</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF/NF: 115 Total: 115</p> <p>Census payor type: Medicare: 15 Medicaid: 77 Other: 23 Total: 115</p> <p>Sample: 5</p> <p>These deficiencies reflect State findings cited in accordance with 410</p>	F000000	<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.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation. The provider alleges compliance as of May 10, 2013.</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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	IAC 16.2. Quality review 5/01/13 by Suzanne Williams, RN				

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F000223 SS=B	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</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. Based on record review, the facility failed to ensure resident to resident physical abuse did not occur for 4 of 5 residents reviewed for abuse in a sample of 5. (Resident #B, Resident #C, Resident #D, Resident #E)</p> <p>Findings include:</p> <p>1. Resident #B's clinical record was reviewed on 4-24-13 at 3:45 p.m. His diagnoses included, but were not limited to, anoxic brain injury, dementia, previous history of alcohol abuse, anxiety and depression. His most recent Minimum Data Set (MDS) assessment, dated 2-19-13, indicated he was moderately cognitively impaired and exhibited disorganized thinking.</p> <p>Resident #C's clinical record was reviewed on 4-24-13 at 11:57 a.m. His diagnoses included, but were not limited to, senile dementia, Alzheimer's type of advanced stage</p>	F000223	<p>F 223 SS: B Free From Abuse/Involuntary Seclusion It is the policy of this facility to comply with regulatory requirement Free From Abuse/Involuntary Seclusion. 1.) Resident B, C, D, E's Care Plan was reviewed and updated to reflect interventions for wandering and aggressive behavior. Resident B and D were reassessed and transferred to another unit at the facility at the time of the incident. 2.) Care plans reviewed on all residents residing on the dementia units for appropriate behavioral interventions and compared to behavior tracking sheets 3.) Staff has been re-educated on the facility policy and procedure related to abuse and neglect, reporting procedures and residents rights on May 7, 2013. Social Services or designee will QA monitor behavior forms, 3x's weekly x 4 weeks, weekly x 4 weeks, then monthly x 6 months pending QA review to determine if discontinuation of monitoring is appropriate. 4.) Results of QA</p>	05/10/2013	

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	<p>with psychosis, anxiety, depression and aggressive behaviors. His most recent MDS assessment, dated 4-7-13, indicated he was severely cognitively impaired and exhibited disorganized thinking.</p> <p>The Director of Nursing provided a copy of a "Facility Incident Reporting Form," which indicated it had been electronically mailed to the Indiana State Department (ISDH) on 3-26-13 at 2:40 p.m. This document indicated on 3-25-13 at 6:30 p.m., Resident #C approached Resident #B while both were seated in their wheelchairs. Resident #C grabbed Resident #B's jacket and ran his wheelchair into Resident #B's wheelchair. Nursing notes, dated 3-25-13 at 6:30 p.m., indicated Resident #B then was witnessed by CNA #5 to hit Resident #C twice in the face. Notes indicated CNA #5 immediately separated both residents and notified the nurse on duty. Notes indicated the nurse on duty provided immediate first aid to a scratch on the left upper cheek and assessment to Resident #C. Notification to both residents' physicians and family and/or guardian was conducted, as well as the facility administration. Both residents resided on the same secured hall in the facility. Resident #B was placed</p>		<p>reviews will be forwarded to the Facility Risk Management Quality Initiative, (RMQI), for further evaluation and recommendations acted on as indicated.. 5.) Alleged Compliance: May 10, 2013.</p>	

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	<p>on one on one supervision until he was moved to another secured hall in the facility on 3-26-13. Resident #B was placed on 15 minute checks for the remainder of the evening with no further issues indicated. Both residents care plans have been updated, following this event of 3-25-13.</p> <p>2. Resident #D's clinical record was reviewed on 4-24-13 at 2:45 p.m. His diagnoses included, but were not limited to, schizophrenia, bipolar disorder, hallucinations, sexual behaviors, seizure disorder and end-stage kidney disease with hemodialysis. His most recent MDS assessment, dated 4-16-13, indicated he was moderately cognitively impaired.</p> <p>On 4-23-13 at 7:50 a.m., the DON provided a copy of a "Facility Incident Reporting Form," which indicated it had been electronically mailed to the Indiana State Department (ISDH) on 4-3-13 at 2:03 p.m. This document indicated on 4-2-13 at 5:30 p.m., Resident #D was entering the dining room of the secured hall where he resided. It indicated Resident #D "...Kicked out towards [name of Resident #E], striking her left inner knee," resulting in a dime-sized bruise</p>						

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	<p>to the left inner knee. It indicated both residents were separated by staff and Resident #D was placed in a separate dining area and placed on 15 minute checks with no further incidents noted. Nursing notes, dated 4-2-13, indicated notification of the incident was made to each resident's physician and family, as well as facility administration. Nursing notes indicated the resident indicated, "She was in my way and she is old and blind. It doesn't matter."</p> <p>Review of physician progress notes and pharmacist reviews indicated multiple medication changes have been made in relation to psychoactive, seizure and gastric medications related to timing of hemodialysis and behaviors since the events of 4-2-13. Resident #D is followed by psychiatric services. His care plan has been updated, following this event.</p> <p>On 4-23-13 at 7:50 a.m., the Director of Nursing provided a copy of a policy entitled, "Resident Abuse." This policy was identified as the current policy in use. This policy indicated, "It is inherent in the nature and dignity of each resident at [name of corporation] that he/she be afforded basic human rights, including the right to be free</p>			

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	<p>from abuse, neglect, mistreatment...Acts of abuse directed against residents are absolutely prohibited..."</p> <p>This federal tag relates to complaint IN00127519.</p> <p>3.1-27(a)(1)</p>				

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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 interview, observation and</p>	F000225	<u>F 225 SS: D Investigate/Report</u>	05/10/2013			

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	<p>record review, the facility failed to ensure a staff member who alleged physical abuse of a resident by facility staff immediately reported this abuse allegation to the administrator of the facility for 1 of 5 residents reviewed for abuse in a sample of 5. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 4-23-13 at 9:01 a.m. Her diagnoses included, but were not limited to, CVA (cerebrovascular accident or stroke) with left-sided weakness, vascular dementia, neuropathic pain, bipolar disease and morbid obesity. Her most recent Minimum Data Set (MDS) assessment, dated 2-18-13, indicated she was moderately cognitively impaired and displayed verbal and physical behaviors towards others. It indicated she required extensive assistance of at least one person with transfers from one surface to another, dressing, hygiene, toileting, and mobility. In interview with Resident #A on 4-23-13 at 9:05 a.m., she indicated she had resided at the facility for a least 2 years. She indicated she was treated very well by facility staff and denied any mistreatment or disparaging talk by</p>		<p>Allegations/Individuals It is the policy of this facility to comply with Investigating and Reporting Allegations. 1.) Resident A was assessed by nurse and interviewed for adverse effect by Social Services immediately following notification of incident. 2.) Facility conducted an interview with all other alert and oriented interviewable residents on the hallway that Resident A resides with no concerns or issues noted immediately after incident reported. 3.) Staff was immediately re-educated on reporting allegations of abuse & neglect following incident and again on May 7, 2013. Director of Clinical Services or designee will randomly interview staff on policies and procedures for reporting abuse, daily (5 days/week) x 4 weeks, weekly x 4 weeks, then monthly x 6 months pending QA review to determine if discontinuation of monitoring is appropriate.</p> <p>4.) Results of QA reviews will be forwarded to the Facility Risk Management Quality Initiative, (RMQI), for further evaluation and recommendations acted on as indicated.. 5.) Alleged Compliance: May 10, 2013.</p>		

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	<p>the staff.</p> <p>On 4-23-13 at 7:50 a.m., the Director of Nursing (DON) provided a copy of an "Incident Report Form" which indicated on 4-12-13 at 12:00 p.m. the DON received a report "...by the charge nurse that a CNA reported that [name of Resident #A] had been mistreated by staff during bedcheck. After interviews with staff and the involved resident, the allegation was unsubstantiated." It indicated upon physical assessment of the resident, no injuries were noted. It indicated staff involved were placed on administrative leave, pending results of the investigation, and all staff were re-educated on abuse, neglect and resident rights with the same educational topics provided at a Resident Council Meeting. A resident satisfaction survey was completed of the residents who resided on the same hallway as Resident #A.</p> <p>In interview with the DON on 4-24-13 at 10:30 a.m., she indicated, "From my understanding, [name of CNA #2] witnessed the allegations against [name of Resident #A] on 4-10-13 at 2:00 a.m." She indicated CNA #2 rarely worked on the unit on which Resident #A resided and was not familiar with the resident. She</p>						

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	<p>indicated she received a phone call "around noon" on 4-12-13 from RN #1 in regard to a mandatory inservice scheduled for later on that date. She indicated, "That is when she told me about [name of CNA #2's] allegations...So that's when we began our investigation." She indicated she phoned CNA #2 in regard to the allegations of abuse. She indicated, "CNA #2 only said something when I called her about it on Friday [4-12-13]...the only thing she said was [name of Resident #A] was yelling about her feet and that she did not want to get anyone [other staff] in trouble and that they would know who made the report...she never made it sound like she was afraid of the [other] staff."</p> <p>On 4-23-13 at 7:50 a.m., the DON provided a copy of a written summary of the abuse investigation, dated 4-15-13. This summary indicated she had received a phone call on 4-12-13 around noon in which RN #1 indicated she and LPN #2 had been told on an unspecified date by CNA #2 that Resident #A had been abused by LPN #1 and CNA #6. The abuse allegation indicated LPN #1 and CNA #6 were providing care to Resident #A. It indicated CNA #6 was tickling the resident's feet and the resident</p>			

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	<p>was yelling for her to stop while LPN #1 "stuffed a sock into [name of Resident #A] to 'quiet her.'"</p> <p>In interview with LPN #1 on 4-23-13 at 3:51 a.m., she indicated she had worked with Resident #A frequently. She indicated the resident is care-planned for many behavioral interventions related to her refusal of care and medications, yelling out and physical behaviors toward staff with care. She indicated the resident is a "heavy wetter" and often will require a complete bed change with incontinence care. She indicated, "I'm assuming when [name of CNA #6] went to move her legs to get the old sheet off and the new one on, [name of Resident #A] thought she was trying to mess with her feet." She indicated she washed the resident's face during the care.</p> <p>During a care observation with Resident #A on 4-23-13 at 9:30 a.m., the resident was provided incontinence care by 2 facility staff. During the care, the resident was observed to loudly yell throughout the entire procedure phrases such as "What are you doing", "Quit," and "You're killing me." Upon completion of the care, the resident was queried as to what kind of care she received.</p>			

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	<p>The resident indicated, "Great. Give her [staff member] 2 checkmarks [indicating above average care]."</p> <p>In interview with the DON on 4-24-13 at 10:30 a.m., she indicated in her interviews with RN #1 and LPN #2, "Both told me they were waiting for [name of CNA #2] to come forward to tell me what happened...Both of the nurses told me they knew better, that they should have reported it as soon as they were told by [CNA #2]..." She indicated she had met with RN #1 on 4-12-13 at 4:30 a.m. in regard to another matter. She indicated, "She never mentioned a word about any problem with [name of Resident #A]. Then she called around noon and asked..." about an inservice program later the same date. "That is when she told me about [name of CNA #2's] allegations..."</p> <p>In interview with the DON on 4-24-13 at 5:10 p.m., she indicated that after the alleged abuse occurred on 4-10-13 at 2:00 a.m., the alleged perpetrators continued to work on the same unit as Resident #A. She indicated LPN #1 worked on the same hall for her scheduled shift on 4-11-13 from 11:00 p.m. until 7:00 a.m. on 4-12-13. She indicated CNA #6 worked on the same hall for her</p>			

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	<p>scheduled shift on 4-10-13 from 11:00 p.m. until 4-11-13 at 7:00 a.m. Review of the facility's nursing work schedule for April 2013 indicated LPN #1 and CNA #6 were on suspension from 4-12-13 related to the investigation of the abuse allegations until they returned from suspension on 4-15-13.</p> <p>Review of documents entitled, "Employee Corrective Action Form," for RN, #1, LPN #2, and CNA #2 indicated each was terminated for failure to report an allegation of abuse in a timely fashion. CNA #2's document also indicated an additional comment of "Employee failed to come talk [sign for with] management r/t [related to] abuse allegation." In interview with the DON on 4-24-13 at 10:30 a.m., she indicated she had set up two different times for CNA #2 to come into the facility to discuss the abuse allegations, but she failed to show up either time.</p> <p>On 4-23-13 at 7:50 a.m., the Director of Nursing provided a copy of a policy entitled, "Resident Abuse." This policy was identified as the current policy in use. This policy indicated, "All employees have the duty to respect the rights of all residents, to treat them with dignity and to prevent</p>						

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	<p>others from violating their rights. Any employee who witnesses or has knowledge of an act of abuse to a resident is obligated to report such information to the Clinical Nurse in charge, Director of Clinical Services, and the Executive Director...All incidents of resident abuse are to be reported immediately to the Clinical Nurse in charge, Director of Clinical Services, and the Executive Director...Immediately upon report of an incident to the individual in charge, the suspect(s) shall be segregated from the resident...Any suspect(s), once he/she has (have) been identified will be suspended pending the investigation...The Abuse Coordinator of [name of corporation] will refer any or all incidents and reports of resident abuse to the appropriate state agencies."</p> <p>This federal tag relates to complaint IN00127519.</p> <p>3.1-28(a) 3.1-28(c) 3.1-28(d)</p>				

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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 interview, observation and record review, the facility failed to ensure the current abuse related polices were utilized for an allegation of staff to resident physical abuse for 1 of 5 residents reviewed for abuse in a sample of 5. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 4-23-13 at 9:01 a.m. Her diagnoses included, but were not limited to, CVA (cerebrovascular accident or stroke) with left-sided weakness, vascular dementia, neuropathic pain, bipolar disease and morbid obesity. Her most recent Minimum Data Set (MDS) assessment, dated 2-18-13, indicated she was moderately cognitively impaired and displayed verbal and physical behaviors towards others. It indicated she required extensive assistance of at least one person with transfers from one surface to another, dressing, hygiene, toileting, and mobility. In interview with Resident</p>	F000226	<p><u>F 226 SS: D Develop/Implement Abuse/Neglect, etc Policies</u> It is the policy of this facility to comply with Developing and Implementing Abuse/Neglect, etc Policies. 1.) Social Services interviewed resident A and all other interviewable residents on the hallway immediately following the reporting of incident. No concerns voiced. 2). Facility conducted an interview with all other alert and oriented interviewable residents on the hallway that Resident A resides with no concerns or issues noted. 3.) Staff has been re-educated on the facility policy and procedure related to abuse prevention and immediately reporting potentially reportable occurrences. Director of Clinical Services or designee will randomly interview staff on policies and procedures for reporting abuse, daily (5 days/week) x 4 weeks, weekly x 4 weeks, then monthly x 6 months pending QA review to determine if discontinuation of monitoring is appropriate. 4.) Results of QA reviews will be forwarded to the Facility Risk Management Quality Initiative, (RMQI), for further</p>	05/10/2013

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	<p>#A on 4-23-13 at 9:05 a.m., she indicated she had resided at the facility for a least 2 years. She indicated she was treated very well by facility staff and denied any mistreatment or disparaging talk by the staff.</p> <p>On 4-23-13 at 7:50 a.m., the Director of Nursing (DON) provided a copy of an "Incident Report Form" which indicated on 4-12-13 at 12:00 p.m. the DON received a report "...by the charge nurse that a CNA reported that [name of Resident #A] had been mistreated by staff during bedcheck. After interviews with staff and the involved resident, the allegation was unsubstantiated." It indicated upon physical assessment of the resident, no injuries were noted. It indicated staff involved were placed on administrative leave, pending results of the investigation, and all staff were re-educated on abuse, neglect and resident rights with the same educational topics provided at a Resident Council Meeting. A resident satisfaction survey was completed of the residents who resided on the same hallway as Resident #A.</p> <p>In interview with the DON on 4-24-13 at 10:30 a.m., she indicated, "From my understanding, [name of CNA #2]</p>		<p>evaluation and recommendations acted on as indicated.. 5.) Alleged Compliance: May 10, 2013.</p>		

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	<p>witnessed the allegations against [name of Resident #A] on 4-10-13 at 2:00 a.m." She indicated CNA #2 rarely worked on the unit on which Resident #A resided and was not familiar with the resident. She indicated she received a phone call "around noon" on 4-12-13 from RN #1 in regard to a mandatory inservice scheduled for later on that date. She indicated, "That is when she told me about [name of CNA #2's] allegations...So that's when we began our investigation." She indicated she phoned CNA #2 in regard to the allegations of abuse. She indicated, "CNA #2 only said something when I called her about it on Friday [4-12-13]...the only thing she said was [name of Resident #A] was yelling about her feet and that she did not want to get anyone [other staff] in trouble and that they would know who made the report...she never made it sound like she was afraid of the [other] staff."</p> <p>On 4-23-13 at 7:50 a.m., the DON provided a copy of a written summary of the abuse investigation, dated 4-15-13. This summary indicated she had received a phone call on 4-12-13 around noon in which RN #1 indicated she and LPN #2 had been told on an unspecified date by CNA</p>						

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	<p>#2 that Resident #A had been abused by LPN #1 and CNA #6. The abuse allegation indicated LPN #1 and CNA #6 were providing care to Resident #A. It indicated CNA #6 was tickling the resident's feet and the resident was yelling for her to stop while LPN #1 "stuffed a sock into [name of Resident #A] to 'quiet her.'"</p> <p>In interview with LPN #1 on 4-23-13 at 3:51 a.m., she indicated she had worked with Resident #A frequently. She indicated the resident is care-planned for many behavioral interventions related to her refusal of care and medications, yelling out and physical behaviors toward staff with care. She indicated the resident is a "heavy wetter" and often will require a complete bed change with incontinence care. She indicated, "I'm assuming when [name of CNA #6] went to move her legs to get the old sheet off and the new one on, [name of Resident #A] thought she was trying to mess with her feet." She indicated she washed the resident's face during the care.</p> <p>During a care observation with Resident #A on 4-23-13 at 9:30 a.m., the resident was provided incontinence care by 2 facility staff. During the care, the resident was</p>			

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	<p>observed to loudly yell throughout the entire procedure phrases such as "What are you doing", "Quit," and "You're killing me." Upon completion of the care, the resident was queried as to what kind of care she received. The resident indicated, "Great. Give her [staff member] 2 checkmarks [indicating above average care]."</p> <p>In interview with the DON on 4-24-13 at 10:30 a.m., she indicated in her interviews with RN #1 and LPN #2, "Both told me they were waiting for [name of CNA #2] to come forward to tell me what happened...Both of the nurses told me they knew better, that they should have reported it as soon as they were told by [CNA #2]..." She indicated she had met with RN #1 on 4-12-13 at 4:30 a.m. in regard to another matter. She indicated, "She never mentioned a word about any problem with [name of Resident #A]. Then she called around noon and asked..." about an inservice program later the same date. "That is when she told me about [name of CNA #2's] allegations..."</p> <p>In interview with the DON on 4-24-13 at 5:10 p.m., she indicated that after the alleged abuse occurred on 4-10-13 at 2:00 a.m., the alleged perpetrators continued to work on the</p>			

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	<p>same unit as Resident #A. She indicated LPN #1 worked on the same hall for her scheduled shift on 4-11-13 from 11:00 p.m. until 7:00 a.m. on 4-12-13. She indicated CNA #6 worked on the same hall for her scheduled shift on 4-10-13 from 11:00 p.m. until 4-11-13 at 7:00 a.m. Review of the facility's nursing work schedule for April 2013 indicated LPN #1 and CNA #6 were on suspension from 4-12-13 related to the investigation of the abuse allegations until they returned from suspension on 4-15-13.</p> <p>Review of documents entitled, "Employee Corrective Action Form," for RN, #1, LPN #2, and CNA #2 indicated each was terminated for failure to report an allegation of abuse in a timely fashion. CNA #2's document also indicated an additional comment of "Employee failed to come talk [sign for with] management r/t [related to] abuse allegation." In interview with the DON on 4-24-13 at 10:30 a.m., she indicated she had set up two different times for CNA #2 to come into the facility to discuss the abuse allegations, but she failed to show up either time.</p> <p>On 4-23-13 at 7:50 a.m., the Director of Nursing provided a copy of a policy</p>			

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	<p>entitled, "Resident Abuse." This policy was identified as the current policy in use. This policy indicated, "All employees have the duty to respect the rights of all residents, to treat them with dignity and to prevent others from violating their rights. Any employee who witnesses or has knowledge of an act of abuse to a resident is obligated to report such information to the Clinical Nurse in charge, Director of Clinical Services, and the Executive Director...All incidents of resident abuse are to be reported immediately to the Clinical Nurse in charge, Director of Clinical Services, and the Executive Director...Immediately upon report of an incident to the individual in charge, the suspect(s) shall be segregated from the resident...Any suspect(s), once he/she has (have) been identified will be suspended pending the investigation...The Abuse Coordinator of [name of corporation] will refer any or all incidents and reports of resident abuse to the appropriate state agencies."</p> <p>This federal tag relates to complaint IN00127519.</p> <p>3.1-28(a)</p>						

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F009999	<p>State finding:</p> <p>3.1-14 PERSONNEL</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5TU PPD)....</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure newly hired employees had pre-employment physicals and/or TB (tuberculosis) screenings conducted in a timely manner for 6 of 10 employee records reviewed. (CNA #1, CNA #2, CNA #3, CNA #4, RN #1, RN #2)</p> <p>Findings include:</p> <p>Review of employee records on 4/24/13 indicated the following:</p> <p>1. CNA #1 began employment with the facility on 12-28-12. Her pre-employment physical was signed on 10-26-12 by an area physician's</p>	F009999	<p>F9999 It is the practice of the facility to ensure each employee has a physical within one month prior to employment including Tuberculin Skin Test. 1.) HR conducted audits on CNA #1, #2, #3, #4 and RN #1 & #2 Staff Employee files to ensure Tuberculin Skin Test and physical is present in File. 2.) HR conducted audits on all employee Files to ensure Tuberculin Skin Test And employee physicals in place. 3.) HR and Nursing Staff re-educated on State Regulation requiring Tuberculin Skin Test and Employee Physical within One month prior to employment Business Office Manager or designee will audit employee files daily (5 days/week) x 4 weeks, weekly x 4 weeks, then monthly x 6 months pending QA review to determine if discontinuation of monitoring is appropriate. 4.) Results of QA reviews will be forwarded to the Facility Risk Management Quality Initiative, (RMQI), for further evaluation and recommendations acted on as indicated.. 5.) Alleged Compliance: May 10, 2013.</p>	05/10/2013	

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	<p>assistant. Her initial TB screening with PPD was indicated to have been conducted on 10-26-12. There was not a second-step testing conducted within the next 3 weeks documented. Another document, entitled, "Employee Tuberculosis Screening" indicated the TB test was "redone" with an initial TB test date of 1-28-13 and a second TB test was conducted on 3-1-13. Both tests were read 2 days after the tests were administered with results indicated as 0 mm (millimeters).</p> <p>2. CNA #2 began employment with the facility on 7-26-12. Her pre-employment physical was signed on 8-2-12 by an area physician's assistant. Her initial TB screening with PPD was indicated to have been conducted on 7-26-12. There was not a second-step testing conducted until 10-7-12. Both tests were read 2 days after the tests were administered with results indicated as 0 mm.</p> <p>3. CNA #3 began employment with the facility on 7-27-12. Her initial TB screening with PPD was indicated to have been conducted on 1-19-13. The second-step testing was conducted on 2-5-13. Both tests were read 2-3 days after the tests</p>						

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	<p>were administered with results indicated as 0 mm.</p> <p>4. CNA #4 began employment with the facility on 1-15-13. Her pre-employment physical was signed on 1-19-2011 by an area physician. Her initial TB screening with PPD was indicated to have been conducted on 3-1-13. The second-step testing was conducted on 3-15-13. Both tests were read 2 days after the tests were administered with results indicated as 0 mm.</p> <p>5. RN #1 began employment with the facility on 3-7-12. Her initial TB screening with PPD was conducted without a date indicated. This TB screening was read on 4-30-12 with the results indicated as 0 mm. There was no other documentation of previous TB screening or a second step PPD test.</p> <p>6. RN #2 began employment with the facility on 1-24-13. Her initial TB screening with PPD was indicated to have been conducted on 1-30-13. The second-step testing was conducted on 2-14-13. Both tests were read 2 days after the tests were administered with results indicated as 0 mm.</p>						

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	<p>In interview with the Administrator on 4-24-13 at 10:15 a.m., she indicated, "Our policy on [pre-employment] physicals says [they are to be conducted] within 60 days of hire, I believe."</p> <p>On 4-24-13 at 1:05 p.m., the Administrator provided a copy of a policy entitled, "Post-Offer / Pre-Employment Physician Examinations and Health Screening." This policy was indicated to be the current policy. It indicated, "...It is the policy of The Company, that in applicable states all new employees must receive a post-offer, pre-employment physical examination, conducted by a licensed physician or approved designee if state law mandates. All newly hired employees must complete a pre-placement health screening. In applicable states, pre-employment physical examinations will be conducted after a conditional offer has been made to an individual, but prior to his/her first day of employment...This will include...a statement that the employee is free from communicable diseases and TB screening for these employees involved is resident care..."</p> <p>3.1-14(t)</p>			

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