

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2015
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NAME OF PROVIDER OR SUPPLIER  APERION CARE TOLLESTON PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00186733, IN00186943, IN00187168, and IN00188012. This visit resulted in a Partial Extended Survey-Immediate Jeopardy.</p> <p>Complaint IN00186733 - Substantiated. No deficiencies related to the allegations area cited.</p> <p>Complaint IN00186943 -Substantiated. No deficiencies related to the allegations area cited.</p> <p>Complaint IN00187168 -Substantiated. No deficiencies related to the allegations area cited.</p> <p>Complaint IN00188012-Substantiated. Federal/State deficiencies are cited at F323.</p> <p>Survey dates: December 2 and 3, 2015 Partial extend survey dates: December 4,5, 7, and 8 2015</p> <p>Facility number: 008505 Provider number: 155580 AIM number: 200064830</p> <p>Census bed type:</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 the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a post survey desk review on or after January 28, 2015.</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 0323 SS=J Bldg. 00	<p>SNF: 2 SNF/NF: 106 Total: 108</p> <p>Census payor type: Medicare: 13 Medicaid: 77 Other: 18 Total: 108</p> <p>Sample: 11 Extended sample: 4</p> <p>These deficiencies reflect State findings in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on December 14, 2015 by #09674.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure adequate supervision was provided for a cognitively impaired male with a history</p>	F 0323	<b>The facility disputes this</b>	12/28/2015

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	<p>behaviors including, but not limited to, wandering into other resident rooms, exposing himself, and touching staff members inappropriately. The lack of supervision resulted in the resident entering the room of a dependent and cognitively impaired female resident with female resident found on the floor and both residents found unclothed. This resulted in an Immediate Jeopardy. (Residents #E and #H)</p> <p>The Immediate Jeopardy began on 11/21/15 when Resident #H entered a female resident's room and was found to have removed his clothing while sitting next to a cognitively impaired dependent female resident who was lying on the floor on her abdomen and was also disrobed. The Director of Nursing and the facility Administrator were notified of the Immediate Jeopardy on 12/3/15 at 7:05 p.m. The Immediate Jeopardy was removed on 12/5/15, but noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Finding includes: 1. On 12/2/15 at 10:00 a.m. Resident #E was observed in bed being turned by the CNA. The mattress had bolsters</p>		<p><b>tag. We do not believe this resident's behavior warranted an Immediate Jeopardy. This resident's behaviors were never directed at other residents and were not aggressive towards other residents. <i>This Plan of Correction is the center's credible</i></b></p>				

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	<p>attached.</p> <p>On 12/3/15 at 8:35 a.m. the resident was observed awake in bed. She was laying on a scoop mattress with a mat on the floor on the left side of the resident's bed.</p> <p>The record for Resident #E was reviewed on 12/2/15 at 3:50 p.m. The resident's diagnoses included, but were not limited to, adult failure to thrive, bipolar disorder, multiple sclerosis, and major depressive disorder.</p> <p>Review of the 9/28/15 Minimum Data Set quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (3). A score of (3) indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required extensive assistance of two staff members for bed mobility and transfers. The assessment indicated the resident was totally dependent on two staff members.</p> <p>The 11/2015 Nursing Progress notes were reviewed. An entry made on 11/21/15 at 10:15 p.m. indicated the RN was summoned to Resident #E's room by the CNA. The resident was found on the floor in a prone (laying on her stomach) position and disrobed with her brief and</p>		<p><b>allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is</b></p>				

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	<p>dressings to the coccyx removed. A Foley catheter was in place and draining amber urine. The resident denied pain and was unable to explain how she got on the floor. The bed was in the lowest position and her call light was in reach. Reddened areas were noted to the left side of her face, left shoulder, arm, wrist, and her left knee. An entry made on 11/21/15 at 11:00 p.m. indicated the resident was sent out to the hospital.</p> <p>A Fall IDT (Interdisciplinary Team) note was entered on 11/24/15. This note indicated the resident was observed on the floor on her left side with her bed in the lowest position.</p> <p>The resident's 11/21/15 Hospital Emergency Department records were reviewed. The records indicated the resident was a female admitted with a history of Multiple Sclerosis, migraine, and dementia who presented to the Emergency Room from a fall from the bed. The patient had a bruised hand and a small bruise to her face. The patient was oriented to self and was aphasic. The records indicated a review of the the resident's systems listed she denied headaches, dizziness, back or abdominal pain. The Physical Exam indicated the resident appeared well-developed and in no distress. No assessment of her Genital</p>		<p><b><i>prepared and/or executed solely because it is required by the provisions of federal and state law.</i></b></p> <p><b>F323</b></p> <p><b>ACCIDENTS AND SUPERVISION</b></p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents <b>1) Immediate actions taken for those residents identified:</b> · Upon notification of new information received from the surveyor on 12/3/15 at approximately 7:10 pm, Resident H was placed on 1:1 (one-on- one supervision) and was sent out to Methodist Northlake Emergency Room for evaluation. This resident has no history of inappropriate sexual behaviors</p>	
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	<p>or Urinary system was recorded. The Clinical Impression was listed a fall and concussion with no loss of consciousness. The patient was to be sent back to the nursing facility.</p> <p>A Fall Investigation Worksheet, dated 11/21/15 at 11:00 p.m., indicated the activity at the time of the fall was unknown. The resident was not using any assistive devices. It was an unwitnessed fall. The conclusion of the root cause analysis was that the resident rolled out of bed. The resident was oriented to person, place, and time. There were no physiological or situational factors noted.</p> <p>Hand written statements in regards to the fall investigation:</p> <p>CNA #1's statement, dated 11/21/15 with no time documented, indicated while doing my last round I went into Resident #E's room and saw Resident #H in the room naked sitting in his wheelchair and Resident #E on the floor naked, as well. I then called for a nurse.</p> <p>CNA #3 statement dated 11/21/15 at 10:15 p.m. indicated, RN #1 came and got me and the nurse. We went into Resident #E's room and she was naked on the floor face down. Resident #H was</p>		<p>toward other residents, only staff. Resident H remained on 1:1 until he left the facility. Upon return to facility from the hospital on 12/4/15 at approximately 1:00 am, resident was again placed on 1:1. Family was notified of emergency discharge plan and was in agreement to take resident home with home health services, and family agreed that they were able to care for the resident at home. Resident H was discharged home safely with family and home health services on 12/4/15 at approximately 10:15 am. · All staff present during the alleged incident on 11/21/15 were immediately re-interviewed regarding new information received, and statements were obtained. <b>2) How the facility identified other residents:</b> · All residents were reviewed for inappropriate behaviors and wandering. · Residents residing in the facility have the potential to be affected by the alleged deficient practice. <b>3) Measures put into place/ System changes:</b> · All staff were re-educated on behaviors that may place other residents at risk, such as sexually inappropriate behavior, deliberate entering of other resident rooms, and verbal or physical aggression toward others. Education includes reporting of behavior immediately, appropriate interventions such as increased supervision, 1:1, 15 minute</p>		

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	<p>naked in his chair.</p> <p>2. On 12/3/15 at 8:55 a.m.. Resident #H was observed in his wheelchair in the main dining room self propelling himself.</p> <p>The record for Resident #H was reviewed on 12/3/15 at 9:15 a.m. The resident's diagnoses included, but were not limited to, dementia, anxiety disorder, anemia, and major depressive disorder.</p> <p>The 9/19/15 Minimum Data Set significant change assessment indicated the resident's BIMS (Brief Interview for Mental Status) was not completed as the resident was rarely understood. The assessment indicated the resident required extensive assistance of one staff member for bed mobility and transfers and a wheel chair was used for mobility.</p> <p>The resident's current Care Plans were reviewed. A Care Plan initiated on 7/25/15 and revised on 11/30/15 indicated the resident displayed behaviors. The behaviors included, touching staff inappropriately on the breast and buttock, flashing his private parts in the hallways and making sexual comments. He also tried to throw urine on staff and hit staff when upset. The intervention included, but were not limited to, inform resident the behavior</p>		<p>checks, notifying physician/psychiatric services, Social Services, DON, Administrator and family as appropriate, and documentation of the behaviors. · Social Services and/or Director of Nursing will audit behavior documentation daily (up to 5 times per week) on normal business days to identify documented behaviors and ensure appropriate interventions and monitoring were put in place and care plan updated. · Observation rounds will be completed at least 5 times per week on varied shifts x60 days, then 3 times per week thereafter to monitor for residents exhibiting behaviors that may potentially affect others and ensure appropriate interventions are implemented as identified. · At least 10 staff per week working on varied shifts will be interviewed regarding any recent resident behaviors and to ensure staff knows appropriate steps to follow including notifications, implementing interventions, monitoring and documentation. · The Administrator and Director of Nursing are responsible for oversight of these audits and observations. <b>4) How the corrective actions will be monitored:</b> The results of these audits will be reviewed in Quality Assurance Meeting monthly for a total of 6 months.</p>	

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	<p>was unacceptable and tell him "No". Inform the family, obtain a psychological consultation and social service one on one as needed. Staff were to redirect the resident by offering him a snack, cup of coffee, or activity.</p> <p>A Care Plan initiated on 9/17/15 and revised on 11/30/15 indicated, the resident wanders aimlessly and often tried to wander into other residents' rooms. The interventions included, but were not limited to, distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television or books. Staff were to identify patterns of wandering and intervene appropriately. Resident was to be provided activities: toileting, walking, reorientation strategies, such as signs, pictures, and memory boxes. The resident was to be re-educated on the location of his room.</p> <p>A facility psychiatric evaluation completed on 8/3/14 indicated, the history of the present illness was a resident with metabolic encephalopathy (abnormality that affects brain function), Spanish speaking only, who presents with impulsive behaviors, resistance to care, noncompliance with dressings, and public urination in his room. He had very poor comprehension even when</p>			

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	<p>spoken to in his native language, he had difficulty understanding or following directions. His poor cognition was related to his metabolic encephalopathy and vascular dementia.</p> <p>Review of the 10/31/15 facility psychiatric visit indicated the reason for the visit was cognitive symptoms, behavior symptoms, confusion, refusing and resisting care or medications, and sexual impulsivity. The impression was the resident was diagnosed with senile dementia with behavioral disturbances. The chief complaint was behavioral disturbance (inappropriate with female staff and noncompliant with rules), and senile dementia-mild.</p> <p>A Behavior/Mood Charting form dated 9/7/15 at 5:45 a.m., indicated the resident was exit seeking and observed leaving out the door, buttons to pad not properly functioning and resident noted pushing buttons on pad lock which opened with no difficulty. This occurred in the hallway, family was called and the resident was reassured and redirected. The resident accepted the intervention and was talkative. The resident was directed back into the facility and stated that it was a beautiful day.</p> <p>A Behavior/Mood Charting form, dated</p>			

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	<p>9/14/15 at 10:21 a.m., indicated the resident was verbally aggressive, socially inappropriate, and was resistive to care. The resident was sitting in front of his room preventing staff from entering room. The resident made statements this was his house only. The resident removed objects like roommate's chair and bedside table from the room into the hallway. The interventions tried were 1:1 with social worker and staff, conversation, left alone and reproached and reassurance. The resident was uncooperative and the behavior lasted 30 minutes. The resident's behavior improved.</p> <p>A Behavior/Mood Charting form, dated 9/15/15 at 22:58 (10:58 p.m.), indicated the resident was wandering down to the other end of the building trying to urinate in garbage cans and plate lids. The resident was agitated and easily upset. This behavior occurred in the hallway. The resident was offered a snack and redirected. He was uncooperative and the behavior continued for 2 minutes. The resident's behavior improved.</p> <p>A Behavior/Mood Charting form, dated 9/22/14 at 10:06 (8:06 p.m.), indicated the resident was wandering in the hallway. No interventions were provided, the behavior lasted 2 minutes and the</p>			

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	<p>behavior improved.</p> <p>A Behavior/Mood Charting form, dated 9/26/15 at 14:27 (2:47 p.m.), indicated the resident was trying to push the bed out of the room. The resident was throwing pieces of the bed and was attempting to hit the CNA. He was agitated and easily upset. He was redirected and had 1:1 with staff. He was uncooperative and the behavior continued. This lasted for 3 minutes and the outcome was unchanged.</p> <p>A Behavior/Mood Charting form, dated 9/30/15 at 6:30 a.m., indicated the resident was wandering, physically aggressive, social inappropriate and resisted care. The resident refused to allow staff to give care. He was agitated and easily upset. This behavior occurred in the hallway. The resident was left alone and re-approached, a phone call was made to family, and he was redirected. He was uncooperative and the behavior continued. This behavior lasted form 1:00 a.m. until 6:30 a.m. The interventions were unsuccessful.</p> <p>A Behavior/Mood Charting form, dated 10/7/15 at 21:20 (9:20 p.m.), indicated the resident was wandering. He was upset and stated his roommate kept yelling at him and told him to get out of</p>			

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	<p>the room. He was fearful. The incident happened in the resident's room. The resident was reassured, redirected, reoriented and had 1:1 with staff. He accepted the interventions provided but was still fearful. The behavior lasted most of the shift. The outcome was successful.</p> <p>A Behavior/Mood Charting form, dated 11/9/15 at 18:14 (6:14 p.m.), indicated the resident was socially inappropriate. He said sexually inappropriate comments to the writer. This occurred in the hallway. He was redirected and accepted the intervention. This behavior lasted 3 minutes and the outcome was successful.</p> <p>A Nursing Progress Notes indicated an entry was made on 11/21/15 at 9:39 p.m. The entry indicated the writer was called to Resident #E's room by another Nurse. The resident was observed sitting in a wheel chair completely disrobed and a gown was placed on the resident. The resident was immediately re-directed into the hallway to be taken to his room. The resident was unable to be interviewed due to language barrier. Upon assessment a skin tear was observed to his left anterior lower leg. The resident was resting quietly in bed at this time. Safety was maintained.</p>			

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	<p>A Behavior/Mood Charting form, dated 11/27/15 at 14:18 (2:18 p.m.), indicated the resident was attempting to throw urine on the Admissions Coordinator and two CNAs. He had repeated verbalization. This behavior occurred in the hallway. The resident was provided 1:1 with staff. He accepted the intervention provided. The behavior lasted 2 minutes and the outcome was successful.</p> <p>A Behavior/Mood Charting form, dated 11/28/15 at 2:59 a.m., indicated the resident was hitting staff, throwing shows (sic), attempting to enter other residents' rooms. The resident was refusing to cooperate with staff. He had repetitive verbalizations, insomnia, repetitive physical movements, was agitated and easily upset. This behavior occurred in the hallway and lasted one hour. The interventions attempted were 1:1 with staff, conversation, offered food and snack, and a call to the family. The resident was hostile, uncooperative, and the behavior continued. The outcome was unchanged.</p> <p>A Social Service Note, dated 11/30/15 at 14:40 (2:40 p.m.), indicated the writer spoke to the resident in regards to recent behavior. The resident appeared to be in a happy mood, was smiling and flirting.</p>			

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	<p>The resident showed no signs of distress or poor mood. The resident stated he did not behave in this manner and his memory was poor. The resident was educated that verbal and physical aggression was not appropriate.</p> <p>A Social Service Note, dated 12/2/15 at 15:38 (3:38 p.m.), indicated the writer, Social Service Director, and the Unit Manager met with the resident and family to discuss the resident's recent behaviors on 11/27 and 11/28. The resident's family indicated he has been redirecting the resident to improve his behavior and to be more gracious toward others. Staff indicated that redirection was being applied by staff when needed. The family asked if the resident's medication could be increased to help with his behaviors. The Social Service Director indicated the resident's doctor would be notified.</p> <p>A Nursing Note, dated 12/3/15 at 20:47 (9:47 p.m.), indicated due to behaviors exhibited by resident toward staff and fellow residents, MD notified and obtained an order for the resident be sent to the Emergency Room for Psych Evaluation. One to one care initiated at 7:10 p.m.</p> <p>When interviewed on 12/3/15 at 9:30</p>			

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	<p>a.m., RN #1 indicated she worked on 11/21/15 and was assigned to care for Resident #E when she was observed on the floor. CNA #1 came out of the resident's room and indicated she was on the floor. The RN indicated the resident was on the floor on her abdomen and could not say how she fell. The RN indicated she and three other CNA's log rolled the resident over and placed her back and into bed using the Hoyer ( a mechanical lifting device) lift. The resident had red areas on her face and left knee with no swelling present. RN #1 also indicated Resident #H was present in the room when they arrived. He was midway in the room, between the two beds. The RN indicated Resident #E resided in the bed by the window and Resident #H was sitting in the wheel chair facing the bathroom. The male resident had no clothing on but then stated "I think he had a brief on." Resident #E had no clothing on and her gown was on her right hand but off her shoulder hanging down by her feet and she was on her stomach. Resident #H's clothes were in the room on a night stand folded neatly. The RN indicated they put a gown on Resident #H when they entered the room and he kept saying "siesta (sleep)" in Spanish and other words in Spanish. The RN indicated she did not recall the names of the CNA's .</p>			

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	<p>The RN indicated she asked Resident #E if the other resident had touched her and she said "I don't think so" and "with both of them in that position I didn't know what to think." The RN indicated Resident #H was confused. RN #1 indicated neither of the CNA's reported any physical contact between the two residents. The RN indicated there was another Nurse working on the unit that was taking care of Resident #H though she could not recall her name at this time.</p> <p>When interviewed on 12/3/15 at 10:50 a.m., the Director of Nursing indicated she received a phone call on 11/21/15. She was informed Resident #E was found on the floor in her room, a male resident (Resident #H) was in the room and both resident's were disrobed. The staff reported the resident's face was red. The Director of Nursing indicated RN#1 was assigned to care for Resident #E and the RN had obtained statements from the other staff members who were present. The DON indicated CNA #1 was assigned to care for Resident #E. CNA #1 informed her she was the first person who observed Resident #E on the floor. The CNA had last seen the resident at approximately 9:45 p.m. The resident was found face down on the floor next to her bed and Resident #H was found in his wheel chair next to the resident's bed.</p>			

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	<p>The DON indicated no staff members had reported observing any contact between the two residents. The DON indicated RN #1 stated that Resident #H would not have the ability to get up from the floor and into his chair. The DON indicated no visitors were observed in the facility when she arrived and the Administrator reviewed the security cameras and no visitors were observed. The DON further indicated Resident #H had no injuries. She asked RN #1 and CNA #1 if there had been any resident to resident contact with the two residents and they both denied any contact occurred.</p> <p>When interviewed on 12/3/15 at 11:10 a.m., the facility Administrator indicated he received a call on 11/21/15 around 10:15 or 10:20 p.m. related to Resident #E being found on the floor with Resident #H in her room and both residents were undressed. The Administrator indicated he and the DON both came into the facility and the RN on duty had the staff complete written statements. The Administrator indicated he reviewed the security cameras and they showed Resident #H at the Nursing Station at 9:40 p.m. and it looked like staff were pointing towards his room. The camera indicated the resident rolled down the hallway around 9:45 p.m. and into Resident #E's room. He was in</p>			

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	<p>Resident #E's room until 10:12 p.m. (27 minutes). The camera showed CNA #1 entered the room at that time. The Administrator indicated the camera showed the CNA's making their rounds during this time. The DON was present during this interview and indicated Resident #H was capable of undressing himself.</p> <p>CNA #1 was interviewed via telephone on 12/3/15 at 12:45 p.m. The CNA indicated she found Resident #E when she was making her rounds. When she got to the resident's room at first she did not see the resident in bed and then saw her on the floor with no clothes on. Resident #H was in the room in his wheel chair with no clothes on. She yelled out for other staff to help her. The CNA indicated Resident #E said "OK." The CNA Indicated no body ever reported Resident #H had touched Resident #E.</p> <p>When interviewed on 12/3/15 at 3:20 p.m., LPN #1 indicated she was working on the evening shift the day Resident #E was found on the floor. The LPN indicated she was at the Nursing Station and was called to the resident's room. Resident #E was observed lying face down on the floor. Her brief was not on and was laying around her. Her wound dressing was off. The LPN indicated,</p>			

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	<p>Resident #E can usually say "yes" or "no" but not appropriately and she kept saying "I don't know". There was another resident in the room sitting in his wheelchair and he was disrobed. This resident was Resident #H and his clothes were bunched up on the table and he only had on socks. LPN #1 indicated she removed Resident #H from the room and got him a gown. The resident had a skin tear to his left lower leg. The LPN indicated she had not been aware of any previous contact or sexual behaviors for Resident #H. LPN#1 indicated the resident takes himself in and out of bed and will dress himself if you provide his clothes. The LPN indicated when she came into Resident #E's room the sheets of her bed were on the floor and a pillow was also on the floor. The LPN indicated she thought everyone responded "appropriately" and a CNA took Resident #H to his room without any problems. The LPN indicated she did not recall seeing any visitors at the time of the incident.</p> <p>CNA #3 was interviewed in on 12/3/15 at 4:45 p.m.. The CNA indicated she was working the evening shift on the unit Resident #E resided on. The CNA indicated, CNA #1 came out and called for help and LPN #1 and RN#1 and herself went into Resident #E's room.</p>			

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	Resident #E was in the room on the floor and was naked. CNA #1 was in the room and was saying she opened Resident #E's door, saw the bed was empty, and looked down and saw Resident #E on the floor with Resident #H in his wheelchair in the room. CNA #3 indicated she then saw Resident #H in his wheelchair facing Resident #E and the resident was bending over in his wheelchair facing Resident #E's waist/ buttock area. The CNA indicated some other staff member pushed Resident #H out of the room and when she left Resident #E's room to get a pad for the Hoyer lift she observed Resident #H going into another resident's room. She told someone to get him. She believed it was a female's room he was going into. CNA #3 indicated when she first entered the room Resident #E was on the floor naked, had no sheets or boots on her. The boots and sheets were on the other side of the bed by the foot of the bed. The CNA indicated she did not see the resident's brief in sight. The CNA indicated the resident's roommate was sleeping. CNA #3 indicated Resident #H had wandered into other resident's room and and he takes his clothes off in the hallway. The CNA indicated the resident would try and "grab and rub you". The CNA indicated the resident had reached out at her breast, private parts, and buttock at different times and			

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	<p>everyone was aware of his behaviors.</p> <p>Continued interview with CNA #3 indicated she, RN #1, and LPN #1 all entered Resident #E's room together when CNA #1 was in the room. CNA #3 indicated CNA #1 was holding her face and repeating, "It's my fault." CNA #3 #1 stated, "He was touching her butt." CNA #3 indicated she interpreted this as he was fondling her. The CNA also indicated RN#1 told them to open the Resident #E's leg and noted something whitish dry on her inner thigh and described as "like dry white." CNA #3 stated herself, LPN #1 and RN #1 were all present at this time and RN #1 and CNA #1 asked what was that and RN #1 said she did not know and "She's got to go the hospital anyway." CNA #3 indicated she had a conversation with LPN #1 the next day and the LPN told her she just wrote what they told me to write.</p> <p>Continued interview with CNA #3 indicated she wrote a statement on the day of the above occurrence. The CNA indicated once she wrote the initial statement no one from the facility asked her any more questions about the day.</p> <p>A written statement from CNA #1 was reviewed. The statement indicated while</p>			

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	<p>she was doing her last rounds she entered Resident #E's room and saw Resident #H naked and sitting in his wheel chair and Resident #E was on the floor naked as well. I then called for help. Nothing further was in the written statement.</p> <p>The Immediate Jeopardy began on 11/21/15 and was removed 12/5/15 when the facility assessed residents with behaviors, in-serviced staff on what to do when residents had behaviors and who to report behavioral issues to when they occur in the facility, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy due to continued in-services of staff employees.</p> <p>This Federal tag relates to Complaint IN00188012.</p> <p>3.1-45(a)(2)</p>			

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

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