

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/28/2014
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NAME OF PROVIDER OR SUPPLIER RANDOLPH NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S OAK ST WINCHESTER, IN 47394
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F000000	<p>This visit was for the Investigation of Complaint # IN00153377.</p> <p>Complaint # IN00153377 - Substantiated with deficiencies cited at F 225 and F 226.</p> <p>Survey Date: July 28, 2014</p> <p>Facility Number: 000136 Provider Number: 155231 AIM Number: 100275450</p> <p>Surveyor: Debora Barth, RN</p> <p>Census Bed Type: SNF/NF: 74 Total: 74</p> <p>Census Payor Type: Medicare: 7 Medicaid: 50 Other: 17 Total: 74</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on July 31, 2014, by Janelyn Kulik, RN.</p>	F000000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular does not constitute an admission or agreement by Randolph Nursing Home of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and /or executed in compliance with State and Federal laws. Randolph Nursing Home is requesting paper compliance.	

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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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and</p>			
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	<p>certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to thoroughly investigate and report an allegation of abuse for 1 of 2 residents receiving services from a Level II service provider. (Resident H)</p> <p>Findings include:</p> <p>Interview with LPN # 1, on 7/28/14 at 3:20 p.m., indicated he had received a phone call from an area Level II Service provider on 7/22/14 around 4:30 p.m. He indicated the provider had allegedly witnessed a staff person at the facility, she didn't know his name, slap a resident on the bottom. She indicated the CNA was taking Resident H to assist him with toileting. She left the room and returned while the resident and staff were in the bathroom. She indicated to LPN # 1 that she had opened the bathroom doors and saw CNA # 2 slap the resident on the bottom three times repeatedly - not hard. She indicated the staff person had told her that he did that to "hurry the residents." LPN # 1 indicated, after the report, that he had removed the only male staff member from providing care and called the Director of Nursing (DoN). The DoN told him to inservice the staff,</p>	F000225	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A complete investigation for alleged abuse was conducted for resident H. No other residents were affected. Resident H was assessed with no findings. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No other residents were affected by this deficient practice. All interviewable residents were interviewed and asked if they had been abused, seen abuse, or if they were afraid of anyone with no concerns identified. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All staff attended an in-service on 7/29/14 on the abuse policy and reporting. Each employee then signed the abuse policy and a copy placed in their employee file. The staff will notify the Executive Director of all allegations of abuse and ED, designee will report the allegation to the ISDH. The Regional Director of Operations educated and reinforced with the ED and Director of Nursing reporting</p>	08/27/2014

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	<p>including the male staff person, to not hurry the residents and have the staff all sign an attendance sheet. He did this, then allowed CNA # 2 to return to work, as directed by the DoN. LPN # 1 indicated no other residents made any complaints about CNA # 2 or any other staff at the facility.</p> <p>Residents H, K, L, and M were all interviewed on 7/28/14. None of the residents indicated a fear of any staff or that they had been abused by any staff.</p> <p>Interview with the next of kin for Resident H, on 7/28/14 at 2:45 p.m., indicated she had not been informed of any staff concerns at the facility.</p> <p>CNA # 2 was interviewed at 3:00 p.m. on 7/28/14. He indicated he had patted Resident H on the back to reassure him. He indicated that Resident H had a fear of falling and patting him gave him knowledge of how close help was and he didn't have to worry about falling. He also indicated the Level II staff could not have seen anything that went on in the bathroom because the doors were closed. He indicated he had been inserviced on 7/22/14 by LPN # 1 not to hurry residents in any way. He indicated he had no intent to hurt Resident H or any of his other residents that he provided care.</p>		<p>requirements. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; All allegations of abuse will be monitored by the ED, designee for investigating and reporting to ISDH. Abuse allegations will be reviewed monthly by the Quality Assurance Committee (QAC) for further recommendations for 6 months.</p>	

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	<p>Interview with the Administrator, on 7/28/14 at 2:30 p.m., indicated she had heard that CNA # 2 had been reported for abuse. She indicated the DoN had taken care of the report on 7/22/14 in the afternoon. She indicated the DoN had established there was no intent of harm and so had not carried the investigation any further. The allegation had not been reported to the state agency. She indicated since the survey had started, she had put together an investigation of the incident. She presented a signed statement from CNA # 2, dated 7/22/14. She also presented his orientation to the facility policies for Abuse prevention and recognition. She presented a skin sheet assessment of Resident H, dated 7/23/14, when he had received his next bath after the incident. The skin sheet indicated there were no new areas of concern on the skin for Resident H. She indicated the DoN had started an investigation of the incident on 7/22/14, but the Administrator was unable to locate it and the DoN was unavailable on 7/28/14 for interview or questioning.</p> <p>The clinical record for Resident H was reviewed on 7/28/14 at 1:15 p.m. The resident had diagnoses which included, but were not limited: anemia, hypothyroidism, history of pulmonary</p>			

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	<p>emboli, benign prostatic hypertrophy and moderate mental retardation. There was no documentation of the incident in the resident's record.</p> <p>The facility policy, dated 8/8/13, titled Abuse, Neglect, and Misappropriation of Property was presented by the Administrator on 7/28/14 at 3:30 p.m. It indicated:</p> <p>"Purpose: Prevent abuse, neglect and misappropriation of property. ...Training: ...3. Staff members will identify and assess suspected or alleged reports of abuse and neglect...</p> <p>"Identification: 1. Staff will immediately report any suspicious event that may constitute abuse or neglect. 2. The facility will report the allegation to the State Agency in accordance with state law...</p> <p>"Investigation: 1. The facility will conduct an internal investigation and report the results of the investigation to the enforcement agency in accordance with state law including the state survey and certification agency within five working days of the incident or according to state law. 2. The facility will thoroughly investigate all alleged</p>						

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F000226 SS=D	<p>violations and take appropriate actions...."</p> <p>3.1-28(c) 3.1-28(d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 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 and record review, the facility failed to follow their policies for abuse prevention in regard to investigating and reporting an allegation of abuse for 1 of 3 residents reviewed for possible abuse allegations. (Resident H)</p> <p>Findings include:</p> <p>Interview with LPN # 1, on 7/28/14 at 3:20 p.m., indicated he had received a phone call from an area Level II Service provider on 7/22/14 around 4:30 p.m. He indicated the provider had allegedly witnessed a staff person at the facility, she didn't know his name, slap a resident on the bottom. She indicated the CNA was taking Resident H to assist him with toileting. She left the room and returned</p>	F000226	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Incident report for Resident H was completed and submitted to ISDH on 7/28/14. No other resident was affected. Resident H was assessed with no findings.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All interviewable residents were interviewed with no concerns for abuse identified</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All staff attended an in-service on 7/29/14 on the abuse policy and reporting. Each employee then</p>	08/27/2014

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	<p>while the resident and staff were in the bathroom. She indicated to LPN # 1 that she had opened the bathroom doors and saw CNA # 2 slap the resident on the bottom three times repeatedly - not hard. She indicated the staff person had told her that he did that to "hurry the residents." LPN # 1 indicated, after the report, that he had removed the only male staff member from providing care and called the Director of Nursing (DoN). The DoN told him to inservice the staff, including the male staff person, to not hurry the residents and have the staff all sign an attendance sheet. He did this, then allowed CNA # 2 to return to work, as directed by the DoN. LPN # 1 indicated no other residents made any complaints about CNA # 2 or any other staff at the facility.</p> <p>Residents H, K, L, and M were all interviewed on 7/28/14. None of the residents indicated a fear of any staff or that they had been abused by any staff.</p> <p>Interview with the next of kin for Resident H, on 7/28/14 at 2:45 p.m., indicated she had not been informed of any staff concerns at the facility.</p> <p>CNA # 2 was interviewed at 3:00 p.m. on 7/28/14. He indicated he had patted Resident H on the back to reassure him.</p>		<p>signed the abuse policy and a copy placed in their employee file. The staff will notify the ED of all allegations of abuse and the ED, designee will report and investigate the allegation to the ISDH. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; All staff members and all interviewable residents will be interviewed on a monthly basis regarding abuse and abuse policy by the Staff Development Coordinator times 6 months with results presented to monthly QAC for further review and recommendations.</p>	

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	<p>He indicated that Resident H had a fear of falling and patting him gave him knowledge of how close help was and he didn't have to worry about falling. He also indicated the Level II staff could not have seen anything that went on in the bathroom because the doors were closed. He indicated he had been inserviced on 7/22/14 by LPN # 1 not to hurry residents in any way. He indicated he had no intent to hurt Resident H or any of his other residents that he provided care.</p> <p>Interview with the Administrator, on 7/28/14 at 2:30 p.m., indicated she had heard that CNA # 2 had been reported for abuse. She indicated the DoN had taken care of the report on 7/22/14 in the afternoon. She indicated the DoN had established there was no intent of harm and so had not carried the investigation any further. The allegation had not been reported to the state agency. She indicated since the survey had started, she had put together an investigation of the incident. She presented a signed statement from CNA # 2, dated 7/22/14. She also presented his orientation to the facility policies for Abuse prevention and recognition. She presented a skin sheet assessment of Resident H, dated 7/23/14, when he had received his next bath after the incident. The skin sheet indicated there were no new areas of concern on</p>			

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	<p>the skin for Resident H. She indicated the DoN had started an investigation of the incident on 7/22/14, but the Administrator was unable to locate it and the DoN was unavailable on 7/28/14 for interview or questioning.</p> <p>The clinical record for Resident H was reviewed on 7/28/14 at 1:15 p.m. The resident had diagnoses which included, but were not limited: anemia, hypothyroidism, history of pulmonary emboli, benign prostatic hypertrophy and moderate mental retardation. There was no documentation of the incident in the resident's record.</p> <p>The facility policy, dated 8/8/13, titled Abuse, Neglect, and Misappropriation of Property was presented by the Administrator on 7/28/14 at 3:30 p.m. It indicated:</p> <p>"Purpose: Prevent abuse, neglect and misappropriation of property. ...Training: ...3. Staff members will identify and assess suspected or alleged reports of abuse and neglect...</p> <p>"Identification: 1. Staff will immediately report any suspicious event that may constitute abuse or neglect. 2. The facility will</p>			

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	<p>report the allegation to the State Agency in accordance with state law...</p> <p>"Investigation: 1. The facility will conduct an internal investigation and report the results of the investigation to the enforcement agency in accordance with state law including the state survey and certification agency within five working days of the incident or according to state law. 2. The facility will thoroughly investigate all alleged violations and take appropriate actions. 3. Investigations will be prompt, comprehensive and responsive to the situation and contain founded conclusions. The investigation will include, but is not limited to the following: a. Notification of physician and family; b. Identification and removal of the alleged person or persons; c. Type of alleged abuse; d. Where and when the incident occurred; e. Interviews and or written statements from individuals with first-hand knowledge of the incident; f. Follow-up resolution; g. Measures to prevent repeat incidents; h. All material and documentation of the pertinent data to the investigation is collected, maintained, and safeguarded by the facility; i. Notification of such information and it's release to the proper authorities will be legally required...."</p>						

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