

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155532	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED  08/19/2011
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NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 E MILLER DR BLOOMINGTON, IN47401
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F0000	<p>This visit was for the Investigation of the Complaint IN00094518 and Complaint IN00094913. This visit resulted in a partially extended survey- immediate jeopardy.</p> <p>Complaint IN00094518 - Substantiated, Federal and State deficiencies related to the allegations are cited at F157, F223, F225, F226, and F490.</p> <p>Complaint IN00094913 - Unsubstantiated, due to a lack of evidence.</p> <p>Survey dates: August 17, 2011 Extended dates: August 18, and 19, 2011</p> <p>Facility number: 000460 Provider number: 155532 AIM number: 100290620</p> <p>Survey team: Melinda Lewis, RN- TC (August 17, 2011) Marla Potts, RN (August 17 and 19, 2011) Sharon Whiteman RN (August 18, 2011)</p> <p>Census bed type: SNF/NF: 30 Total: 30</p>	F0000		

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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	<p>Census payor type: Medicare: 4 Medicaid: 25 Other: 1 Total: 30</p> <p>Sample: 13</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 22, 2011 by Bev Faulkner, RN</p>				

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F0157 SS=D	<p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to ensure a resident's legal representative was notified of allegations of mistreatment by a staff member, for 1 of 1 completed investigations reviewed, in the sample of 13. (Resident B)</p> <p>Findings include:</p>	F0157	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F 157 Notify of Changes (a) What corrective	08/26/2011			

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	<p>During interview with the Health Facility Administrator (HFA) on 8/17/11 at 9:15 A.M., she indicated she had reported an allegation of abuse to the state agency and provided the documentation she had faxed in, as well as the investigation of the allegations. She indicated the two Certified Nursing Assistants, CNA #1 and CNA #2, involved had been fired. She indicated she had no documentation of an inservice provided to staff members and had not obtained statements from all staff members who had worked with the two CNA's accused of abuse. She indicated she knew her staff and knew no one else was abusing anyone, she had talked with each staff member one on one about the policy for abuse, just had not written anything down. The HFA indicated when she had become aware of the situation, she had told the Director of Nursing (DON) to suspend CNA #1, but she found out a couple days later she had suspended CNA #2. The HFA indicated the DON had told her CNA #2 was also involved and that was the first the HFA knew about CNA#2's involvement. She indicated both CNA's were fired; CNA #1 for abuse and CNA #2 for witnessing it and not reporting it. The HFA indicated that was the company policy. The HFA indicated she could not remember when either of the CNA's were suspended but would try</p>		<p>action(s) will be accomplished for those residents found to have been affected by the practice: C.N.A.s #1 and #2 were terminated prior to survey. HFA immediately resigned her position. Resident #B wife was notified of incident prior to survey. Active licensed staff on duty was reeducated by a teachable moment on physician /family notification. <b>(b)How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b> A facility audit was conducted to identify current residents that have had documented allegations (QIS interviews and family interviews of non interviewable residents) had proper Family and MD notification. © <b>What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</b> Licensed nursing staff was re educated regarding MD/Family notification of allegations ANE, and or mistreatment by a staff member. Licensed staff was educated to document on the 24 hour report for follow up and discussion at morning meeting. <b>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</b> DNS /Designee will</p>		

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	<p>to find the dates.</p> <p>The incident reporting form, 5 day follow-up, dated as having been faxed on 6/29/11 at 12:47 P.M., indicated "Reported by: HFA name, Resident B, Diagnoses: Alzheimer's, Diabetes Mellitus, Brief Description of Incident: Reported by CNA #3 that CNA #1 was rude and used excessive force when moving resident on or around 6/23/11. Immediate Action Taken: Suspension of employee. Resident assessed and reinterpreted [sic]. Initiated interviews for other alert and oriented residents. Preventative measures taken: ANE inservice schedule. Follow up-unable to substantiate, CNA #1 denies the allegations and with interviews could not substantiate the report. Employee has been terminated."</p> <p>In an in interview with Resident B's spouse, on 8/17/11 at 12:30 P.M., she indicated she had not been informed of the alleged abuse to Resident B. She stated a CNA had let this slip to her one day. She stated the CNA had said "I can't believe you didn't move your husband." She stated when I asked her why she said that the CNA said "You didn't know about CNA # 1 slapping him?" She stated she then went to speak to the Administrator and the Director of Nursing and got two</p>		<p>review 24 hour report to identify any allegations of ANE, and or mistreatment, any identified issues will result in review of Residents clinical record to assure documentation of MD/Family notification this will be an ongoing plan of correction. The Facility Risk Manager will report results at the next QA/Risk Management meeting and monthly thereafter until substantial compliance has been achieved and quarterly monitoring by the RDCO to maintain compliance as recommended. (e) <b>Date of compliance:</b> 8-26-11</p>		

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	<p>different stories of the incident.</p> <p>The clinical record for Resident B was reviewed on 8/17/11 at 9:30 A.M. The record indicated Resident B had diagnoses that included but were not limited to; Alzheimer's disease, anxiety and depression. The MDS [Minimum Data Set] assessment, dated 7/6/11, indicated Resident B had short and long term memory problems and severely impaired decision making. Resident B required extensive assistance of one with bed mobility, and extensive assistance of two with transfers and toilet use.</p> <p>The clinical record lacked any documentation of the incident of alleged abuse or the notification of Resident B's spouse.</p> <p>The Abuse policy, dated 3/11, provided by the HFA on 8/17/11 at 10:00 A.M., included for Protocols for investigating...the facility will investigate each allegation thoroughly and report the results to the HFA...the DNS shall notify the resident's representative regarding the alleged incident. Inform the representative that an investigation has been initialed and appropriate actions will be taken...document this contact in the clinical record."</p>				

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

PRINTED: 09/08/2011

FORM APPROVED

OMB NO. 0938-0391

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	This federal tag relates to Complaint IN00094518.  3.1-5(b)(2)				

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F0223 SS=L	<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 interview, record review and observation, the facility failed to ensure residents were free from abuse, for 12 of 13 residents reviewed for abuse. This had the potential to affect all 30 of 30 residents residing within the facility. Resident A, B, C, D, F, G, H, I, J, K, L, M.</p> <p>The Immediate Jeopardy began on 6/22/11 when abuse of a resident by a staff member was reported to have occurred in the facility. The Corporate Registered Nurse Consultant was notified of the Immediate Jeopardy at 1:00 P.M. on 8/17/11. The immediate jeopardy was removed on 8/19/11, but non-compliance remained at the lower scope and severity of widespread, no actual harm with potential for more than minimal harm that</p>	F0223	<p>alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F-223 Abuse Prevention – Free From(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:#1Resident #D and #B allegations of verbal abuse were reported to IDOH as required on 8/17 and 8/18/11. C.N.A's #1 and #2 was terminated prior to survey. Resident #B allegations of verbal abuse was submitted to ISDH on 6/29/11 – however upon further investigation an addendum was submitted on 8/17/11 to the ISDH of physical mistreatment that had been reported by another staff member. #2C.N.A #5 was suspended pending investigation Resident # B, #I, #D, #C, and #F allegations of verbal abuse were reported to ISDH as required on</p>	08/26/2011	

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	<p>is not immediate jeopardy.</p> <p>Findings include:</p> <p>1. During interview with the Health Facility Administrator (HFA) on 8/17/11 at 9:15 A.M., she indicated she had reported an allegation of abuse to the state agency and provided the documentation she had faxed in as well as the investigation of the allegations. She indicated the two Certified Nursing Assistants, CNA #1 and CNA # 2, involved had been fired.</p> <p>A note from CNA #4, dated 6/29/11, indicated "Back when name of Resident D, was put on fluid restriction, she was wanting more to drank [sic] there was some confusion with whether or not she could have more. She, Resident D, asked for a glass of milk, the nurses said it was ok, CNA #1 then brought her 2 glasses of milk sat them on the table in front of her and said something to this effect if she wants to kill herself let her go ahead and drink all that she wants." During interview with CNA #4, on 8/18/11 at 2 p.m., she indicated CNA #1 had said within hearing of Resident D to the effect of "go ahead and kill yourself it's ok with me."</p> <p>A written statement from CNA #3, dated</p>		<p>8/17 and 8/18/11. CNAs #1, #2, and #5 have been terminated after investigation. #3C.N.A #5 was suspended pending investigation C.N.A #6 was suspended pending investigation Resident # D, #C, #G allegations of verbal abuse was reported to ISDH as required on 8/17 and 8/18/11. RN # 1 was suspended – pending outcome of investigation and since terminated #4 Resident H allegations of verbal abuse were reported to ISDH as required on 8/17/11. C.N.A #7 was suspended pending investigation. #5Resident #A allegations of verbal abuse was reported to ISDH as required on 8-17-11. RN # 1 was suspended – pending outcome of investigation and since terminated #6Resident # J and #K allegations was reported to ISDH as required on 8-17 and 8-18-11 C.N.A #1 was terminated prior to survey. Re-education on the facility standards and guidelines for reporting and investigation of abuse neglect (verbal and physical) and exploitation for current staff on duty was immediately begun - 8/17/11. The Social Service Director was reeducated on the facility standard and guidelines for reporting abuse neglect and exploitation. <b>.(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b></p>		

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	<p>June 29, 2011, indicated "I have witnessed CNA #2 and CNA #1 use excessive force on Resident B while tending to him. I have also been a witness to CNA #1 speaking very rudely to him. I have not witnessed either of them strike Resident B but there was an occurrence when I believe I heard CNA #1 slap Resident B in his room while my back was turned. I asked CNA #1 what happened immediately after. She was defensive and said he wouldn't let go of me. She never confirmed or denied slapping Resident B."</p> <p>During interviews with Physical Therapy Assistant (PTA #1) on 8/17/11 at 9:30 A.M. and 2:30 P.M., he indicated CNA #3, told him in the car that CNA #2 had punched a resident in the face. He indicated CNA #3 had later changed it to CNA #1. PTA #1 indicated this was on a Friday night, he thought 6/22/11.</p> <p>The HFA provided employee counseling forms, on 8/17/11 at 10:00 A.M. The employee counseling form, dated 6/29/11, for CNA #1 indicated "suspension 2 or 3 days, upon investigation, reported by CNA that CNA #1 was very rude and used excessive force while moving resident on or around 6/23/11. CNA did not witness either CNA which was CNA #2, strike the resident but she believes she heard a slap.</p>		<p>Residents who are cognitively intact were interviewed using the QIS Interview Process for Abuse to determine if any allegations of abuse (verbal and/or physical) had not been reported or reported to someone within the facility and not acted upon.</p> <p>Non-interviewable residents had a call placed to their responsible party/guardian/POA, etc., and where interviewed using the QIS Family interview process with a focus on the Abuse section to determine if any allegations of abuse (verbal and/or physical) had not been reported or reported to someone within the facility and not acted upon. Any issues identified where immediately addressed, investigated and reported according to facility, state, and federal requirements.</p> <p><b>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</b> The Facility Management and Direct Care Staff were re-educated on the facility standards and guidelines for reporting and investigation of abuse neglect (verbal and physical) and exploitation. The Social Service Director or Designee will meet monthly with the Resident Council to ensure any allegations of abuse, neglect, and or exploitation are brought to the facility Management Team and/or designated Risk Manager for investigating, reporting,</p>		

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	<p>CNA #1 did not deny slapping resident." Another form, dated 7/1/11, for CNA #1, indicated "Discharge due to speaking with Residents and staff members. I have decided to Discharge CNA #1."</p> <p>An employee counseling form for CNA #2, dated 7/1/11, indicated "Discharge, excessive force when moving residents, also not reporting to DON (Director of Nursing) or HFA. CNA #2 used excessive force when moving resident also did not report team member who also used excessive force when moving a resident...."</p> <p>2. During interview with CNA #9 on 8/17/11 at 10:15 A.M., CNA #9 indicated CNA #3 had told her a couple of months ago that CNA #2 and CNA #1 had smacked Resident B. CNA#9 indicated she had reported to her charge nurse and the HFA that morning (8/17), what she thought was abuse that she observed the day before on 8/16/11. CNA #9 indicated on 8/16/11, her and CNA #6 heard Resident 'I' screaming from the shower room. CNA #9 indicated CNA #5 had been giving the resident a shower but had left her alone in the shower room without a call bell. CNA #9 indicated her and CNA #6 went to see what was wrong and had dressed Resident 'I' and transferred her to her chair. CNA #9 indicated CNA</p>		<p>resolution, and follow-up in a timely manner. The Facility Management Team will review event reports, grievances, and concerns daily during the Monday through Friday stand up meeting in order to investigate, resolve, and follow-up with any allegations of abuse neglect or exploitation in the appropriate required time frame. <b>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</b> The Administrator/DNS/Director of Social Services/designee will randomly pick 4 residents to interview weekly to determine if any residents have allegations of abuse or neglect that has not been reported and/or do not feel safe and have no fear of reprisal. If any of the 4 resident's picked are considered "non-interviewable" then their responsible party will be contacted. This will be weekly x 4 weeks, then monthly for 2 additional months to determine if any allegations of abuse, neglect or exploitations have been made and then to ensure that it has been investigation and promptly reported according to facility, state, and federal requirements. The Facility Risk Manager /designee will report results of the above findings at the next QA/Risk Management meeting and monthly thereafter until</p>		

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	<p>#5, upon returning to the shower room had asked them what they were doing. When they (CNA #9 and #6) told CNA #5 the resident had been screaming and they went to see what was wrong, CNA #5 went into the hall and told the resident 'Don't you never ever start screaming like that again.' "</p> <p>CNA #9 further indicated Resident D, Resident C and Resident F all had complaints concerning treatment by CNA #5.</p> <p>CNA #9 indicated Resident F was out of the facility at this time for an appointment. CNA #9 indicated Resident F was very concerned with conserving water and had asked CNA #5 to turn her water off and CNA #5 had became upset. Resident F then asked CNA #9 and #10 to provide her care as CNA #5 had given her a dirty look and was hateful and she did not want her providing care again. Resident F's clinical record was reviewed on 8/17/11 at 11:00 A.M. The MDS [Minimum Data Set] assessment, dated 7/28/11, indicated Resident F had no problems with cognition. Resident F required limited assistance of one with bed mobility, extensive assistance of one with bathing and was dependent with toilet use.</p> <p>CNA #9 further indicated that Resident D had told her some time back that CNA #5</p>		substantial compliance has been achieved and quarterly oversight by the RDCO is recommended when completing her system review which has a focus on A-N-E. (e) <b>Date of compliance: 8/26/11</b>		

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	<p>was getting her up with a stand lift and her foot fell off. When Resident D complained, CNA #5 accused her of whining and told Resident D not to ever ask her for anything again. CNA #9 indicated Resident D does not want CNA #5 providing care for her. She indicated this is not written anywhere, but just common knowledge among the CNA's.</p> <p>On 8/17/11 at 9:30 A.M., CNA # 5 was observed in a resident room providing care.</p> <p>3. During an interview with Resident D on 8/17/11 at approximately 10:30 A.M., she indicated CNA #5 had told her she did not like her, will not come into her room or do anything for her. She indicated if she asked for anything, CNA #5 would turn her head or just say, "No." Resident D indicated she had asked for milk, and CNA #5 looked at her and said "No." Resident D indicated she had told the HFA about this and the HFA brought CNA #5 into the room, and CNA #5 simply denied ever doing anything.</p> <p>Resident D's clinical record was reviewed on 8/17/11 at 1:00 P.M. The MDS [Minimum Data Set] assessment of 7/13/11, indicated Resident D had no problems with cognition. Resident D required extensive assistance of two with</p>				

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	<p>bed mobility, and was dependent on two staff with transfers and toilet use.</p> <p>In an interview with Resident C on 8/17/11 at 10:25 A.M., he was observed to be in bed with his cat on the bed beside him. He indicated CNA # 5 was very rough in handling him. He indicated CNA # 5 was very rude and talked down to him. He also indicated CNA # 6 had a chip on her shoulder and was mean during care. He further indicated he had reported this to the Administrator, but she didn't do anything. He indicated after reporting this to the Administrator she had told him his pet cat that had lived with him at the facility for 5 years had to go. He indicated he had banned CNA # 5 from providing any care for him.</p> <p>The clinical record for Resident C was reviewed on 8/17/11 at 1:20 P.M. The record indicated Resident C had diagnoses that included but were not limited to chronic kidney disease and depression. The MDS [Minimum Data Set] assessment, dated 6/15/11, indicated Resident C had no impairment in cognition. Resident C required extensive assistance of two with bed mobility and toilet use. The Nurse's Notes, dated 8/12/11 at 11:00 P.M., indicated "Asked me if I knew about his cat, was very upset about having to lose her."</p>				

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	<p>In an interview with Resident G, on 8/17/11 at 11:00 A.M., she indicated CNA # 5 was "always talking down to me." She stated CNA # 5 would always make comments about her clothing and how she combed her hair. She stated "I didn't want her to talk to me that way. I want to do as much as I can for myself." She also indicated she was a minister, and she stated that RN # 1 had called her the devil. She was very upset and misty eyed and asked "Why would she do something like that? I am not a bad person."</p> <p>The MDS [Minimum Data Set] assessment, dated 7/13/11, indicated Resident G had moderately impaired cognition. Resident G was independent with bed mobility, transfers, and ambulation. Resident G required limited assistance of one with toilet use and personal hygiene.</p> <p>4. During interview with the HFA on 8/17/11 at 11:30 A.M., she indicated the only other allegation of abuse that she was aware of was on a form she had found in DON #1's office (old DON who now is on leave and will return as a floor nurse). The HFA went to the Business Office Manager's office and returned with the three notes at this time. The HFA indicated she had just found it lately and</p>				

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	<p>was starting an investigation.</p> <p>There were 3 notes stapled together. Note 1 written by CNA #3, dated 7/7/11, indicated: "Resident H's family member made complaint that CNA #7 was very rough and rude with Resident H last night. CNA #7 allegedly came in to put her to bed and said something along the lines of what do you think you are doing? When Resident H asked who she was talking about CNA #7 said you know what you did. Resident H says that CNA #7 was easy about undressing her and preparing her for bed. Resident H's family member is very upset and would like to speak to HFA as soon as possible. According to her this was an issue in the past."</p> <p>5. During interview with Resident A's family on 8/17/11 at 12:00 P.M., they indicated while visiting at supper time, RN #1 was heard to be very hateful with Resident A. The family of Resident A further indicated that yesterday (8/16) they had heard CNA #5 yell at Resident L to get back in the bed and she would get to her when she could. The family further indicated Resident M was a longtime friend of their family. Resident A's family had given a phone number for them to Resident M. This was taken away by the HFA and Resident M told she was not allowed to have the number or call the</p>				

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	<p>family. Resident A's family indicated Resident M was scared to talk about it now and they had provided the number again and told her to keep it hid.</p> <p>6. On 8/17/11 at 2:00 P.M., CNA # 10 provided a written statement, dated 8/17/11, which indicated "To whom it may concern, I (CNA # 10's name) saw CNA # 1 handle Resident (Resident J's name) in an unprofessional manner. She was rough when turning resident didn't explain what she was doing to the resident left B.M. [bowel movement] on bed and resident. We were doing walk thru at shift change. She also treated (Resident K's name) in room (number) the same way, never explained what was going on with them turned him and changed him in a rough manner again no peri care. I had to go behind her after she left and clean said residents. This is before I left in July 2011 (for vacation)..." During interview with CNA #10 at this same time, she indicated this had been reported to the HFA, and was before CNA #1 was suspended for other allegations of abuse.</p> <p>The Abuse Prevention Program, policy and procedure, dated 8/2006, provided by the Health Facility Administrator, on 8/17/11 at 10:00 A.M., indicated, "Abuse Reporting...will have no tolerance with anyone not reporting and following the 7</p>				

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	<p>steps of abuse, neglect and exploitation...when any allegation or confirmed abuse occurs...With any allegation or suspected or witnessed abuse every employee has a legal obligation to report the occurrence."</p> <p>The Immediate Jeopardy that began on 6/22/11 was removed on 8/19/11, when the facility demonstrated policies and procedures had been put in place to ensure staff were knowledgeable about the abuse protocol, but noncompliance remained at the lowered scope and severity of widespread, no actual harm, with potential for more than minimal harm, that is not immediate jeopardy.</p> <p>This federal tag relates to Complaint IN00094518.</p> <p>3.1-27(a)(1) 3.1-27(b)</p>				

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

PRINTED: 09/08/2011

FORM APPROVED

OMB NO. 0938-0391

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F0225 SS=L	<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, record review, and observation, the facility failed to ensure allegations of abuse voiced by residents and staff members were immediately</p>	F0225	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies.	08/26/2011	

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	<p>reported to the administrator and thoroughly investigated, for 9 of 13 residents reviewed for abuse. This had the potential to affect all 30 of 30 residents residing within the facility. Residents B, C, D, F, H, I, J, K, and L.</p> <p>The Immediate Jeopardy began on 6/22/11 when a certified nursing assistant who had witnessed abuse at some point in the past, discussed it with a facility PTA [physical therapy assistant] who was providing her a ride home. The therapist then waited 2 days to tell the DON, with no documentation of the administrator being notified until the 3rd day. This resulted in a delayed investigation of the abuse, allowing the 2 staff members accused to continue to work on the floor with residents, as well as the Health Facility Administrator failing to immediately suspend and investigate other allegations of abuse made by other staff members and failure of staff members to immediately report suspicions of abuse to the Administrator. The Corporate Registered Nurse Consultant was notified of the Immediate Jeopardy at 1:00 P.M. on 8/17/11. The immediate jeopardy was removed on 8/19/11, but noncompliance remained at the lower scope and severity of widespread, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p>		<p>This plan of correction is prepared and/or executed solely because required. F-225 Investigate/Report/Allegations (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:#1C.N.A's #1 and #2 was terminated prior to survey. Resident #B allegations of verbal abuse was submitted to ISDH on 6/29/11 – however upon further investigation an addendum was submitted on 8/17/11 to the ISDH of physical mistreatment that had been reported by another staff member #2C.N.A #5 was suspended pending investigation Resident # B, #I, #D, #C, and #F allegations of verbal abuse were reported to ISDH as required on 8/17 and 8/18/11. CNAs #1, #2, and #5 have been terminated after investigation. #3C.N.A #5 was suspended pending investigation C.N.A #6 was suspended pending investigation Resident # D, #C, #G allegations of verbal abuse was reported to ISDH as required on 8/17 and 8/18/11. #4LPN #1 was educated on the facility standards and guidelines for reporting and investigation of abuse neglect (verbal and physical) and exploitation RN # 1 was suspended – pending outcome of investigation and since terminated Re-education on the facility standards and guidelines for reporting and investigation of abuse neglect (verbal and</p>		

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	<p>Findings include:</p> <p>1. During interview with the Health Facility Administrator (HFA) on 8/17/11 at 9:15 A.M., she indicated she had reported an allegation of abuse to the state agency and provided the documentation she had faxed in, as well as the investigation of the allegations. She indicated the two Certified Nursing Assistants, CNA #1 and CNA #2, involved had been fired. She indicated she had no documentation of an inservice provided to staff members and she had not obtained statements from all staff members who had worked with the two CNA's accused of abuse. She indicated she knew her staff and knew no one else was abusing anyone. She said she had talked with each staff member one on one about the policy for abuse, just had not written anything down. The HFA indicated when she had become aware of the situation, she had told the Director of Nursing (DON) to suspend CNA #1, but she found out a couple days later she had suspended CNA #2. The HFA indicated the DON had told her CNA #2 was also involved and that was the first the HFA knew about CNA#2's involvement. She indicated both CNA's were fired, CNA #1 for abuse and CNA #2 for witnessing it and not reporting it. The HFA indicated</p>		<p>physical) and exploitation for current staff on duty was immediately begun - 8/17/11. #5C.N.A #5 was suspended pending investigation HFA resigned position immediately during survey process. #6Resident # J and #K allegations was reported to ISDH as required on 8-17 and 8-18-11 C.N.A #1 was terminated prior to survey. <b>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b> Residents who are cognitively intact were interviewed using the QIS Interview Process for Abuse to determine if any allegations of abuse (verbal and/or physical) had not been reported or reported to someone within the facility and not acted upon. Non-interviewable residents had a call placed to their responsible party/guardian/POA, etc., and where interviewed using the QIS Family interview process with a focus on the Abuse section to determine if any allegations of abuse (verbal and/or physical) had not been reported or reported to someone within the facility and not acted upon. Any issues identified where immediately addressed, investigated and reported according to facility, state, and federal requirements. <b>(c) What measures will be put into place or what systematic changes you will make to</b></p>		

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	<p>that was the company policy. The HFA indicated she could not remember when either of the CNA's were suspended but would try to find the dates.</p> <p>The incident reporting form, 5 day follow-up, dated as having been faxed, 6/29/11 at 12:47 P.M., indicated "Reported by: HFA name, Resident B, Diagnoses: Alzheimer's, Diabetes Mellitus, Brief Description of Incident: Reported by CNA #3 that CNA #1 was rude and used excessive force when moving resident on or around 6/23/11. Immediate Action Taken: Suspension of employee. Resident assessed and reinterpreted [sic]. Initiated interviews for other alert and oriented residents. Preventative measures taken: ANE inservice schedule. Follow up-unable to substantiate, CNA #1 denies the allegations and with interviews could not substantiate the report. Employee has been terminated."</p> <p>Statements obtained from staff members included: "CNA #4, dated 6/29/11, Just to bring to attention that (CNA #2 name) in my personal opion [sic] is a little aggressive with personal care to residents. Maybe a fast turn her [sic] or a little bit hard to the other side.[sic] I personally would not have her take care take of my grandma." Another note from CNA #4,</p>		<p><b>ensure that the practice does not recur:</b> The Facility Management and Direct Care Staff were re-educated on the facility standards and guidelines for reporting and investigation of abuse neglect (verbal and physical) and exploitation. The Social Service Director or Designee will meet monthly with the Resident Council to ensure any allegations of abuse, neglect, and or exploitation are brought to the facility Management Team and/or designated Risk Manager for investigating, reporting, resolution, and follow-up in a timely manner. The Facility Management Team will review event reports, grievances, and concerns daily during the Monday through Friday stand up meeting in order to investigate, resolve, and follow-up with any allegations of abuse neglect or exploitation in the appropriate required time frame. <b>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</b> The Administrator/DNS/Director of Social Services/designee will randomly pick 4 residents to interview weekly to determine if any residents have allegations of abuse or neglect that has not been reported and/or do not feel safe and have no fear of reprisal. If any of the 4 resident's picked are considered</p>		

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	<p>dated 6/29/11, "Back when (name of Resident D), was put on fluid restriction, she was wanting more to drank [sic] there was some confusion with whether or not she could have more. She, Resident D, asked for a glass of milk, the nurses said it was ok. CNA #1 then brought her 2 glasses of milk sat them on the table in front of her and said something to this effect if she wants to kill herself let her go ahead and drink all that she wants."</p> <p>During interview with CNA #4, on 8/18/11 at 2 p.m., she indicated CNA #1 had said within the hearing of Resident D to the effect of "go ahead and kill yourself it's ok with me." CNA #4 indicated she did not report it at the time because a charge nurse heard it, too. CNA #4 could not remember what nurse for sure but thought it was DON #1. CNA #4 indicated she wrote the statements concerning CNA #1 and #2 on 6/29/11, because the HFA asked her to document anything she knew had occurred with those CNA's.</p> <p>A written statement, from CNA #3, dated June 29, 2011, indicated " I have witnessed CNA #2 and CNA #1 use excessive force on Resident B while tending to him. I have also been a witness to CNA #1 speaking very rudely to him. I have not witnessed either of them strike Resident B, but there was an occurrence</p>		<p>"non-interviewable" then their responsible party will be contacted. This will be weekly x 4 weeks, then monthly for 2 additional months to determine if any allegations of abuse, neglect or exploitations have been made and then to ensure that it has been investigation and promptly reported according to facility, state, and federal requirements. The Facility Risk Manager /designee will report results of the above findings at the next QA/Risk Management meeting and monthly thereafter until substantial compliance has been achieved and quarterly oversight by the RDCO is recommended when completing her system review which has a focus on A-N-E. (e) <b>Date of compliance:</b> 8/26/11</p>		

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	<p>when I believe I heard CNA #1 slap Resident B in his room while my back was turned. I asked CNA #1 what happened immediately after. She was defensive and said he wouldn't let go of me. She never confirmed or denied slapping Resident B."</p> <p>A written statement from PTA #1, dated 7/18/11, indicated : I received a call from CNA #3 on 7/18/11 at approximately 9 p.m. in regards to repeated phone calls from CNA #1 and CNA #2...CNA #3 told me that they had been harassing her and threatening to find her and harm her. She also informed me that CNA #2 had told her that she was going to call corporate and tell them that she had caught us having sex in the building to try and get us (me and CNA #3) fired, since we had according to CNA #2 gotten her and CNA #1 fired. So today I addressed this with HFA...."</p> <p>During interviews with PTA #1 on 8/17/11 at 9:30 A.M. and 2:30 P.M., he indicated CNA #3 had told him, while riding in a car, that CNA #2 had punched a resident in the face. He indicated CNA #3 had later changed it the CNA #1. PTA #1 indicated this was on a Friday night, he thought 6/22, because there was a going away party for a nurse he and other staff members attended. He indicated he told</p>						

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	<p>the DON on Sunday when he came to work as he did not work on Saturday. PTA #1 indicated he remembered talking to the HFA about this on he believed Monday, but did not write anything down and was not asked to write a statement. PTA #1 indicated he thought the HFA then had CNA #3 write something up the next time she was at work.</p> <p>The HFA provided employee counseling forms on 8/17/11 at 10:00 A.M. The HFA further indicated at this time, the DON had not called her on 6/24/11 and told her about the PTA's report of allegations made by CNA #3 on 6/22/11. The employee counseling form, dated 6/29/11, for CNA #1 indicated "Suspension 2 or 3 days, upon investigation, reported by CNA that CNA #1 was very rude and used excessive force while moving resident on or around 6/23/11. CNA did not witness either CNA which was CNA #2, strike the resident but she believes she heard a slap to slap. CNA #1 did not deny slapping resident. State report filed 6/29/11."</p> <p>Another form, dated 7/1/11, for CNA #1, indicated "Discharge due to speaking with Residents and staff members. I have decided to Discharge CNA #1."</p> <p>An employee counseling form for CNA #2, dated 7/1/11, indicated discharge, excessive force when moving residents,</p>						

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	<p>also not reporting to DON or HFA. CNA #2 used excessive force when moving resident. Also did not report team member who also used excessive force when moving a resident -this was a state reportable on 6/29/11. I gave a 3 day suspension for investigation of this matter." No date as to when the 3 day suspension was documented.</p> <p>The facility Office Manager on 8/18/11 at 1:00 P.M., indicated CNA#1 worked on 6/23, 25, 26, 29, with her last day to work as 6/30/11. CNA #2 worked 6/22, 26, with the last day to have worked as 6/27/11.</p> <p>The facility lacked evidence of having reported rough treatment of Resident B by CNA #2 to the state agency, having immediately reported or investigated the allegations or documented the statements made by staff members..</p> <p>2. During interview with CNA #9 on 8/17/11 at 10:15 A.M., she indicated she was glad the HFA had fired CNA #1 and #2 as they were mean and did not follow protocol for lift use. CNA #9 indicated this was normal for them, but the previous DON had made excuses for them. CNA #9 indicated she had expressed concerns to the previous DON and the previous HFA. She indicated they had simply cut</p>						

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	<p>her time on the schedule to almost nothing afterwards.</p> <p>CNA #9 indicated CNA #3 had told her a couple of months ago that CNA #2 and CNA #1 had smacked Resident B. CNA #9 indicated she had not been asked for any statements concerning abuse she had witnessed. CNA #9 indicated she had reported to her charge nurse and the HFA that morning (8/17), what she thought was abuse that she observed the day before (8/16). CNA #9 indicated on 8/16/11, her and CNA #6 heard Resident 'I' screaming from the shower room. CNA #9 indicated CNA #5 had been giving the resident a shower, but had left her alone in the shower room without a call bell. CNA #9 indicated her and CNA #6 went to see what was wrong and had dressed Resident 'I' and transferred her to her chair. CNA #9 indicated CNA #5, upon returning to the shower room, had asked them what they were doing. When they (CNA #9 and #6) told CNA #5 the resident had been screaming and they went to see what was wrong, CNA #5 went into the hall and told the resident 'Don't you never ever start screaming like that again.' "</p> <p>CNA #9 indicated she told her charge nurse, LPN #1 this morning, 8/17/11, she indicated LPN #1 told her to go tell the HFA when she got to the facility, which she had done and provided the HFA a</p>				

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	<p>write up on it.</p> <p>CNA #9 further indicated Resident D, Resident C and Resident F all had complaints concerning treatment by CNA #5. She indicated they should be spoken to.</p> <p>CNA #9 indicated Resident F was out of the facility at this time. CNA #9 indicated Resident F was very concerned with conserving water and had asked CNA #5 to turn her water off and CNA #5 had become upset. Resident F then asked CNA #9 and #10 to provide her care as CNA #5 had gave her a dirty look and was hateful and she did not want her providing care again. Resident F's clinical record was reviewed on 8/17/11 at 11:00 A.M. The MDS [Minimum Data Set] assessment, dated 7/28/11, indicated Resident F had no problems with cognition. Resident F required limited assistance of one with bed mobility, extensive assistance of one with bathing and was dependent with toilet use.</p> <p>CNA #9 further indicated Resident D had told her, some time back, that CNA #5 was getting her up with a stand lift, and her foot fell off. When Resident D complained, CNA #5 accused her of whining and told Resident D not to ever ask her for anything again. CNA #9</p>				

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	<p>indicated Resident D does not want CNA #5 providing care for her. She indicated this is not written anywhere, but just common knowledge among the CNA's.</p> <p>On 8/17/11 at 9:30 A.M., CNA # 5 was observed in a resident room providing care.</p> <p>3. During an interview with Resident D on 8/17/11 at approximately 10:30 A.M., she indicated CNA #5 had told her she did not like her, will not come into her room or do anything for her. She indicated if she asked for anything, CNA #5 would turn her head or just say, "No." Resident D indicated she had asked for milk, and CNA #5 looked at her and said "No." Resident D indicated she had told the HFA about this and the HFA brought CNA #5 into the room, and CNA #5 simply denied ever doing anything.</p> <p>Resident D's clinical record was reviewed on 8/17/11 at 1:00 P.M. The MDS [Minimum Data Set] assessment, 7/13/11, indicated Resident D had no problems with cognition. Resident D required extensive assistance of two with bed mobility, and dependent on two staff with transfers and toilet use.</p> <p>In an interview with Resident C, on 8/17/11 at 10:25 A.M., he was observed to</p>			

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	<p>be in bed with his cat beside him. He indicated CNA # 5 was very rough in handling him. He indicated CNA # 5 was very rude and talked down to him. He also indicated CNA # 6 had a chip on her shoulder and was mean during care. He further indicated he had reported this to the Administrator but she didn't do anything. He indicated after reporting this to the Administrator she had told him his pet cat that had lived with him at the facility for 5 years had to go. He indicated he had banned CNA # 5 from providing any care for him.</p> <p>The clinical record for Resident C was reviewed on 8/17/11 at 1:20 P.M. The record indicated Resident C had diagnoses that included but were not limited to chronic kidney disease and depression. The MDS [Minimum Data Set] assessment, dated 6/15/11, indicated Resident C had no impairment in cognition. Resident C required extensive assistance of two with bed mobility and toilet use. The Nurse's Notes, dated 8/12/11 at 11:00 P.M., indicated "Asked me if I knew about his cat, was very upset about having to lose her."</p> <p>4. During interview with LPN #1, on 8/17/11 at 11:15 A.M., she indicated she had told CNA #9 to tell the HFA when she (the Administrator) got there that morning</p>				

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	<p>about the incident with CNA # 5 and Resident 'I'. She confirmed that CNA #5 was still working at that time. She indicated she had only been working for 5 or 6 days and really did not know what the abuse protocol was. She indicated she just had not had a chance to attend general orientation.</p> <p>LPN #1's employee file was obtained from the Office Manager on 8/17/11 at 12:00 P.M. Documentation of training in the facility abuse protocol was lacking. The last 10 hired employees files were reviewed, on 8/17/11 at 1:00 P.M. Three of the 10 new employees had not been trained in the facility abuse protocol.</p> <p>5. During interview with the HFA on 8/17/11 at 11:30 A.M., she indicated the only other allegation of abuse that she was aware of was on a form she had found in DON #1's office (old DON who now is on leave and will return as a floor nurse). The HFA went to the Business Office Manager's office and returned with the three notes at this time. The HFA indicated she had just found it lately and was starting an investigation. There were 3 notes stapled together. Note 1 written by CNA #3, dated 7/7/11, indicated: "Resident H's family member made complaint that CNA #7 was very rough and rude with Resident H last night.</p>				

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	<p>CNA #7 allegedly came in to put her to bed and said something along the lines of what do you think you are doing? When Resident H asked who she was talking about CNA #7 said you know what you did. Resident H says that CNA #7 was easy about undressing her and preparing her for bed. Resident H's family member is very upset and would like to speak to HFA as soon as possible. According to her this was an issue in the past."</p> <p>Note 2- dated 8/16/11 2:20 p.m., written by the HFA indicated "Spoke with CNA #7 about this note, told her I was accusing [sic] her of anything, all CNA's are going to keep their resident dry and safe. She was ok when she left office."</p> <p>Note 3- written by CNA #7, no date, indicated "FYI- CNA on days, every morning before I go home I check my people second of all me and CNA #8 had split up sections I never leave any of my residents wet or dirty so you need to talk with someone else or don't accuse me of leaving anyone soaked because I don't do that." [sic]</p> <p>The HFA indicated on 8/17/11 at 11:30 A.M., she had received no other reports of abuse. When asked about the allegations made by CNA #9 to her charge nurse and</p>						

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	<p>to the HFA that a.m., the HFA indicated she had not had time to investigate it yet. She further indicated she did not consider what was reported to her abuse. Nurse Consultant #1 indicated it was considered abuse and CNA #5 would be sent home pending investigation. The HFA further indicated when she took over the facility it was a mess and she was trying to clean it up. She indicated she had not documented some of the things done because there was not time to look into things and document them. She indicated if she suspended all the staff accused of abuse there be no one to work.</p> <p>6. On 8/17/11 at 2:00 P.M., CNA # 10 provided a written statement, dated 8/17/11, which indicated "To whom it may concern, I (CNA # 10's name) saw CNA # 1 handle Resident (Resident J's name) in an unprofessional manner. She was rough when turning resident, didn't explain what she was doing to the resident, left B.M. [bowel movement] on bed and resident. We were doing walk thru at shift change. She also treated (Resident K's name) in room (number) the same way, never explained what was going on with them, turned him, and changed him in a rough manner, again no peri care. I had to go behind her after she left and clean said residents. This is before I left in July 2011... (on vacation)."</p>				

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	<p>During interview with CNA #10 at this same time, she indicated this had been reported to the HFA, and was before CNA #1 was suspended for other allegations of abuse.</p> <p>The Immediate Jeopardy that began on 6/22/11 was removed on 8/19/11, when the facility demonstrated policies and procedures had been put in place to ensure staff were knowledgeable concerning the abuse protocol which included how to report abuse and the procedures for investigating, but noncompliance remained at the lower scope and severity of widespread, no actual harm, with potential for more than minimal harm, that is not immediate jeopardy.</p> <p>This federal tag relates to Complaint IN00094518.</p> <p>3.1-28(c) 3.1-28(d)</p>				

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

PRINTED: 09/08/2011

FORM APPROVED

OMB NO. 0938-0391

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F0226 SS=L	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview, record review and observation, the facility failed to ensure policies and procedures were implemented to protect residents from staff members who created an environment of fear, for 12 of 13 residents reviewed for abuse. This had the potential to affect all 30 of 30 residents residing within the facility. Residents A, B, C, D, F, G, H, I, J, K, L, and M</p> <p>The Immediate Jeopardy began on 6/22/11 when a certified nursing assistant who had witnessed abuse at some point in the past, discussed it with a facility PTA [physical therapy assistant] who was providing her a ride home. The therapist then waited 2 days to tell the DON, with no documentation of the Administrator notified until the 3rd day. This resulted in a delayed investigation of the abuse,</p>	F0226	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F-226 Practice and Guidelines regarding Abuse (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: #1C.N.A's #1 and #2 was terminated prior to survey. Resident #B allegations of verbal abuse was submitted to ISDH on 6/29/11 – however upon further investigation an addendum was submitted on 8/17/11 to the ISDH of physical mistreatment that had been reported by another staff member #2C.N.A #5 was suspended pending investigation Resident # B, #I, #D, #C, and #F</p>	08/26/2011	

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	<p>allowing the 2 staff members accused to continue to work on the floor with residents, as well as the health facility administrator failing to immediately suspend and investigate other allegations of abuse made by other staff members and failure of staff members to immediately report suspicions of abuse to the administrator. The Corporate Registered Nurse Consultant was notified of the Immediate Jeopardy at 1:00 P.M. on 8/17/11. The immediate jeopardy was removed on 8/19/11, but noncompliance remained at the lower scope and severity of widespread, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings include:</p> <p>1. During interview with the Health Facility Administrator (HFA) on 8/17/11 at 9:15 A.M., she indicated she had reported an allegation of abuse to the state agency and provided the documentation she had faxed in as well as the investigation of the allegations. She indicated the two Certified Nursing Assistants, CNA # 1 and CNA #2, involved had been fired. She indicated she had no documentation of an inservice provided to staff members and had not obtained statements from all staff members who had worked with the two</p>		<p>allegations of verbal abuse were reported to ISDH as required on 8/17 and 8/18/11. CNAs #1, #2, and #5 have been terminated after investigation. #3C.N.A #5 was suspended pending investigation C.N.A #6 was suspended pending investigation Resident # D, #C, #G allegations of verbal abuse was reported to ISDH as required on 8/17 and 8/18/11. #4LPN #1 was educated on the facility standards and guidelines for reporting and investigation of abuse neglect (verbal and physical) and exploitation RN # 1 was suspended – pending outcome of investigation and since terminated Re-education on the facility standards and guidelines for reporting and investigation of abuse neglect (verbal and physical) and exploitation for current staff on duty was immediately begun - 8/17/11 #5Resident H allegations of verbal abuse were reported to ISDH as required on 8/17/11. C.N.A #7 was suspended pending investigation. Resident #A allegations of verbal abuse was reported to ISDH as required on 8-17-11. RN # 1 was suspended – pending outcome of investigation and since terminated #6Resident #A allegations of verbal abuse was reported to ISDH as required on 8-17-11. RN # 1 was suspended – pending outcome of investigation and since</p>		

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	<p>CNA's accused of abuse. She indicated she knew her staff and knew no one else was abusing anyone. She had talked with each staff member one on one about the policy for abuse, just had not written anything down. The HFA indicated when she had become aware of the situation, she had told the Director of Nursing (DON) to suspend CNA #1, but she found out a couple days later she had suspended CNA #2. The HFA indicated the DON had told her CNA #2 was also involved and that was the first the HFA knew about CNA#2's involvement. She indicated both CNA's were fired, CNA #1 for abuse and CNA #2 for witnessing it and not reporting it. The HFA indicated that was the company policy. The HFA indicated she could not remember when either of the CNA's were suspended but would try to find the dates.</p> <p>The incident reporting form, 5 day follow-up, dated as having been faxed, 6/29/11 at 12:47 P.M., indicated, "Reported by: HFA name, Resident B, Diagnoses: Alzheimer's, Diabetes Mellitus. Brief Description of Incident: Reported by CNA #3 that CNA #1 was rude and used excessive force when moving resident on or around 6/23/11. Immediate Action Taken: Suspension of employee. Resident assessed and reinterpreted [sic]. Initiated interviews</p>		<p>terminated #7Resident # J and #K allegations was reported to ISDH as required on 8-17 and 8-18-11 C.N.A #1 was terminated prior to survey. <b>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b> Residents who are cognitively intact were interviewed using the QIS Interview Process for Abuse to determine if any allegations of abuse (verbal and/or physical) had not been reported or reported to someone within the facility and not acted upon. Non-interviewable residents had a call placed to their responsible party/guardian/POA, etc., and where interviewed using the QIS Family interview process with a focus on the Abuse section to determine if any allegations of abuse (verbal and/or physical) had not been reported or reported to someone within the facility and not acted upon. Any issues identified where immediately addressed, investigated and reported according to facility, state, and federal requirements. <b>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</b> The Facility Management and Direct Care Staff were re-educated on the facility standards and guidelines for reporting and investigation of</p>		

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	<p>for other alert and oriented residents. Preventative measures taken: ANE inservice schedule. Follow up-unable to substantiate. CNA #1 denies the allegations and with interviews could not substantiate the report. Employee has been terminated."</p> <p>Statements obtained from staff members included: "CNA #4, dated 6/29/11, Just to bring to attention that (CNA #2 name) in my personal opion [sic] is a little aggressive with personal care to residents. Maybe a fast turn her [sic] or a little bit hard to the other side.[sic] I personally would not have her take care of my grandma." Another note from CNA #4, dated 6/29/11, "Back when name of Resident D, was put on fluid restriction, she was wanting more to drank [sic] there was some confusion with whether or not she could have more. She, Resident D, asked for a glass of milk, the nurses said it was ok, CNA #1 then brought her 2 glasses of milk sat them on the table in front of her and said something to this effect if she wants to kill herself let her go ahead and drink all that she wants."</p> <p>During interview with CNA #4, on 8/18/11 at 2 p.m., she indicated CNA #1 had said within the hearing of Resident D to the effect of "go ahead and kill yourself its ok with me." CNA #4 indicated she</p>		<p>abuse neglect (verbal and physical) and exploitation. The Social Service Director or Designee will meet monthly with the Resident Council to ensure any allegations of abuse, neglect, and or exploitation are brought to the facility Management Team and/or designated Risk Manager for investigating, reporting, resolution, and follow-up in a timely manner. The Facility Management Team will review event reports, grievances, and concerns daily during the Monday through Friday stand up meeting in order to investigate, resolve, and follow-up with any allegations of abuse neglect or exploitation in the appropriate required time frame. <b>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</b> The Administrator/DNS/Director of Social Services/designee will randomly pick 4 residents to interview weekly to determine if any residents have allegations of abuse or neglect that has not been reported and/or do not feel safe and have no fear of reprisal. If any of the 4 resident's picked are considered "non-interviewable" then their responsible party will be contacted. This will be weekly x 4 weeks, then monthly for 2 additional months to determine if any allegations of abuse, neglect</p>		

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	<p>did not report it at the time because a charge nurse heard it, too. CNA #4 could not remember what nurse for sure but thought it was DON #1. CNA #4 indicated she wrote the statements concerning CNA #1 and #2 on 6/29/11, because the HFA asked her to document anything she knew had occurred with those CNA's.</p> <p>A written statement from CNA #3, dated June 29, 2011, indicated, "I have witnessed CNA #2 and CNA #1 use excessive force on Resident B while tending to him. I have also been a witness to CNA #1 speaking very rudely to him. I have not witnessed either of them strike Resident B but there was an occurrence when I believe I heard CNA #1 slap Resident B in his room while my back was turned. I asked CNA #1 what happened immediately after. She was defensive and said he wouldn't let go of me. She never confirmed or denied slapping Resident B."</p> <p>A written statement from PTA #1, dated 7/18/11, indicated: "I received a call from CNA #3 on 7/18/11 at approximately 9 p.m. in regards to repeated phone calls from CNA #1 and CNA #2...CNA #3 told me that they had been harassing her and threatening to find her and harm her. She also informed me that CNA #2 had told</p>		<p>or exploitations have been made and then to ensure that it has been investigation and promptly reported according to facility, state, and federal requirements. The Facility Risk Manager /designee will report results of the above findings at the next QA/Risk Management meeting and monthly thereafter until substantial compliance has been achieved and quarterly oversight by the RDCO is recommended when completing her system review which has a focus on A-N-E. (e) <b>Date of compliance:</b> 8/26/11</p>				

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	<p>her that she was going to call corporate and tell them that she had caught us having sex in the building to try and get us (me and CNA #3) fired, since we had according to CNA #2 gotten her and CNA #1 fired. So today I addressed this with HFA...."</p> <p>During interviews with PTA #1 on 8/17/11 at 9:30 A.M. and 2:30 P.M., he indicated CNA #3 had told him while riding in a car, that CNA #2 had punched a resident in the face. He indicated CNA #3 had changed it the CNA #1. PTA #1 indicated this was on a Friday night, he thought 6/22, because there was a going away party for a nurse he and other staff members attended. He indicated he told the DON on Sunday when he came to work as he did not work on Saturday. PTA #1 indicated he remembered talking to the HFA about this on he believed Monday, but did not write anything down and was not asked to write a statement. PTA #1 indicated he thought the HFA then had CNA #3 write something up the next time she was at work.</p> <p>The HFA provided employee counseling forms, on 8/17/11 at 10:00 A.M. The HFA further indicated at this time, the DON had not called her on 6/24/11 and told her about the PTA's report of allegations made by CNA #3 on 6/22/11.</p>				

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	<p>The employee counseling form, dated 6/29/11, for CNA #1 indicated "Suspension 2 or 3 days, upon investigation, reported by CNA that CNA #1 was very rude and used excessive force while moving resident on or around 6/23/11. CNA did not witness either CNA which was CNA #2, strike the resident but she believes she heard a slap to slap. CNA #1 did not deny slapping resident. State report filed 6/29/11." Another form, dated 7/1/11, for CNA #1, indicated "Discharge due to speaking with Residents and staff members. I have decided to Discharge CNA #1."</p> <p>An employee counseling form for CNA #2, dated 7/1/11, indicated "Discharge, excessive force when moving residents also not reporting to DON or HFA. CNA #2 used excessive force when moving resident. Also did not report team member who also used excessive force when moving a resident -this was a state reportable on 6/29/11. I gave a 3 day suspension for investigation of this matter." No date as to when the 3 day suspension was documented.</p> <p>The facility Office Manager, on 8/18/11 at 1:00 P.M., indicated CNA#1 worked 6/23, 25, 26, 29 with her last day to work as 6/30/11. CNA #2, worked 6/22, 26,</p>						

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	<p>with the last day to have worked as 6/27/11.</p> <p>The facility lacked evidence of having reported rough treatment of Resident B by CNA #2 to the state agency, having immediately reported or investigated the allegations or documented the statements made by staff members.</p> <p>In an in interview with Resident B's spouse, on 8/17/11 at 12:30 P.M., she indicated she had not been informed of the alleged abuse to Resident B. She stated a CNA had let this slip to her one day. She stated the CNA had said "I can't believe you didn't move your husband." She stated when I asked her why she said that the CNA said "You didn't know about CNA # 1 slapping him?" She stated she then went to speak to the Administrator and the Director of Nursing and got two different stories of the incident.</p> <p>The clinical record for Resident B was reviewed on 8/17/11 at 9:30 A.M. The record indicated Resident B had diagnoses that included but were not limited to, Alzheimer's disease, anxiety and depression. The MDS [Minimum Data Set] assessment, dated 7/6/11, indicated Resident B had short and long term memory problems and severely impaired decision making. Resident B required</p>				

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	<p>extensive assistance of one with bed mobility, and extensive assistance of two with transfers and toilet use.</p> <p>2. During interview with CNA #9 on 8/17/11 at 10:15 A.M., she indicated she was glad the HFA had fired CNA #1 and #2 as they were mean and did not follow protocol for lift use. CNA #9 indicated this was normal for them, but the previous DON had made excuses for them. CNA #9 indicated she had expressed concerns to the previous DON and the previous HFA. She indicated they had simply cut her time on the schedule to almost nothing afterwards.</p> <p>CNA #9 indicated CNA #3 had told her a couple of months ago that CNA #2 and CNA #1 had smacked Resident B. CNA #9 indicated she had not been asked for any statements concerning abuse she had witnessed. CNA #9 indicated she had reported to her charge nurse and the HFA that morning (8/17), what she thought was abuse that she observed the day before (8/16). CNA #9 indicated on 8/16/11, her and CNA #6 heard Resident 'I' screaming from the shower room. CNA #9 indicated CNA #5 had been giving the resident a shower, but had left her alone in the shower room without a call bell. CNA #9 indicated her and CNA #6 went to see what was wrong and had dressed Resident</p>						

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	<p>'T and transferred her to her chair. CNA #9 indicated CNA #5, upon returning to the shower room, had asked them what they were doing. When they (CNA #9 and #6) told CNA #5 the resident had been screaming and they went to see what was wrong, CNA #5 went into the hall and told the resident 'Don't you never ever start screaming like that again.' "</p> <p>CNA #9 indicated she told her charge nurse, LPN #1 this morning, 8/17/11, she indicated LPN #1 told her to go tell the HFA when she (the Administrator) got to the facility, which she had done and provided the HFA a write up on it.</p> <p>CNA #9 further indicated Resident D, Resident C and Resident F, all had complaints concerning treatment by CNA #5. She indicated they should be spoken to.</p> <p>CNA #9 indicated Resident F was out of the facility at this time. CNA #9 indicated Resident F was very concerned with conserving water and had asked CNA #5 to turn her water off and CNA #5 had became upset. Resident F then asked CNA #9 and #10 to provide her care as CNA #5 had gave her a dirty look and was hateful and she did not want her providing care again.</p> <p>Resident F's clinical record was reviewed on 8/17/11 at 11:00 A.M. The MDS [Minimum Data Set] assessment, dated</p>						

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	<p>7/28/11, indicated Resident F had no problems with cognition. Resident F required limited assistance of one with bed mobility, extensive assistance of one with bathing and was dependent with toilet use.</p> <p>CNA #9 further indicated Resident D had told her, some time back, that CNA #5 was getting her up with a stand lift, and her foot fell off. When Resident D complained, CNA #5 accused her of whining and told Resident D not to ever ask her for anything again. CNA #9 indicated Resident D does not want CNA #5 providing care for her. She indicated this is not written anywhere, but just common knowledge among the CNA's.</p> <p>On 8/17/11 at 9:30 A.M., CNA # 5 was observed in a resident room providing care.</p> <p>3. During an interview with Resident D on 8/17/11 at approximately 10:30 A.M., she indicated CNA #5 had told her she did not like her, will not come into her room or do anything for her. She indicated if she asked for anything, CNA #5 would turn her head or just say, "No." Resident D indicated she had asked for milk, and CNA #5 looked at her and said "No." Resident D indicated she had told the HFA about this and the HFA brought CNA</p>				

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	<p>#5 into the room, and CNA #5 simply denied ever doing anything.</p> <p>Resident D's clinical record was reviewed on 8/17/11 at 1:00 P.M. The MDS [Minimum Data Set] assessment of 7/13/11, indicated Resident D had no problems with cognition. Resident D required extensive assistance of two with bed mobility, and dependent on two staff with transfers and toilet use.</p> <p>In an interview with Resident C, on 8/17/11 at 10:25 A.M., he was observed to be in bed with his cat beside him. He indicated CNA # 5 was very rough in handling him. He indicated CNA # 5 was very rude and talked down to him. He also indicated CNA # 6 had a chip on her shoulder and was mean during care. He further indicated he had reported this to the Administrator, but she didn't do anything. He indicated after reporting this to the Administrator, she had told him his pet cat that had lived with him at the facility for 5 years had to go. He indicated he had banned CNA # 5 from providing any care for him.</p> <p>The clinical record for Resident C was reviewed on 8/17/11 at 1:20 P.M. The record indicated Resident C had diagnoses that included but were not limited to chronic kidney disease and depression.</p>						

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	<p>The MDS [minimum data set] assessment, dated 6/15/11, indicated Resident C had no impairment in cognition. Resident C required extensive assistance of two with bed mobility and toilet use. The Nurse's Notes, dated 8/12/11 at 11:00 P.M., indicated "Asked me if I knew about his cat, was very upset about having to lose her."</p> <p>In an interview with Resident G, on 8/17/11 at 11:00 A.M., she indicated CNA # 5 was always talking down to me. She stated CNA # 5 would always make comments about her clothing and how she combed her hair. She stated "I didn't want her to talk to me that way. I want to do as much as I can for myself." She also indicated she was a minister, and she stated that RN # 1 had called her the devil. She was very upset and misty eyed and asked "Why would she do something like that? I am not a bad person."</p> <p>The MDS [Minimum Data Set] assessment, dated 7/13/11, indicated Resident G had moderately impaired cognition. Resident G was independent with bed mobility, transfers, and ambulation. Resident G required limited assistance of one with toilet use and personal hygiene.</p> <p>4. During interview with LPN #1, on</p>				

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	<p>8/17/11 at 11:15 A.M., she indicated she had told CNA #9 to tell the HFA when she got there that morning about the incident with CNA # 5 and Resident 'T'. She confirmed that CNA #5 was still working at that time. LPN #1 indicated she had only been working for 5 or 6 days and really did not know what the abuse protocol was. She indicated she just had not had a chance to attend general orientation.</p> <p>LPN #1's employee file was obtained from the Office Manager on 8/17/11 at 12:00 P.M. Documentation of training in the facility abuse protocol was lacking. The last 10 hired employees files were reviewed, on 8/17/11 at 1:00 P.M. Three of the 10 new employees had not been trained in the facility abuse protocol.</p> <p>5. During interview with the HFA on 8/17/11 at 11:30 A.M., she indicated the only other allegation of abuse that she was aware of was on a form she had found in DON #1's office (old DON who now is on leave and will return as a floor nurse). The HFA went to the Business Office Manager's office and returned with the three notes at this time. The HFA administrator indicated she had just found it lately and was starting an investigation. There were 3 notes stapled together. Note 1 written by CNA #3, dated 7/7/11,</p>				

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	<p>indicated: "Resident H's family member made complaint that CNA #7 was very rough and rude with Resident H last night. CNA #7 allegedly came in to put her to bed and said something along the lines of what do you think you are doing? When Resident H asked who she was talking about, CNA #7 said you know what you did. Resident H says that CNA #7 was easy about undressing her and preparing her for bed. Resident H's family member is very upset and would like to speak to HFA as soon as possible. According to her this was an issue in the past."</p> <p>Note 2- dated 8/16/11 2:20 p.m., written by the HFA indicated "Spoke with CNA #7 about this note, told her I was accusing [sic] her of anything, all CNA's are going to keep their resident dry and safe. She was ok when she left office."</p> <p>Note 3- written by CNA #7, no date, indicated, "FYI- CNA on days, every morning before I go home, I check my people second of all me and CNA #8 had split up sections I never leave any of my residents wet or dirty so you need to talk with someone else or don't accuse me of leaving anyone soaked because I don't do that." [sic]</p> <p>The HFA indicated on 8/17/11 at 11:30</p>				

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	<p>A.M., she had received no other reports of abuse. When asked about the allegations made by CNA #9 to her charge nurse and to the HFA that a.m., the HFA indicated she had not had time to investigate it yet. She further indicated she did not consider what was reported to her abuse. Nurse Consultant # 1 indicated it was considered abuse and CNA #5 would be sent home pending investigation. The HFA further indicated when she took over the facility it was a mess and she was trying to clean it up. She indicated she had not documented some of the things done because there was not time to look into things and document them. She indicated if she suspended all the staff accused of abuse there be no one to work.</p> <p>6. During interview with Resident A's family on 8/17/11 at 12:00 P.M., they indicated while visiting at supper time, RN #1 was heard to be very hateful with Resident A. The family of Resident A further indicated yesterday (8/16) they had heard CNA #5, yell at Resident L to get back in the bed and she would get to her when she could. The family further indicated Resident M was a longtime friend of their family. Resident A's family had given a phone number for them to Resident M. This was taken away by the HFA and Resident M told she was not allowed to have the number or call the</p>				

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	<p>family. The family of Resident A indicated Resident M was scared to talk about it now and they had provided the number again and told her to keep it hid.</p> <p>7. On 8/17/11 at 2:00 P.M., CNA # 10 provided a written statement, dated 8/17/11, which indicated "To whom it may concern, I (CNA # 10's name) saw CNA # 1 handle Resident (Resident J's name) in an unprofessional manner. She was rough when turning resident, didn't explain what she was doing to the resident, left B.M. [bowel movement] on bed and resident. We were doing walk thru at shift change. She also treated (Resident K's name) in room (number) the same way, never explained what was going on with them, turned him and changed him in a rough manner, again no peri care. I had to go behind her after she left and clean said residents. This is before I left in July 2011 (for vacation)..." During interview with CNA #10 at this same time, she indicated this had been reported to the HFA, and was before CNA #1 was suspended for other allegations of abuse.</p> <p>8. The Health Facility Administrator provided, on 8/17/11 at 11:00 A.M., the last inservice provided on abuse to facility staff. The inservice was dated 3/25/11. CNA #2, PTA #1, CNA #6, CNA #9,</p>						

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	<p>CNA#7 and DON #1 had all signed as having attended. CNA#1 and CNA # 5 were not documented to have attended.</p> <p>The Abuse Prevention Program, policy and procedure, dated 8/2006, provided by the Health Facility Administrator, on 8/17/11 at 10:00 A.M., indicated, "Abuse Reporting...will have no tolerance with anyone not reporting and following the 7 steps of abuse, neglect and exploitation...when any allegation or confirmed abuse occurs, the appropriate state agencies need to be notified, and the DON and Administrator...need to check and see if this or any other thing has happened to any other resident...With any allegation or suspected or witnessed abuse every employee has a legal obligation to report the occurrence."</p> <p>The Abuse policy, dated 3/11, for Protocols for investigating, included: "Any employee who suspects an alleged violation shall notify the HFA/ DNS (Director of Nursing Services) ...immediately...the facility will investigate each allegation thoroughly and report the results to the HFA...the DNS shall notify the residents representative regarding the alleged incident. Inform the representative that an investigation has been initialed and appropriate actions will be taken...document this contact in the</p>				

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	<p>clinical record...if the suspect is an employee, they shall be placed on immediate suspension pending the results of the investigation...if the allegation involves physical abuse...a background check will be conducted to determine if any disqualifying offenses have occurred since the previous check...The investigation shall include interviews of employee, visitors or residents who may have knowledge of the alleged incident. Written documentation will be kept of each interview taken. The employee, resident or visitor may write their own report if desired...written statements form involved parties should be based on facts not opinions...training -orientation and ongoing in service training."</p> <p>The Immediate Jeopardy that began on 6/22/11 was removed on 8/19/11, when the facility demonstrated policies and procedures had been put in place to ensure staff were knowledgeable concerning the prevention of abuse, but noncompliance remained at the lowered scope and severity of widespread, at no actual harm, with potential for more than minimal harm, that is not immediate jeopardy.</p> <p>This federal tag relates to Complaint IN00094518.</p>				

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F0490 SS=L	<p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on interview, record review and observation, the facility failed to ensure the health facility administrator responded to allegations and reports of resident abuse immediately by initiating an investigation, protecting residents during the investigation by not allowing accused staff members to continue working, reporting all allegations to the state agency, and documenting all allegations, for 7 of 13 residents reviewed for abuse. This had the potential to affect all 30 residents residing within the facility. Residents D, B, I, C, H, J, and K</p> <p>The Immediate Jeopardy began on 6/22/11 when a staff member alleged abuse was occurring in the facility. The</p>	F0490	<p><b>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F 490 Administration</b></p> <p>(a)What corrective action(s) will be accomplished for those been affected by the practice: #1 Resident #D and #B allegations of verbal abuse were reported to IDOH as required on 8/17 and 8/18/11. C.N.A's #1 and #2 was terminated prior to survey. Resident #B allegations of verbal abuse was submitted to ISDH on 6/29/11 – however upon further investigation an addendum was submitted on 8/17/11 to the ISDH</p>	08/26/2011	

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	<p>HFA did not immediately suspend staff members accused of abuse or complete a thorough investigation of the allegation. The HFA did not document or investigate residents' complaints against staff members thoroughly, nor insure all staff were aware of the policy and procedure for allegations of abuse. The Corporate Registered Nurse Consultant was notified of the Immediate Jeopardy at 1:00 P.M. on 8/17/11. The immediate jeopardy was removed on 8/19/11, but noncompliance remained at the lower scope and severity level of widespread, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings include:</p> <p>1. During interview with the Health Facility Administrator (HFA) on 8/17/11 at 9:15 A.M., she indicated she had reported an allegation of abuse to the state agency and provided the documentation she had faxed in as well as the investigation of the allegations. She indicated the two Certified Nursing Assistants, CNA #1 and CNA #2, involved had been fired. She indicated she had no documentation of an inservice provided to staff members and had not obtained statements from all staff members who had worked with the two CNA's accused of abuse. She indicated</p>		<p>of physical mistreatment that had been reported by another staff member #2 C.N.A #5 was suspended pending investigation. C.N.A #6 was suspended pending investigation. Resident # D and #C allegations of verbal abuse was reported to ISDH as required on 8/17 and 8/18/11. #4 LPN #1 was educated on the facility standards and guidelines for reporting and investigation of abuse neglect (verbal and physical) and exploitation Re-education on the facility standards and guidelines for reporting and investigation of abuse neglect (verbal and physical) and exploitation for current staff on duty was immediately begun - 8/17/11. #5 Resident H allegations of verbal abuse were reported to ISDH as required on 8-17-11 C.N.A #7 was suspended pending investigation. #6 Resident # J and #K allegations was reported to ISDH as required on 8-17 and 8-18-11 C.N.A #1 was terminated prior to survey. #7 Staff member(s) who failed to report event(s) of alleged abuse (verbal/physical) so they could be investigated and reported according to facility, state, and federal requirements have been suspended pending outcome of facility investigation. Also, any alleged perpetrator has been suspended pending investigation. Administrator was suspended until outcome of the investigation but chose to resign</p>		

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	<p>she knew her staff and knew no one else was abusing anyone. She had talked with each staff member one on one about the policy for abuse, just had not written anything down. The HFA indicated when she had become aware of the situation, she had told the Director of Nursing (DON) to suspend CNA #1, but she found out a couple days later she had suspended CNA #2. The HFA indicated the DON had told her CNA #2 was also involved and that was the first the HFA knew about CNA#2's involvement. She indicated both CNA's were fired, CNA #1 for abuse and CNA #2 for witnessing it and not reporting it. The HFA indicated that was the company policy. The HFA indicated she could not remember when either of the CNA's were suspended but would try to find the dates.</p> <p>The incident reporting form, 5 day follow-up, dated as having been faxed, 6/29/11 at 12:47 P.M., indicated "Reported by: HFA name, Resident B, Diagnoses: Alzheimer's, Diabetes Mellitus. Brief Description of Incident: Reported by CNA #3 that CNA #1 was rude and used excessive force when moving resident on or around 6/23/11. Immediate Action Taken: Suspension of employee. Resident assessed and reinterpreted [sic]. Initiated interviews for other alert and oriented residents.</p>		<p>effectively immediately on 8/17/11. Primary physician and responsible parties were notified 8/17 &amp; 8/18/11 of alleged incident or allegations. The Federal Immediate was completed and report as instructed. <b>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b> Residents who are cognitively intact were interviewed using the QIS Interview Process for Abuse to determine if any allegations of abuse (verbal and/or physical) had not been reported or reported to someone within the facility and not acted upon. Non-interviewable residents had a call placed to their responsible party/guardian/POA, etc., and where interviewed using the QIS Family interview process with a focus on the Abuse section to determine if any allegations of abuse (verbal and/or physical) had not been reported or reported to someone within the facility and not acted upon. Any issues identified where immediately addressed, investigated and reported according to facility, state, and federal requirements. (c)What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Facility Management Staff has been re-educated on the timely reporting of any allegations, suspicion, or witnessed ANE</p>		

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	<p>Preventative measures taken: ANE (abuse/neglect) inservice schedule. Follow up-unable to substantiate, CNA #1 denies the allegations and with interviews could not substantiate the report. Employee has been terminated."</p> <p>Statements obtained from staff members included: "CNA #4, dated 6/29/11, Just to bring to attention that (CNA #2 name) in my personal opion [sic] is a little aggressive with personal care to residents. Maybe a fast turn her [sic] or a little bit hard to the other side. [sic] I personally would not have her take care take of my grandma."</p> <p>Another note from CNA #4, dated 6/29/11, "Back when name of Resident D was put on fluid restriction, she was wanting more to drank [sic] there was some confusion with whether or not she could have more. She, Resident D, asked for a glass of milk, the nurses said it was ok, CNA #1 then brought her 2 glasses of milk sat them on the table in front of her and said something to this effect if she wants to kill herself let her go ahead and drink all that she wants."</p> <p>During interview with CNA #4, on 8/18/11 at 2 p.m., she indicated CNA #1 had said within the hearing of Resident D to the effect of "go ahead and kill yourself its ok with me." CNA #4</p>		<p>including sexual misconduct to the appropriate agencies including law enforcement. A comprehensive in-service was conducted facility wide to re-educate staff members on what constitutes Abuse. Staff members were also re-educated and made aware of their responsibility to report any allegation of Abuse/misconduct to the Administrator and Abuse Coordinator immediately. Staff has bee re-educated on the Unusual Occurrence Hotline 317-233-5359 number in common areas of the facility, and handheld Code Cards have been issued to staff. The 24-hour nursing report form will be another means to communicate to the administrative staff any unusual occurrences that have been identified or reported on their unit. (d)How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Regional Director of Operations and/or the Regional Director of Clinical Operations will review at a minimum of two times weekly, for the next 4 weeks then two times monthly for 2 months - all event reports and grievance submitted to determine if any fall under ANE, and to determine that follow up was in accordance to our state and federal reporting guidelines. Any deviation from the above POC will be dealt with</p>		

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	<p>indicated she did not report it at the time because a charge nurse heard it, too. CNA #4 could not remember what nurse for sure but thought it was DON #1. CNA #4 indicated she wrote the statements concerning CNA #1 and #2 on 6/29/11, because the HFA asked her to document anything she knew had occurred with those CNA's.</p> <p>A written statement, from CNA #3, dated June 29, 2011, indicated " I have witnessed CNA #2 and CNA #1 use excessive force on Resident B while tending to him. I have also been a witness to CNA #1 speaking very rudely to him. I have not witnessed either of them strike Resident B, but there was an occurrence when I believe I heard CNA #1 slap Resident B in his room while my back was turned. I asked CNA #1 what happened immediately after. She was defensive and said he wouldn't let go of me. She never confirmed or denied slapping Resident B."</p> <p>A written statement from PTA #1, dated 7/18/11, indicated, "I received a call from CNA #3 on 7/18/11 at approximately 9 p.m. in regards to repeated phone calls from CNA #1 and CNA #2...CNA #3 told me that they had been harassing her and threatening to find her and harm her. She also informed me that CNA #2 had told</p>		<p>immediately, for either further education and/or disciplinary action if needed. Reports of these findings will be presented to the monthly QA/Risk Management meeting to determine that compliance has been met. (e) <b>Date of compliance: 8/26/11</b></p>		

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	<p>her that she was going to call corporate and tell them that she had caught us having sex in the building to try and get us (me and CNA #3) fired, since we had according to CNA #2 gotten her and CNA #1 fired. So today I addressed this with HFA...."</p> <p>During interviews with PTA #1 on 8/17/11 at 9:30 A.M. and 2:30 P.M., he indicated CNA #3 told him, while riding in a car, that CNA #2 had punched a resident in the face. He indicated CNA #3 later changed it the CNA #1. PTA #1 indicated this was on a Friday night, he thought 6/22, because there was a going away party for a nurse he and other staff members attended. He indicated he told the DON on Sunday when he came to work as he did not work on Saturday. PTA #1 indicated he remembered talking to the HFA about this on he believed Monday, but did not write anything down and was not asked to write a statement. PTA #1 indicated he thought the HFA then had CNA #3 write something up the next time she was at work.</p> <p>The HFA provided employee counseling forms on 8/17/11 at 10:00 A.M. The HFA further indicated at this time, the DON had not called her on 6/24/11 and told her about the PTA's report of allegations made by CNA #3 on 6/22/11. the employee</p>				

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	<p>counseling form, dated 6/29/11, for CNA #1 indicated "Suspension 2 or 3 days, upon investigation, reported by CNA that CNA #1 was very rude and used excessive force while moving resident on or around 6/23/11. CNA did not witness either CNA which was CNA #2, strike the resident but she believes she heard a slap to slap. CNA #1 did not deny slapping resident. State report filed 6/29/11." Another form, dated 7/1/11, for CNA #1, indicated "Discharge due to speaking with Residents and staff members. I have decided to Discharge CNA #1."</p> <p>An employee counseling form for CNA #2, dated 7/1/11, indicated "discharge, excessive force when moving residents, also not reporting to DON or HFA. CNA #2 used excessive force when moving resident, also did not report team member who also used excessive force when moving a resident-this was a state reportable on 6/29/11. I gave a 3 day suspension for investigation of this matter." No date as to when the 3 day suspension was documented.</p> <p>The facility Office Manager, on 8/18/11 at 1:00 P.M., indicated CNA#1 worked 6/23, 25, 26, 29 with her last day to work as 6/30/11. CNA #2 worked 6/22, 26, with the last day to have worked, 6/27/11.</p>						

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	<p>The facility lacked evidence of having reported rough treatment of Resident B by CNA #2 to the state agency, having immediately reported or investigated the allegations or documented the statements made by staff members.</p> <p>In an in interview with Resident B's spouse, on 8/17/11 at 12:30 P.M., she indicated she had not been informed of the alleged abuse to Resident B. She stated a CNA had let this slip to her one day. She stated the CNA had said "I can't believe you didn't move your husband." She stated when I asked her why she said that the CNA said "you didn't know about CNA # 1 slapping him?" She stated she then went to speak to the Administrator and the Director of Nursing and got two different stories of the incident.</p> <p>The clinical record for Resident B was reviewed on 8/17/11 at 9:30 A.M. The record indicated Resident B had diagnoses that included but were not limited to Alzheimer's disease, anxiety and depression. The MDS [Minimum Data Set] assessment, dated 7/6/11, indicated Resident B had short and long term memory problems and severely impaired decision making. Resident B required extensive assistance of one with bed mobility, and extensive assistance of two with transfers and toilet use.</p>			

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	<p>2. During interview with CNA #9 on 8/17/11 at 10:15 A.M., CNA #9 indicated she had reported to her charge nurse and the HFA that morning (8/17), what she thought was abuse that she observed the day before (8/16). CNA #9 indicated on 8/16/11, her and CNA #6 heard Resident 'T' screaming from the shower room. CNA #9 indicated CNA #5 had been giving the resident a shower, but had left her alone in the shower room without a call bell. CNA #9 indicated her and CNA #6 went to see what was wrong and had dressed Resident 'T' and transferred her to her chair. CNA #9 indicated CNA #5, upon returning to the shower room, had asked them what they were doing. When they (CNA #9 and #6) told CNA #5 the resident had been screaming and they went to see what was wrong, CNA #5 went into the hall and told the resident 'Don't you never ever start screaming like that again.'"</p> <p>CNA #9 indicated she told her charge nurse, LPN #1 this morning, 8/17/11. She indicated LPN #1 told her to go tell the HFA when she (the Administrator) got to the facility, which she had done and provided the HFA a write up on it. CNA #9 was observed working in the facility on 8/17/11 at 11:00 A.M.</p> <p>During an interview with Resident D on 8/17/11 at approximately 10:30 A.M., she</p>						

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	<p>indicated CNA #5 had told her she did not like her, will not come into her room or do anything for her. She indicated if she asked for anything, CNA #5 would turn her head or just say, "No." Resident D indicated she had asked for milk, and CNA #5 looked at her and said "No." Resident D indicated she had told the HFA about this and the HFA brought CNA #5 into the room, and CNA #5 simply denied ever doing anything.</p> <p>Resident D's clinical record was reviewed on 8/17/11 at 1:00 P.M. The MDS [Minimum Data Set] assessment of 7/13/11, indicated Resident D had no problems with cognition. Resident D required extensive assistance of two with bed mobility, and dependent on two staff with transfers and toilet use.</p> <p>In an interview with Resident C on 8/17/11 at 10:25 A.M., he was observed in bed with his cat beside him. He indicated CNA # 5 was very rough in handling him. He indicated CNA # 5 was very rude and talked down to him. He also indicated CNA # 6 had a chip on her shoulder and was mean during care. He further indicated he had reported this to the Administrator, but she didn't do anything. He indicated after reporting this to the Administrator, she had told him his pet cat that had lived with him at the facility for 5 years had to go. He indicated he had</p>						

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	<p>banned CNA # 5 from providing any care for him.</p> <p>The clinical record for Resident C was reviewed on 8/17/11 at 1:20 P.M. The record indicated Resident C had diagnoses that included but were not limited to chronic kidney disease and depression. The MDS [Minimum Data Set] assessment, dated 6/15/11, indicated Resident C had no impairment in cognition. Resident C required extensive assistance of two with bed mobility and toilet use. The Nurse's Notes, dated 8/12/11 at 11:00 P.M., indicated "Asked me if I knew about his cat, was very upset about having to lose her."</p> <p>On 8/17/11 at 9:30 A.M., CNA # 5 was observed in a resident room providing care.</p> <p>4. During interview with LPN #1, on 8/17/11 at 11:15 A.M., she indicated she had told CNA #9 to tell the HFA when she got there that morning about the incident with CNA # 5 and Resident 'I'. She confirmed that CNA #5 was still working at that time. LPN #1 indicated that she had only been working for 5 or 6 days and really did not know what the abuse protocol was. She indicated she just had not had a chance to attend general orientation.</p>			

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	<p>LPN #1's employee file was obtained from the Office Manager on 8/17/11 at 12:00 P.M. Documentation of training in the facility abuse protocol was lacking. The last 10 hired employees files were reviewed, on 8/17/11 at 1:00 P.M. Three of the 10 new employees had not been trained in the facility abuse protocol.</p> <p>5. During interview with the HFA on 8/17/11 at 11:30 A.M., she indicated the only other allegation of abuse that she was aware of was on a form she had found in DON #1's office (old DON who now is on leave and will return as a floor nurse). The HFA went to the Business Office Manager's office and returned with the three notes at this time. The HFA indicated she had just found it lately and was starting an investigation. There were 3 notes stapled together.</p> <p>Note 1 written by CNA #3, dated 7/7/11, indicated: "Resident H's family member made complaint that CNA #7 was very rough and rude with Resident H last night. CNA #7 allegedly came in to put her to bed and said something along the lines of what do you think you are doing? When Resident H asked who she was talking about CNA #7 said you know what you did. Resident H says that CNA #7 was easy about undressing her and preparing</p>			

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	<p>her for bed. Resident H's family member is very upset and would like to speak to HFA as soon as possible. According to her this was an issue in the past."</p> <p>Note 2- dated 8/16/11 2:20 p.m., written by the HFA indicated "Spoke with CNA #7 about this note, told her I was accusing [sic] her of anything, all CNA's are going to keep their resident dry and safe. She was ok when she left office."</p> <p>Note 3- written by CNA #7, no date, indicated "FYI- CNA on days, every morning before I go home I check my people, second of all me and CNA #8 had split up sections I never leave any of my residents wet or dirty so you need to talk with someone else or don't accuse me of leaving anyone soaked because I don't do that." (sic)</p> <p>The HFA indicated on 8/17/11 at 11:30 A.M., she had received no other reports of abuse. When asked about the allegations made by CNA #9 to her charge nurse and to the HFA that a.m., the HFA indicated she had not had time to investigate it yet. She further indicated she did not consider what was reported to her abuse. Nurse Consultant #1 indicated it was considered abuse and CNA #5 would be sent home pending investigation. The HFA further</p>				

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	<p>indicated when she took over the facility it was a mess and she was trying to clean it up. She indicated she had not documented some of the things done because there was not time to look into things and document them. She indicated if she suspended all the staff accused of abuse there be no one to work.</p> <p>6. On 8/17/11 at 2:00 P.M., CNA # 10 provided a written statement, dated 8/17/11, which indicated "To whom it may concern, I (CNA # 10's name) saw CNA # 1 handle Resident (Resident J's name) in an unprofessional manner. She was rough when turning resident, didn't explain what she was doing to the resident, left B.M. [bowel movement] on bed and resident. We were doing walk thru at shift change. She also treated (Resident K's name) in room (number) the same way, never explained what was going on with them, turned him and changed him in a rough manner, again no peri care. I had to go behind her after she left and clean said residents. This is before I left in July 2011 (for vacation)..." During interview with CNA #10 at this same time, she indicated this had been reported to the HFA, and was before CNA #1 was suspended for other allegations of abuse.</p> <p>7. During interview with the RN Nurse</p>				

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	<p>consultant on 8/17/11 at 1:00 P.M., she indicated the HFA had just left the facility and quit without notice.</p> <p>The Abuse Prevention Program, policy and procedure, dated 8/2006, provided by the Health Facility Administrator, on 8/17/11 at 10:00 A.M., indicated, "Abuse Reporting...will have no tolerance with anyone not reporting and following the 7 steps of abuse, neglect and exploitation...when any allegation or confirmed abuse occurs, the appropriate state agencies need to be notified, and the DON and Administrator...need to check and see if this or any other thing has happened to any other resident...With any allegation or suspected or witnessed abuse every employee has a legal obligation to report the occurrence.</p> <p>The Abuse policy, dated 3/11, for Protocols for investigating, included: "Any employee who suspects an alleged violation shall notify the HFA/ DNS (director of nursing services)...immediately...the facility will investigate each allegation thoroughly and report the results to the HFA...the DNS shall notify the residents representative regarding the alleged incident. Inform the representative that an investigation has been initialed and appropriate actions will be taken...document this contact in the clinical record...if the suspect is an</p>				

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	<p>employee, they shall be placed on immediate suspension pending the results of the investigation...if the allegation involves physical abuse...a background check will be conducted to determine if any disqualifying offenses have occurred since the previous check...The investigation shall include interviews of employee, visitors or residents who may have knowledge of the alleged incident. Written documentation will be kept of each interview taken. The employee, resident or visitor may write their own report if desired...written statements from involved parties should be based on facts not opinions...training -orientation and ongoing in service training."</p> <p>The Immediate Jeopardy that began on 6/22/11 was removed on 8/19/11, when the facility demonstrated policies and procedures had been put in place to ensure staff were knowledgeable concerning the duties of the facility administration, but noncompliance remained at the lowered scope and severity of widespread no actual harm, with potential for more than minimal harm, that is not immediate jeopardy.</p> <p>This federal tag relates to Complaint IN00094518.</p>			

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

PRINTED: 09/08/2011

FORM APPROVED

OMB NO. 0938-0391

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