

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155428	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/06/2012
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NAME OF PROVIDER OR SUPPLIER  MERIDIAN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2102 S MERIDIAN ST INDIANAPOLIS, IN 46225
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F0000	<p>This visit was for the investigation of complaints IN00107748 and IN00108157.</p> <p>Complaint IN00107748 Substantiated - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00108157 - Unsubstantiated due to lack of evidence.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates June 2, 4 &amp; 6, 2012</p> <p>Facility number: 000386 Provider number: 155428 AIM number: 100286820</p> <p>Survey team: Mary Jane G. Fischer RN</p> <p>Census Bed Type: SNF/NF: 32 Total: 32</p> <p>Census Payor Type: Medicare: 1 Medicaid: 29 Other: 2 Total: 32</p> <p>Sample: 4</p>	F0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 6/11/12 by Suzanne Williams, RN</p>			

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, interview and record review, the facility failed to ensure</p>	F0225	Preparation and/or execution of this	07/06/2012			

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	<p>an allegation of abuse was reported immediately, in that when facility staff had knowledge of a suspicious sexual remark by another staff member [employee #14] toward a dependent resident [Resident "D"], the staff members failed to immediately report the incident to the Administrator. The Administrator failed to report the allegation to the State Agency and other local authorities regarding the investigation of an allegation involving a resident. [Resident "D"]. This deficient practice affected 1 of 4 residents reviewed for abuse in the sample of 4.</p> <p>Findings include:</p> <p>The record for Resident "D" was reviewed on 06-04-12 at 11:00 a.m. Diagnoses included, but were not limited to, traumatic brain injury, depressive disorder, seizure disorder and anxiety. These diagnoses remained current at the time of the record review.</p> <p>During interview on 06-04-12 at 1:25 p.m. Certified Nurses Aide employee #3 indicated, "I heard that the Activity Assistant said [resident "D"]'s 'thing' was big. The door was open. I think it's all talk - nothing happened." When interviewed if the Administrator had been notified, the employee indicated "no."</p>		<p><b>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.</b></p> <p><b>F-225 Staff Treatment of Residents</b> <b>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</b></p> <ul style="list-style-type: none"> <li>· Staff member (employee # 14) was suspended pending the outcome of the investigation, and allegation of abuse was reported immediately on 6/4/12.</li> <li>· Resident #D was interviewed – and has no knowledge of the alleged allegation.</li> <li>· The Federal Immediate Report was submitted to ISDH on 6/4/12. The facility after investigation and interview with Resident #D was unable to substantiate the allegations of abuse.</li> <li>· The Facility Management and Staff were re-educated on the facility standards and guidelines for timely reporting of any allegations of abuse neglect and exploitation.</li> <li>· Administrator was 1:1 inserviced on necessary steps in reportable process per ISDH regulations and standards by Regional Director.</li> <li>·</li> </ul> <p><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 to determine if any allegations of abuse had been reported according to facility, state, and federal requirements in a timely manner. Residents who are cognitively impaired had calls made to their responsibility</p>				

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	<p>During interview on 06-04-12 at 2:05 p.m., Certified Nurses Aide employee #12 indicated "I was in the dining room; me, [name of Certified Nurses Aide employee #13], and a housekeeper. [Name of employee #13] said [name of Resident "D"] told him that [name of the Activity Assistant] [explicit sexual action] with [resident's] privates." When interviewed if she had notified the Administrator, the Certified Nurses Aide employee #12 indicated, "No I didn't report it, but I know I should have."</p> <p>During interview on 06-04-12 at 2:15 p.m., Certified Nurses Aide employee #13 indicated "They called me at home about it. [Name of Activity Assistant] walked in [Resident "D"]'s room, and [name of Resident "D"] took his thing out of [resident] pants. [Name of Activity Assistant] told another CNA to go and take care of [name of Resident "D"]." When further interviewed, Certified Nurses Aide employee #13 indicated he talked to the Administrator about the incident.</p> <p>During interview on 06-04-12 at 3:00 p.m., the Administrator indicated she was made aware of an incident which occurred "sometime the previous week," but had not been informed by facility staff until</p>		<p>party to identify any allegation(s) of abuse. In addition, cognitively intact residents were asked if they had ever witnessed abuse of <u>any</u> other residents in facility. Any allegations of abuse would have been re- interviewed by DNS/RDCO. No additional allegations were reported.</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 timely reporting of allegations and investigation of abuse, neglect and exploitation. The Social Service Director or Designee will meet weekly with the Resident Council to ensure any allegations of abuse, neglect, and or exploitation are brought to the Administrator/ Risk Manager for investigating, reporting, resolution, and follow-up in a timely manner until the Council determines weekly meetings are no longer necessary. In addition, "resident rights and responsibilities" was reviewed and discussed at next two subsequent resident Council Meetings. 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 a timely manner. In addition, HFA may contact RDO/RDCO via telephone should there be any questions/direction needed.</p> <p><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 or designee will</p>		

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	<p>06-01-12. The Administrator indicated the incident involved the Activity Assistant and Resident "D", and had not suspended the employee pending investigation.</p> <p>The Administrator indicated she was notified that the Activity Assistant viewed the resident's penis, and then made a derogatory remark about the resident.</p> <p>The Administrator indicated she had interviewed staff and the Social Service designee interviewed resident ["D"] named to be involved.</p> <p>The Administrator indicated she asked the staff members, who were working that day, two questions.</p> <p>"1.) Have you at any time heard [name of Activity Assistant] say he has seen [name of Resident "D"] penis?"</p> <p>"2.) Have you at any time heard [name of Resident "D"] make an allegation towards [name of Activity Assistant]?"</p> <p>The reply that all 5 staff members [Certified Nurses Aides employees #12, 13, 14, 15 and 16] gave to the questions were "no."</p> <p>The Administrator further indicated she made the determination the incident didn't occur; however, other residents had not</p>		<p>randomly interview 5 residents weekly x 4 weeks, then 5 residents monthly for 5 additional months to determine if any allegations of abuse neglect or exploitations have been made and reported promptly. Any allegations identified will be re-interviewed by DNS/RDCO to ensure accuracy. There will also be monthly oversight by the RDO/RDCO during facility visits. The Facility Risk Manager will report results at the next QA/Risk Management meeting and monthly thereafter for 5 additional months. If compliance has been achieved ( as demonstrated by no further failure to report abuse allegations promptly), then Facility Management Team will continue to quarterly report any further findings through the QA/Risk Management process.</p> <p>(e) <b>Date of compliance: 7/6/12</b></p>		

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	<p>been interviewed, the employee not suspended while the investigation was in progress, and ISDH nor local authorities had been notified of the investigation of an allegation.</p> <p>When interviewed, the Administrator indicated the Activity Assistant did not work Saturday [06-02-12] but had worked on Sunday [06-03-12] from 8:00 a.m. to 4:30 p.m.</p> <p>During observation on 06-04-12, the employee was observed working in the facility with other residents. The Administrator indicated the employee came in to work at 8:00 a.m.</p> <p>Review of facility policy on 06-04-12 at 8:30 a.m., titled "Abuse, Neglect, and Exploitation," dated as "issued 02-04 [2004]" indicated the following:</p> <p>"Standard [bold type]: To address with employees the seven (7) components regarding mistreatment, abuse, neglect, injuries of unknown origin, involuntary seclusion and misappropriation of resident property or funds in accordance with Federal Law."</p> <p>"Guideline: 4. When any allegation or confirmed abuse, neglect, or exploitation of a resident occurs, the appropriate state</p>						

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	<p>agencies including but not limited to the IN [Indiana] Board of Health through phone or fax, Ombudsman, Local Police will be notified. The Administrator and Director of Nursing will be notified immediately. Staff members involved will be suspended from work pending investigation. 6. Protection: The facility will protect residents from harm during an investigation up to and including putting suspected employees on suspension pending investigation. 7, Reporting: All allegations of abuse, neglect, or misappropriation of resident property must be reported to the appropriate state agencies according to Ohio &lt;sic&gt; law including the agency for licensure and certification immediately. The Local Ombudsman or Police may need to be notified depending on the circumstances.</p> <p>3.1-28(c)</p>				

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on observation, interview and record review, the facility failed to ensure the implementation of facility policy, in that when facility staff members reported that a staff member [employee #14] had inappropriate sexual actions with a cognitively impaired resident, the Administrative staff failed to implement the facility policy in regard to reporting to the State Agency and other local authorities the need for the investigation of an allegation involving a resident. [Resident "D"]. This deficient practice affected 1 of 4 residents reviewed for abuse in the sample of 4.</p> <p>Findings include:</p> <p>The record for Resident "D" was reviewed on 06-04-12 at 11:00 a.m. Diagnoses included, but were not limited to, traumatic brain injury, depressive disorder, seizure disorder and anxiety. These diagnoses remained current at the time of the record review.</p> <p>During interview on 06-04-12 at 1:25</p>	F0226	<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.</b></p> <p><b>F-226 Practice and Guidelines regarding Abuse What corrective action(s) will be accomplished for those residents found to have been pending investigation.</b></p> <p><b>a. affected by the practice:</b> Resident #D suffered no harm due to the allegations of abuse. Staff Member # 14 was suspended pending investigation. Staff Members # 12, 13, 14, 15, and 16 were re-educated on standards and guidelines for reporting, abuse and neglect immediately to the Facility Administrator and Director of Nursing, specifically any allegations.</p> <p><b>1.How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b> Resident interviews were conducted using the QIS Interview process to determine if they had any allegations of abuse or neglect that had not been reported. For cognitively impaired residents, POA was contacted regarding any concerns of abuse/neglect. In addition, all cognitively intact residents were asked if they had ever witnessed abuse or neglect of <u>any</u> residents in building. None were identified. Staff</p>	07/06/2012			

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	<p>p.m. Certified Nurses Aide employee #3 indicated, "I heard that the Activity Assistant said [resident "D"]'s 'thing' was big. The door was open. I think it's all talk - nothing happened." When interviewed if the Administrator had been notified, the employee indicated "no."</p> <p>During interview on 06-04-12 at 2:05 p.m., Certified Nurses Aide employee #12 indicated "I was in the dining room; me, [name of Certified Nurses Aide employee #13], and a housekeeper. [Name of employee #13] said [name of Resident "D"] told him that [name of the Activity Assistant] [explicit sexual action] with [resident's] privates." When interviewed if she had notified the Administrator, the Certified Nurses Aide employee #12 indicated, "No I didn't report it, but I know I should have."</p> <p>During interview on 06-04-12 at 2:15 p.m., Certified Nurses Aide employee #13 indicated "They called me at home about it. [Name of Activity Assistant] walked in [Resident "D"]'s room, and [name of Resident "D"] took his thing out of [resident] pants. [Name of Activity Assistant] told another CNA to go and take care of [name of Resident "D"]." When further interviewed, Certified Nurses Aide employee #13 indicated he talked to the Administrator about the</p>		<p>were interviewed to determine if any allegations or suspicions of abuse or neglect had occurred and had not been reported timely to the Administrator. None were identified.</p> <p><b>1.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 staff will be reeducated on standards and guidelines for reporting abuse and neglect immediately (Including identified allegations) to the Administrator or designee. The Facility Management Team will review event reports, grievances, 24 hour Reports, and concerns daily during the Monday through Friday stand up meeting in order to report, investigate, resolve, and follow-up with any potential allegations of abuse and neglect in a timely manner according to facility Standard and Guidelines. In addition, HFA will contact RDO/RDCO for any direction needed.</p> <p><b>1.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 or designee will randomly interview 5 residents weekly x 4 weeks, then interview 5 residents monthly for 5 additional months to determine if any allegations of abuse neglect or exploitations have been made and reported promptly. There will also be monthly oversight for the next three months by the RDO/RDC to ensure compliance. The Facility Risk Manager will report results at the next QA/Risk Management meeting and monthly thereafter for 5 months. If compliance in reporting policy is achieved, Risk Manager will then report quarterly to QA/Risk Management Committee per</p>				

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	<p>incident.</p> <p>During interview on 06-04-12 at 3:00 p.m., the Administrator indicated she was made aware of an incident which occurred "sometime the previous week," but had not been informed by facility staff until 06-01-12. The Administrator indicated the incident involved the Activity Assistant and Resident "D", and had not suspended the employee pending investigation.</p> <p>The Administrator indicated she was notified that the Activity Assistant viewed the resident's penis, and then made a derogatory remark about the resident.</p> <p>The Administrator indicated she had interviewed staff and the Social Service designee interviewed resident ["D"] named to be involved.</p> <p>The Administrator indicated she asked the staff members, who were working that day, two questions.</p> <p>"1.) Have you at any time heard [name of Activity Assistant] say he has seen [name of Resident "D"] penis?"</p> <p>"2.) Have you at any time heard [name of Resident "D"] make an allegation towards [name of Activity Assistant]?"</p> <p>The reply that all 5 staff members</p>		<p>standard. RDO/RDCO will monitor at each visit to ensure oversight of process.</p> <p><b>Date of compliance: 7/6/12</b></p>				

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	<p>[Certified Nurses Aides employees #12, 13, 14, 15 and 16] gave to the questions were "no."</p> <p>The Administrator further indicated she made the determination the incident didn't occur; however, other residents had not been interviewed, the employee not suspended while the investigation was in progress, and ISDH nor local authorities had been notified of the investigation of an allegation.</p> <p>When interviewed, the Administrator indicated the Activity Assistant did not work Saturday [06-02-12] but had worked on Sunday [06-03-12] from 8:00 a.m. to 4:30 p.m.</p> <p>During observation on 06-04-12, the employee was observed working in the facility with other residents. The Administrator indicated the employee came in to work at 8:00 a.m.</p> <p>Review of facility policy on 06-04-12 at 8:30 a.m., titled "Abuse, Neglect, and Exploitation," dated as "issued 02-04 [2004]" indicated the following:</p> <p>"Standard [bold type]: To address with employees the seven (7) components regarding mistreatment, abuse, neglect, injuries of unknown origin, involuntary</p>						

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NAME OF PROVIDER OR SUPPLIER  MERIDIAN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2102 S MERIDIAN ST INDIANAPOLIS, IN 46225		
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	<p>seclusion and misappropriation of resident property or funds in accordance with Federal Law."</p> <p>"Guideline: 4. When any allegation or confirmed abuse, neglect, or exploitation of a resident occurs, the appropriate state agencies including but not limited to the IN [Indiana] Board of Health through phone or fax, Ombudsman, Local Police will be notified. The Administrator and Director of Nursing will be notified immediately. Staff members involved will be suspended from work pending investigation. 6. Protection: The facility will protect residents from harm during an investigation up to and including putting suspected employees on suspension pending investigation. 7, Reporting: All allegations of abuse, neglect, or misappropriation of resident property must be reported to the appropriate state agencies according to Ohio &lt;sic&gt; law including the agency for licensure and certification immediately. The Local Ombudsman or Police may need to be notified depending on the circumstances.</p> <p>3.1-28(a)</p>				