

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155711	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/19/2013
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NAME OF PROVIDER OR SUPPLIER  HIGHLAND MANOR HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2926 N CAPITOL AVE INDIANAPOLIS, IN 46208
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F000000	<p>This visit was for the Investigation of Complaint IN00130548.</p> <p>Complaint IN00130548 Substantiated. Federal/state deficiencies related to the allegations are cited at F225 and F226.</p> <p>Survey date: June 19, 2013</p> <p>Facility number: 000567 Provider number: 155711 AIM number: 100289560</p> <p>Survey team: Joyce Hofmann, RN</p> <p>Census bed type: SNF: 1 NF: 12 SNF/NF: 25 Total: 38</p> <p>Census payor type: Medicare: 1 Medicaid: 37 Total: 38</p> <p>Sample: 3</p> <p>This deficiency also reflects state findings in accordance with 410 IAC 16.2.</p>	F000000	<p>Please accept this plan of correction as our credible allegation of compliance. Preparation and execution of correction in general, or this corrective action in particular does not constitute an admission or agreement by Highland Manor Healthcare of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and / or executed in compliance with Federal and State law.</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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	Quality Review completed on 06/24/2013 by Brenda Nunan, RN.				

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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 and record</p>	F000225				07/08/2013	

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	<p>review, the facility failed to prevent further potential abuse while the investigation was in progress for 1 of 3 incidents reviewed for allegations of abuse (Resident B).</p> <p>Findings include:</p> <p>The facility's investigation of incidents was reviewed on 06/19/13 at 11:35 a.m. The June 7, 2013 incident was not reported to the Administrator and/or state officials until June 10, 2013. The investigation report indicated an investigation was initiated after Resident B told the Administrator and Social Service Director that the DON had allegedly threatened to hurt his kids and himself. The investigation report indicated the DON was not suspended pending results of the investigation.</p> <p>Resident B was interviewed on 06/19/13 at 3:33 p.m. Resident B indicated his daughters visited him and had chocolate pudding on their hands. Resident B indicated they were coming in from the patio and the Director of Nursing [DON] was coming down the hall. Resident B indicated he "jokingly" told his daughter to wipe her hands on the DON's clothing. Resident B stated,</p>		<p>All residents have the potential to be affected.</p> <p>Due to investigation completed with no findings of violation in company policy and State/Federal regulations, as well as eye witnesses attesting the facts of the incident were not what the resident reported, nothing further can be done for resident (B).</p> <p>A record review of the past three months of reported allegations of abuse by employees revealed one report of alleged employee on resident abuse investigated and reported. In this case, employee was placed off schedule until investigation was completed and reviewed by the Executive Director of the company. No findings of violations were discovered and employee returned to duty subsequently with a change in floor coverage not including said resident.</p> <p>Administrator in-serviced by company Executive Director on State, Federal and company policy on procedures of investigations of Abuse, with particular attention to protecting the resident from</p>				

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	<p>"the DON took it to heart." Resident B indicated after his children had left the facility, the DON told him she did not appreciate him telling his children to touch her with chocolate on their hands and indicated it could have been a problem for him and indicated his children could have gotten hurt. Resident B indicated he told the DON he did not appreciate her threatening his children. Resident B stated the DON said, "I wasn't threatening, I was promising."</p> <p>The DON was interviewed on 06/19/13 at 5:15 p.m. and indicated Resident B had his two young children visiting and they had been out on the patio and entered the facility when she was coming down the hall. The DON indicated the children's hands and arms were covered with chocolate pudding. Resident B told his daughter to wipe her hands on the DON's dress, not once but twice. The DON indicated she had to put her arm down to block the child from doing so and offered to take the children to wash their hands and the caseworker stepped in and took the children to clean up. The DON indicated after the visit she talked with Resident B and told him it was inappropriate to tell his children to wipe their hands on her clothing</p>		<p>further abuse during an investigation, primarily, suspending said employee until investigation completed and reviewed. Further, in-service included that all facets of the investigation must be documented in the official report with time frames, especially suspension of employees.</p> <p>Executive Director of company will review with Administrator all reportable situations as the initial report is generated for compliance with policies indefinitely.</p> <p>Administrator is responsible for abuse investigation and formal reporting and ensuring resident is safe from further abuse while investigation is in progress. All staff is responsible for abuse reporting and documentation. DON and Administrator will monitor daily, indefinitely. Monitor in QA by record review monthly for three months, then quarterly thereafter for compliance, reporting to the Executive Director immediately of any oversights.</p>	

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	<p>and given a different set of circumstances with someone else the little girl could get hurt. The DON indicated Resident B later came back and said she threatened his children. The DON indicated she tried to explain to him she was not threatening his children, but he kept saying it over and over again and she finally walked away. The DON indicated he later told her not to be around his children.</p> <p>The Administrator was interviewed on 06/19/13 at 5:03 p.m. and indicated he was told by Resident B on Monday, June 10, 2013 about the incident that took place on Friday, June 7, 2013. When asked if the DON was suspended during the investigation, the Administrator indicated no, because there was a reliable eye witness to the whole thing and he knew within an hour of being told about the incident, that it did not happen as Resident B explained. The Administrator indicated he had finished interviews by June 13, 2013 and sent in the follow-up report on June 14, 2013. The Administrator indicated the facility's policy does indicate to suspend the alleged staff pending the investigation.</p> <p>A statement provided by the</p>						

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	<p>Administrator, on 06/19/13 at 5:35 p.m., indicated, "... A decision was made by the Administrator and the Executive Director within a couple of hours of learning of the allegation by [Resident B] to not suspend the Director of Nursing .... "</p> <p>The facility's "ABUSE INVESTIGATION" policy, dated 01/14/2008, indicated, "... Employees of this facility who have been accused of resident abuse will be suspended from duty until the Executive Director has reviewed the results of the investigation...."</p> <p>Review of the facility's "ABUSE PROTECTION POLICY - ELDER ACT, dated 10/2011, indicated, "... Any staff member suspected of abuse will be suspended pending the investigation into the allegation...."</p> <p>Review of the facility's "REPORTABLE UNUSUAL OCCUPANCIES" dated 10/2011, indicated, "... The Administrator shall be responsible for initiation proper interventions to assure the resident is protected from any further abusive acts while the incident is being investigated....."</p> <p>This federal tag is related to</p>						

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	Complaint IN 00130548.  3.1-28(c)			

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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 and record review, the facility failed to implement their policy and procedures for immediate reporting an allegation of abuse and for employee suspension during an investigation of an allegation of resident abuse for 1 of 3 incidents reviewed of allegations of abuse (Resident B).</p> <p>Findings include: The facility's investigation of incidents was reviewed on 06/19/13 at 11:35 a.m. The June 7, 2013 incident was not reported to the Administrator and/or state officials until June 10, 2013. The investigation report indicated an investigation was initiated after Resident B told the Administrator and Social Service Director that the DON had allegedly threatened to hurt his kids and himself. The investigation report indicated the DON was not suspended pending results of the investigation.</p> <p>Resident B was interviewed on</p>	F000226	<p>All residents have the potential to be affected.</p> <p>Due to investigation completed with no findings of violation in company policy and State/Federal regulations, as well as eye witnesses attesting the facts of the incident were not what the resident reported, nothing further can be done for resident (B).</p> <p>A record review of the past three months of reported allegations of abuse by employees revealed one report of alleged employee on resident abuse investigated and reported. In this case, employee was placed off schedule until investigation was completed and reviewed by the Executive Director of the company. No findings of violations were discovered and employee returned to duty subsequently with a change in floor coverage not including said resident.</p>	07/08/2013			

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	<p>06/19/13 at 3:33 p.m. Resident B indicated his daughters visited him and had chocolate pudding on their hands. Resident B indicated they were coming in from the patio and the Director of Nursing [DON] was coming down the hall. Resident B indicated he "jokingly" told his daughter to wipe her hands on the DON's clothing. Resident B stated, "the DON took it to heart." Resident B indicated after his children had left the facility, the DON told him she did not appreciate him telling his children to touch her with chocolate on their hands and indicated it could have been a problem for him and indicated his children could have gotten hurt. Resident B indicated he told the DON he did not appreciate her threatening his children. Resident B stated the DON said, "I wasn't threatening, I was promising."</p> <p>The DON was interviewed on 06/19/13 at 5:15 p.m. and indicated Resident B had his two young children visiting and they had been out on the patio and entered the facility when she was coming down the hall. The DON indicated the children's hands and arms were covered with chocolate pudding. Resident B told his daughter to wipe her hands on the DON's dress, not</p>		<p>Administrator in-serviced by company Executive Director on State, Federal and company policy on procedures of investigations of Abuse, with particular attention to protecting the resident from further abuse during an investigation, primarily, suspending said employee until investigation completed and reviewed. Further, in-service included that all facets of the investigation must be documented in the official report with time frames, especially suspension of employees.</p> <p>Executive Director of company will review with Administrator all reportable situations as the initial report is generated for compliance with policies indefinitely.</p> <p>Administrator is responsible for abuse investigation and formal reporting and ensuring resident is safe from further abuse while investigation is in progress. All staff is responsible for abuse reporting and documentation. DON and Administrator will monitor daily, indefinitely. Monitor in QA by record review</p>	

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	<p>once but twice. The DON indicated she had to put her arm down to block the child from doing so and offered to take the children to wash their hands and the caseworker stepped in and took the children to clean up. The DON indicated after the visit she talked with Resident B and told him it was inappropriate to tell his children to wipe their hands on her clothing and given a different set of circumstances with someone else the little girl could get hurt. The DON indicated Resident B later came back and said she threatened his children. The DON indicated she tried to explain to him she was not threatening his children, but he kept saying it over and over again and she finally walked away. The DON indicated he later told her not to be around his children.</p> <p>The Administrator was interviewed on 06/19/13 at 5:03 p.m. and indicated he was told by Resident B on Monday, June 10, 2013 about the incident that took place on Friday, June 7, 2013. When asked if the DON was suspended during the investigation, the Administrator indicated no, because there was a reliable eye witness to the whole thing and he knew within an hour of being told about the incident, that it did not</p>		<p>monthly for three months, then quarterly thereafter for compliance, reporting to the Executive Director immediately of any oversights.</p>		

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	<p>happen as Resident B explained. The Administrator indicated he had finished interviews by June 13, 2013 and sent in the follow-up report on June 14, 2013. The Administrator indicated the facility's policy does indicate to suspend the alleged staff pending the investigation.</p> <p>A statement provided by the Administrator, on 06/19/13 at 5:35 p.m., indicated, "... A decision was made by the Administrator and the Executive Director within a couple of hours of learning of the allegation by [Resident B] to not suspend the Director of Nursing .... "</p> <p>The facility's "ABUSE INVESTIGATION" policy, dated 01/14/2008, indicated, "... Employees of this facility who have been accused of resident abuse will be suspended from duty until the Executive Director has reviewed the results of the investigation...."</p> <p>Review of the facility's "ABUSE PROTECTION POLICY - ELDER ACT, dated 10/2011, indicated, "... Any staff member suspected of abuse will be suspended pending the investigation into the allegation...."</p> <p>Review of the facility's</p>			

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	<p>"REPORTABLE UNUSUAL OCCUPANCIES" dated 10/2011, indicated, "... The Administrator shall be responsible for initiation proper interventions to assure the resident is protected from any further abusive acts while the incident is being investigated....."</p> <p>This federal tag is related to Complaint IN 00130548.</p> <p>3.1-28(a)</p>			