

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155570	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/04/2016
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NAME OF PROVIDER OR SUPPLIER  PLEASANT VIEW LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 7476 W LANE RD MC CORDSVILLE, IN 46055
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00198283 and IN00198457.</p> <p>Complaint IN00198283 - Unsubstantiated due to lack of sufficient evidence.</p> <p>Complaint IN00198457 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiency is cited.</p> <p>Survey dates: May 2 and 4, 2016</p> <p>Facility number: 000477 Provider number: 155570 AIM number: 100290860</p> <p>Census bed type: SNF/NF: 32 Total: 32</p> <p>Census payor type: Medicare: 2 Medicaid: 23 Other: 7 Total: 32</p> <p>Sample: 5</p>	F 0000	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 the 2567 plan of correction be considered the letter of credible allegation and requests a post survey paper compliance review on or after May 20, 2016.	

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 0223 SS=D Bldg. 00	<p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on May 7, 2016.</p> <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.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident was free from abuse (Resident #E) for 1 of 5 residents reviewed for abuse.</p> <p>Findings include:</p> <p>The clinical record for Resident #E was reviewed on 5/2/16 at 11:45 a.m.</p> <p>Diagnoses included, but were not limited to, dementia and depression.</p>	F 0223	<p><b>**The facility self-reported this complaint to Indiana State Department of Health prior to this survey on April 21, 2016.**</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? LPN #1 is no longer employed with this company as of April 19, 2016. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective</b></p>	05/20/2016

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	<p>On 5/2/16 at 4:30 p.m., the Administrator provided a copy of the incident report, dated 4/21/16. It included, but was not limited to, the following: "...Incident date: 04/14/2016...Incident time: 01:45AM...Resident involved...[Resident #E's name]...Staff involved...[LPN #1's name]...Description added -- 4/21/2016...On April 21, 2016 at approximately 1:15 p.m. the Assistant Director of Nursing (ADON) and the Administrative Assistant were viewing the video surveillance system. Upon viewing the video surveillance system, the ADON and the Administrative Assistant came across an issue in which it could have possibly been considered a neglect situation on April 14, 2016 at approximately 1:45 a.m. with a resident name [Resident #E's name] and a LPN named [LPN #1's name]...I appears that the resident sat himself down on the floor in the hallway...The LPN [LPN #1's name] did not assist the resident up...It appears that {LPN #1's first name} pulled him by his sleeve on his sweater out of another resident's room. The LPN then walked away...."</p> <p>On 5/2/16 at 5:02 p.m., the surveillance video, dated 4/14/16 between 1:50 a.m., and 2:09 a.m., was observed and included the following:</p>		<p><b>action(s) will be taken?</b> No other residents were affected. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b> 1.All staff were in-serviced by our Social Service Consultant with Lacy Beyl &amp; Company during the week of April 29, 2016-May 2, 2016 on "Review of F223 abuse, review of F224 mistreatment, neglect and misappropriation of property, F226 development and implementation of policies and procedures, F225 not employing individuals who have been found guilty of abusing, neglecting or mistreating a resident by a court of law or have a finding in the state nurse aide registry, elder justice act, warning signs of abuse, dementia and cognitive impairment and abuse, facility responsibility, reasonable person concept, psychosocial outcomes in regards to abuse, skills building, ten tips for communication and review of facility abuse policy and procedure". Any staff that was on a leave of absence were in-serviced on the first day that they returned to work. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place?</b> 1.Administrative staff or their designee will monitor the staff,</p>				

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	At 1:55 a.m., LPN (Licensed Practical Nurse) #1 was observed entering room #5. At 1:56 a.m., Resident #E was observed scooting down the hallway on his/her bottom, using his/her hands and heels to move toward room #5. LPN #1 was observed to move Resident #E's feet from the doorway of room #5 with her feet and walked away, leaving Resident #E on the floor. At 1:58 a.m., LPN #1 was observed to walk past Resident #E, engage in conversation, then enter a room on the right side of the hallway. At 1:59 a.m., Resident #E scooted himself into room #5. LPN #1 was observed to enter room #5 and, with his/her right hand on Resident #E's right arm and his/her left hand on Resident #E's right shoulder, drag Resident #E, out of room #5. LPN #1 let go of Resident #E and walked away. At 2:00 a.m., LPN #1 was observed to be conversing with Resident #E. Resident #E, again, began scooting back into room #5 and LPN #1 walked over Resident #E's legs, then, pulled the door to close it. Resident #E's feet were pushed back towards his/her body by the door. LPN #1 was observed to place both hands under the arms of Resident #E and scooted him back from the door. LPN #1 was again, observed to be in conversation with Resident #E, then walk away, leaving Resident #E on the floor. At 2:09		visitors, and other residents daily x 14 days for any signs of verbal, mental, sexual or physical abuse, corporal punishment and involuntary seclusion. 2. Administrative staff or their designee will then monitor the staff, visitors, and other residents 3 times a week x 14 days for any signs of verbal, mental, sexual or physical abuse, corporal punishment and involuntary seclusion. 3. Administrative staff or their designee will then monitor the staff, visitors, and other residents 1 time a week x 5 ½ months for any signs of verbal, mental, sexual or physical abuse, corporal punishment and involuntary seclusion. 4. The QA committee will review the results of the findings during the facility's Quality Assurance meeting for at least 6 months. At the end of the aforementioned 6 month period, the committee may opt to discontinue the review of this data during the QA meetings if compliance is evident.		

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	<p>a.m., Resident #E, still on the floor, again, scooted himself into room #5. Resident #E was then observed to be ambulated out of room #5 by CNA (Certified Nursing Assistant) #2. Resident #E was on the floor from 1:56 a.m., until 2:09 a.m.</p> <p>The email from LPN #1, dated 4/25/16 at 11:30 a.m., included, but was not limited to, the following: "To whom it may concern [sic] on 4-13-16 [sic] I [LPN #1's name] had worked with [Resident #E's name]. This allegation comes several days after I have continued to work with him. All while maintaining his dignity [sic] respect [sic] and independence with no complaints from staff or family... [Resident #E's name] was on the floor going to other residence [sic] rooms and where I did remove him from...I asked [Resident #E's name] to allow me to help them [sic] up of the floor [sic] he would not comply [sic] he reached to me a few times and asked me "do you have a [sic] ink pen and paper" [sic] I replied [sic] "no I didn't have one one me [sic] come on [Resident #E's first name] [sic] lets get up [sic] "he then said [sic] "let me lay her [sic] I'm resting and waiting for my wife" [sic]I did not want to agitate him any further, [sic] I let him do so. I did pull him out of the residence [sic] room into [sic] area where he was safe and</p>			

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	<p>there was no wheelchair traffic and he was not in any harms way and did what he asked me...I do regret the way I handled the situation...In light [sic] [Resident #E's name] sustained no injuries or inquired [sic] infection related to this incident that was brought to my attention 9days [sic] after the event...."</p> <p>The phone interview with CNA #2, dated 4/22/16 and untimed, included, but was not limited to, the following: "Spoke [c with a line over it] [with] [CNA #2's name] on the phone. She stated he was sitting in the hallway [sic] he was safe [sic] did not witness the Nurse [sic] engage [c with a line over it] [with] Resident [sic] but the Nurse [sic] has said he is better off on the floor. [Assistant Director of Nursing's signature]..."</p> <p>The written interview for Resident #G, dated 4/26/16 and untimed, included, but was not limited to, the following: "[Resident #G's first name], [Resident #E's first name] been in my room twice in one night...He walked in room [sic] went to B.R. [bathroom] [sic] then sit [sic] down on my bed. [sic] by window [sic] touched my leg. I pulled my call light [sic] someone came to get him [sic] second time he came in he scooted on his bottom into room [p with a line over it] [after] I opened the door. 3 hrs [hours]</p>			

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	<p>later this happened. this [sic] is the only time this has happened. then [sic] he went to say. [sic] that he scooted into room [sic] I pulled my call light [plus sign] [and] some [sic] came [plus sign] [and] got him [plus sign] [and] took him to his room. I heard something [plus sign] [and] I noticed my door was closed. [sic] so I get [sic] up to open the door [plus sign] [and] [Resident #E's first name] was on the floor [plus sign] [and] started to scoot into my room [sic] I yelled for help [plus sigh] [and] some one came and [the word took with a line through it] walked him to his room. [Assistant Director of Nursing's signature]..."</p> <p>During an interview on 5/4/16 at 11:35 a.m., the Administrator indicated the Assistant Director or Nursing and the Administrative Assistant were reviewing the surveillance tape on 4/21/16 at approximately 1:15 p.m. related to a report that a staff member, not scheduled to work, was in the building. The Administrator indicated, while viewing the video, the incident with Resident #E and LPN #1 was observed. The Administrator indicated she was notified of the incident, and when she arrived at the facility, viewed the video surveillance and immediately reported the incident. The Administrator also indicated, had they not viewed the surveillance tape,</p>			

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	<p>they would not have known the incident had occurred.</p> <p>On 5/2/16 at 3:15 p.m., the Administrative Assistant provided a copy of the document titled, "ABUSE", and indicated as current. It included, but was not limited to, the following: "POLICY: The resident has the right to be free from verbal, sexual, physical and mental abuse...INTENT: Each resident has the right to be free fro abuse...Residents must not be subjected to abuse by anyone, including, but not limited to, facility..."Abuse" means the willful infliction of injury, unreasonable confinement intimidation, or punishment...This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being..."Physical abuse" includes, but is not limited to, actually laying hands on a resident in an abrupt manner...transporting a resident in an abrupt manner...Any other action or lack of action that you have a duty to perform and your failure to act or the nature of your action could negatively affect the resident's health, safety or welfare...."</p> <p>3.1-27(a)(1)(3)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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