

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN 47553
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	<p>This visit was for the Investigation of Complaint IN00103975 and Complaint IN 00103754</p> <p>Complaint IN00103975- Substantiated. Federal /State deficiencies related to the allegations were cited at F-225 and F-226.</p> <p>Complaint IN00103754- Substantiated. No deficiencies related to the allegations were cited:</p> <p>Survey dates: 02/27/12, 02/28/12, and 02/29/12</p> <p>Facility number: 000571 Provider number: 155374 AIM number: 100266920</p> <p>Survey Team: Sharon Whiteman, RN TC Susan Worsham, RN</p> <p>Census bed type: SNF: 02 SNF/NF 34 Total: 36</p> <p>Census Payor Type: Medicare: 05 Medicaid: 24 Other: 07</p>	F0000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in this Statement of Deficiencies or any violation of regulation. This Plan of Correction is submitted to meet regulations established by state and federal law. We reserve the right to contest the findings or allegations as party to any proceedings. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and respectfully requests desk review on or after March 14, 2012.</p>	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOGOOTE, IN 47553
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Total: 36</p> <p>Sample: 06</p> <p>This deficiency also reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 2, 2012 by Bev Faulkner,RN</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/29/2012	
NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN 47553			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
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 interview and record review, the facility failed to insure facility staff</p>	F0225	F225Investigate/Report Allegations/IndividualsIt is the intent of this facility to ensure that	03/14/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/29/2012	
NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN 47553			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>reported potential abuse allegations in a timely manner for 1 of 3 residents reviewed for potential reportable occurrences in a sample of 6. (Resident #A)</p> <p>Findings Include:</p> <p>During interview of Resident A's family member on 02/27/12 at 10:00 a.m., Resident A's family member indicated that the family came to visit Resident A on Friday 01/28/12 and CNA #1 was taking care the resident. The family indicate CNA #1 was acting "whacked out" and was wearing sunglasses. The family member indicated they didn't report this at the time due to CNA #1's (family member) was the charge nurse working and they did not want retaliation. Resident A's family member indicated sometime during the first week of February CNA#2 reported to the family member that while she was assisting CNA #1 with providing personal care to Resident A, CNA #1 made inappropriate comments in Resident A's presence regarding Resident A's pubic hair and stated he "made his wife shave hers." CNA #2 reported to the family member sometime around 02/06/12 or 2/7/12. The family member indicated they reported the next day to the Administrator. The family member</p>		<p>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 pcedures (including to the State Survey and Certification Agency). The facility maintains evidence that all alleged violations are thoroughly investigated and prevents further potential abuse while the investigation is in progress. Corrective Action for those residents found to have been affected by the deficient practice: Resident A no longer resides in the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents would have the potential to be affected. Staff were inserviced on timely reporting of any potential abuse allegations. Unusual reporting guidelines were reiewwed to ensure all alleged violations involving any area of abuse are reported to the Administrator and ISDH according to state law. 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 were inserviced on timely reporting. All staff were inserviced on the facility's policy</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/29/2012	
NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN 47553			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>indicated CNA #1 resigned right after this and no longer works at the facility.</p> <p>During interview of the Social Services Director (SSD) on 02/27/12 at 10:45 a.m. The SSD indicated she had worked at the facility for the past 3 months and had been inserviced on abuse during her orientation. The SSD indicated she was approached by CNA #2 on Friday (02/03/12) and the CNA indicated she had something to tell her. The SSD indicated she was busy at the time and then when she attempted to find out what the CNA wanted the CNA was busy. The SSD indicated she attempted to call the CNA over the weekend but did not have the CNA's correct phone number. The Administrator provided copies of CNA #2's time card on 02/28/12 at 1:00 p.m. The time card indicated CNA #2 had worked at the facility on the weekend following 02/03/12. The SSD indicated CNA #2 did not work at the facility on Monday 02/06/12 and when the CNA #2 arrived at the facility on Tuesday 02/07/12, the CNA reported to her that CNA #1 had worked with her and had made inappropriate comments about a non-verbal resident's vaginal area. The SSD indicated it was a Tuesday morning when CNA #2 reported the allegation to her. The SSD indicated CNA #2 couldn't give her dates or times and she "couldn't</p>		<p>entitled "Resident Safety Abuse Statement." Staff are also inserviced upon hire and at a minimum annually. How the corrective action will be monitored to ensure the deficient practice will not recur: To ensure continuing compliance and under the direction of the Administrator and/or designee a Quality Assurance Tool, "Staff Treatment of Residents" will be completed weekly x 4 weeks, monthly x 2 and quarterly x 2. Results of the audit will be forwarded to the Quality Assurance Committee quarterly to ensure continuing compliance or additional action as warranted.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN 47553
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>get anyone to document anything." The SSD indicated she (the SSD) then went to the Administrator and verbally reported what the CNA told her. The SSD indicated CNA #2 had told her (the SSD) that she had reported the incident to LPN #3. The SSD indicated that LPN #3 had never been informed.</p> <p>On 02/27/11 at 11:10 a.m., the Administrative Assistant provided CNA #2's phone number. Two unsuccessful attempts were made to contact CNA #2 by phone. An error message was received which indicated, "The number or code you dialed is incorrect."</p> <p>A "Daily Staffing" schedule was provided by the DON on 02/27/12 at 11:30 a.m. The staffing schedule indicated that CNA #2 was originally scheduled to work day shift but had called in.</p> <p>During interview of the Administrator on 02/27/12 at 12:30 p.m., the Administrator indicated the first she heard of anything regarding CNA #1's inappropriate behavior was when the family approached her on Tuesday (02/07/12) and reported CNA #1 acting strange like he was high or drunk and he (CNA #1) had thrown up his hands and said "something has happened &amp; you will find out." The Administrator indicated CNA #2 (who</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/29/2012	
NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOGOOTE, IN 47553			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>had allegedly heard inappropriate remarks made by CNA #1 in front of a resident) had talked to LPN #3 but didn't tell her what she wanted, but just told her that she had something to tell Social Services. The Administrator indicated that this was on a Friday (2/3/2012). The Administrator indicated that CNA #1 did work on the next Sunday (02/05/12). The Administrator provided a copy of one of CNA #1's time card. The time card indicated the last night CNA #1 worked was on 02/06/12 when he clocked in on 02/06/12 (Monday) at 7:14 p.m. and clocked out on 02/07/12 (Tuesday) at 7:29 a.m.</p> <p>During interview of the DON on 02/27/12 at 12:55 p.m., the DON indicated that the Administrator had stopped by her office on Friday (02/03/12) and had made an inappropriate comment "in passing" regarding CNA #1. The DON indicated the Administrator did not say who the resident was. The DON indicated she saw Resident A's family and the Social Services Director in the Administrator's office on Tuesday (02/07/12) and that was when she found out that CNA #1 was let go due to erratic behavior.</p> <p>Interview of the Administrator on 02/28/12 at 10:10 a.m., indicated when</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/29/2012	
NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN 47553			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>she made the remark to the DON on Friday (02/03/12) she was talking about something that had happened at another facility. The Administrator indicated she had interviewed staff and the only staff who had reported CNA #1 saying something inappropriate about a resident was CNA #2 and CNA #2 had reported to the Administrator that CNA #1 didn't mean to harm the resident but was talking to her (CNA #2) when he made the inappropriate remarks.</p> <p>During interview of CNA #6 on 02/28/12 at 11:40 a.m., CNA #6 indicated she was told by CNA #2 that when CNA #2 was working with CNA #1 and they were providing care for Resident A that CNA #1 had made remarks about Resident A. CNA #6 indicated CNA #2 told her she didn't know what to do because she didn't want to go to the DON because CNA #1's (family member) and the DON were friends and she was afraid of retaliation. CNA #6 indicated she told CNA #2 she should go to the Social Services Director and if that didn't work she needed to fill out a grievance paper. CNA #6 indicated this conversation took place on the "following Monday (2/6/12)." CNA #6 indicated she then went directly to the Social Services Director and reported what CNA #2 had told her.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/29/2012	
NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN 47553			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>During Interview of LPN #3 on 02/28/12 at 11:00 a.m., LPN #3 indicated she wasn't aware that anyone reported (CNA #1) acting odd. LPN # 3 indicated she had heard CNA #1 had made inappropriate comments toward Resident A. LPN #3 indicated Resident A's family had approached her around the beginning of February while she was feeding a resident and told her the same. LPN #3 indicated the family reported to her that CNA #1 was making inappropriate remarks about Resident A. LPN #3 indicated she had finished feeding and then went immediately to the DON and reported what she had been told by the family regarding CNA #1. LPN #3 indicated the DON told her that the family was already in the Administrator's office.</p> <p>Although CNA #2 had reported inappropriate remarks made by CNA #1 to Resident A's family and other staff, the CNA did not report the remarks to the DON or the Administrator. The Social Services Director indicated CNA #2 had reported an allegation to her on Tuesday morning (2/7/12), the Administrator indicated the first she had heard of anything was when the family approached her.</p> <p>CNA #1's personnel file was reviewed on 02/27/12 at 12:00 p.m. and indicated</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/29/2012	
NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN 47553			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>CNA #1 had been inserviced on resident rights and abuse. The file indicated CNA #1 was terminated on 02/08/12 due to ""resignation without notice."</p> <p>A copy of an investigative report was provided by the Administrator on 02/27/12 at 2:00 p.m.</p> <p>The investigative report was dated February 9, 2012. The number 7 had been hand written over the 9 indicating report should have been dated, February 7, 2012. This would have been the first Tuesday in February.</p> <p>The investigative report indicated, "On this date at approximately 2:30 PM this writer was approached by [Name of Resident A's family]. They asked to speak in private regarding some questionable action observed with a Certified Nursing Assistant, [CNA #1's name]. [Family member's name] stated that on Sunday night she had asked [CNA #1's name] for thickened water. He returned to the resident's room without the water and seemed 'hyper' stating he forgot. Further she stated he was wearing sun glasses in the building and seemed to be 'on something.' [Family member's name] stated [CNA #1's name] said, 'Can't tell you right now but you will find out.' [Family member's name] did not know</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN 47553
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>what the comment meant.... Both (family members) denied that they had reported this information or their concerns to any staff at that time stating [CNA#1's name] nurse was also his [family member] and they did not want any retaliation against [Resident A's name]. This writer explained that they were doing the right thing by reporting any concerns and assured them any concerns were followed up. Noted that another charge nurse was on duty at that time....[Family member's name] then asked if this writer was aware of any comments of the sexual nature made by [CNA #1's name]. When this writer denied knowledge of such she [family member's name] stated that she had been told by another employee that [CNA #1's name] had made comments about the women and used the word 'pu-y.' She further stated she had been told these conversations had taken place in her [family member's name] room. [Family member's name] declined to name the employee who had shared this information. This writer assured the family we would take their concerns seriously and would investigate.</p> <p>February 9, 2011 (sic) Investigative Findings: Notified [DON's name] Director of Nursing Services immediately after speaking with the [family member's name]. ...None of the employees contacted were aware of any inappropriate</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN 47553
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>comments made by the employee. The family declined to name any employee who had shared the comments with them. Given this lack of substantiating information the investigation failed to reveal any inappropriate conduct by [CNA #1's name] at this time."</p> <p>The investigation indicated that on 2/9/12, the DON was able to contact CNA # 2 and during interview CNA # 2 indicated that on Friday, 2/3/2012 she had worked with CNA #1 and he had made inappropriate comments about women's pubic areas in the presence of CNA # 2 while in the room with Resident A.</p> <p>The investigation also included, "She (CNA #2) said he (CNA #1) was talking to her (co-worker and comment was not directed at resident) [CNA #2] states she does not believe comment was made to try and hurt resident. [CNA #2] did state she and [CNA #1] were in [Resident A's] room at the time. [CNA #2] stated she had reported the conversation to her charge nurse and the charge nurse reported to Social Services Director. [CNA #2] said she did talk with [Social Services Directors name] about this but denied talking with anyone else or the family about the incident. [CNA #2] denied anyone else hearing the conversation. Given [CNA #2's name]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN 47553
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>report, it does appear that [CNA #1's name] may have said something to another employee however with [CNA #1's name] resignation it is not possible to obtain a statement from him at this time. This incident does not appear to be a state reportable incident under the guidelines of the ISDH but does seem to have warranted further investigation if [CNA #1's] name were still employed at the facility....."</p> <p>Review of Resident A's clinical record on 02/28/12 at 9:45 a.m. indicated the following:</p> <p>Resident A had diagnoses, which included but were not limited to, Diabetes and Progressive Alzheimer's disease.</p> <p>A most recent MDS (minimum data set) assessment, dated 12/16/11, indicated Resident A had severe cognitive impairment and required total assistance of staff for personal hygiene and bathing and the resident was incontinent of bowel and bladder.</p> <p>The facility did not provide any documentation supporting Social Services Department had documented any concerns regarding this incident.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOGOOTE, IN 47553
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This Federal/State tag relates to Complaint IN00103975.  3.1-28(c)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/29/2012
NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN 47553		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
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 interview and record review, the facility failed to insure facility staff reported potential abuse allegations in a timely manner according to facility policy for 1 of 3 residents reviewed for potential reportable occurrences in a sample of 6. (Resident #A)</p> <p>Findings Include:</p> <p>During interview of Resident A's family member on 02/27/12 at 10:00 a.m., Resident A's family member indicated that the family came to visit Resident A on Friday 01/28/12 and CNA #1 was taking care the resident. The family indicate CNA #1 was acting "whacked out" and was wearing sunglasses. The family member indicated they didn't report this at the time due to CNA #1's (family member) was the charge nurse working and they did not want retaliation. Resident A's family member indicated sometime during the first week of February CNA#2 reported to the family member that while she was assisting CNA #1 with providing personal care to</p>	F0226	F226Develop/Implement Abuse/Neglect, ETC. PoliciesIt is the intent of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. Corrective action for those residents found to have been affected by the deficient practice:Resident A no longer resides in the facility.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:All residents would have the potential to be affected. Staff were inserviced on timely reporting of any potential abuse allegations. Unusual reporting guidelines were reviewed to ensure all alleged violations involving any area or abuse are reported to the Administrator and ISDH according to state law.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 were inserviced on timely reporting of any potential abuse allegations. All staff were	03/14/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN 47553
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Resident A, CNA #1 made inappropriate comments in Resident A's presence regarding Resident A's pubic hair and stated he "made his wife shave hers." CNA #2 reported to the family member sometime around 02/06/12 or 2/7/12. The family member indicated they reported the next day to the Administrator. The family member indicated CNA #1 resigned right after this and no longer works at the facility.</p> <p>During interview of the Social Services Director (SSD) on 02/27/12 at 10:45 a.m. The SSD indicated she had worked at the facility for the past 3 months and had been inserviced on abuse during her orientation. The SSD indicated she was approached by CNA #2 on Friday (02/03/12) and the CNA indicated she had something to tell her. The SSD indicated she was busy at the time and then when she attempted to find out what the CNA wanted the CNA was busy. The SSD indicated she attempted to call the CNA over the weekend but did not have the CNA's correct phone number. The Administrator provided copies of CNA #2's time card on 02/28/12 at 1:00 p.m. The time card indicated CNA #2 had worked at the facility on the weekend following 02/03/12. The SSD indicated CNA #2 did not work at the facility on Monday 02/06/12 and when the CNA #2</p>		<p>inserviced ont he facility's policy entitled "Resident Safety Abuse Statement." Staff are also inserviced upon hire and at a minimum annually.How the corrective action will be monitored to ensure the deficient pracice will not recur.To ensure continuing compliance and under the direction of the Administrator and/or designee a Quality Assurance tool, "Staff Treatment of Residents" will be completed weekly x 4 weeks, monthly x 2 and quarterly x 2. Results of the audit will be forwarded to the Quality Assurance Committee quarterly to ensure continuing compliance or additional action as warranted.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN 47553
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>arrived at the facility on Tuesday 02/07/12 the CNA reported to her that CNA #1 had worked with her and had made inappropriate comments about a non-verbal resident's vaginal area. The SSD indicated CNA #2 couldn't give her dates or times and she "couldn't get anyone to document anything." The SSD indicated she (the SSD) then went to the Administrator and verbally reported what the CNA told her. The SSD indicated CNA #2 had told her (the SSD) that she had reported the incident to LPN #3. The SSD indicated that LPN #3 had never been informed.</p> <p>During interview of the Administrator on 02/27/12 at 12:30 p.m., the Administrator indicated the first she heard of anything regarding CNA #1's inappropriate behavior was when the family approached her on Tuesday (02/07/12) and reported CNA #1 acting strange like he was high or drunk and he (CNA #1) had thrown up his hands and said "something has happened &amp; you will find out." The Administrator indicated CNA #2 (who had allegedly heard inappropriate remarks made by CNA #1) had said that she reported the remarks to LPN #3, but the only thing she had said to LPN #3 was that she needed to talk to Social Services. The Administrator indicated that this was on a Friday (2/3/12). The Administrator</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/29/2012	
NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOGOOTE, IN 47553			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>indicated that CNA #1 did work on the next Sunday (02/05/12). The Administrator provided a copy of one of CNA #1's time card. The time card indicated the last night CNA #1 worked was on 02/06/12 when he clocked in on 02/06/12 (Monday) at 7:14 p.m. and clocked out on 02/07/12 (Tuesday) at 7:29 a.m.</p> <p>During interview of the DON on 02/27/12 at 12:55 p.m., the DON indicated that the Administrator had stopped by her office on Friday (02/03/12) and had made an inappropriate comment in passing about CNA #1. The DON indicated the Administrator did not say who the resident was. The DON indicated she saw Resident A's family and Social Services Director in the Administrator's office on Tuesday (02/07/12) and that was when she found out that CNA #1 was let go due to erratic behavior.</p> <p>Interview of the Administrator on 02/28/12 at 10:10 a.m., indicated when she made the remark to the DON on Friday (02/03/12) she was talking about something that had happened at another facility. The Administrator indicated she had interviewed staff and the only staff who had reported CNA #1 saying something inappropriate about a resident</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/29/2012	
NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN 47553			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>was CNA #2 and CNA #2 had reported to the Administrator that CNA #1 didn't mean to harm the resident but was talking to her (CNA #2) when he made the inappropriate remarks.</p> <p>Interview of the DON on 02/28/12 at 10:10 a.m., indicated CNA #2 had called in "this morning" and was sobbing hysterically and quit, but did not say why she had quit. The DON indicated CNA #1 did not intend for remarks to hurt the resident.</p> <p>During interview of CNA #6 on 02/28/12 at 11:40 a.m., CNA #6 indicated she was told by CNA #2 that when CNA #2 was working with CNA #1 and they were providing care for Resident A that CNA #1 had made inappropriate remarks about Resident A. CNA #6 indicated CNA #2 told her she didn't know what to do because she didn't want to go to the DON because CNA #1's (family member) and the DON were friends and she was afraid of retaliation. CNA #6 indicated she told CNA #2 she should go to the Social Services Director and if that didn't work she needed to fill out a grievance paper. CNA #6 indicated this conversation took place on the "following Monday (2/6/12)." CNA #6 indicated she then went directly to the Social Services Director and reported what CNA #2 had</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/29/2012	
NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN 47553			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>told her.</p> <p>During Interview of LPN #3 on 02/28/12 at 11:00 a.m. LPN #3 indicated she had heard that CNA #1 had made inappropriate comments about Resident A. LPN #3 indicated Resident A's family had approached her around the beginning of February while she was feeding a resident and told her the same. LPN #3 indicated the family reported to her that CNA #1 was making inappropriate remarks about Resident A. LPN #3 indicated she had finished feeding and then went immediately to the DON and reported what she had been told by the family regarding CNA #1. LPN #3 indicated the DON told her that the family was already in the Administrator's office.</p> <p>Although CNA #2 had reported inappropriate remarks made by CNA #1 to Resident A's family and other staff, the CNA did not report the remarks to the DON or Administrator. The Social Services Director had indicated CNA #2 had attempted unsuccessfully to talk to her on Friday (February 3, 2012) but did not talk to her until the following Tuesday morning (February 7, 2012). The Administrator indicated that the first she heard of the allegation was when the family had approached her and reported concerns.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN 47553
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A copy of an investigative report was provided by the Administrator on 02/27/12 at 2:00 p.m.</p> <p>The investigative report was dated February 9, 2012. The number 7 had been hand written over the 9 indicating report should have been dated, February 7, 2012. This would have been the first Tuesday in February.</p> <p>The investigative report indicated, "On this date at approximately 2:30 PM this writer was approached by [Name of Resident A's family]. They asked to speak in private regarding some questionable action observed with a Certified Nursing Assistant, [CNA #1's name]. [Family member's name] stated that on Sunday night she had asked [CNA #1's name] for thickened water. He returned to the resident's room without the water and seemed 'hyper' stating he forgot. Further she stated he was wearing sun glasses in the building and seemed to be 'on something.' [Family member's name] stated [CNA #1's name] said, 'Can't tell you right now but you will find out.' [Family member's name] did not know what the comment meant.... Both (family members) denied that they had reported this information or their concerns to any staff at that time stating [CNA#1's name]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN 47553
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>nurse was also his [family member] and they did not want any retaliation against [Resident A's name]. This writer explained that they were doing the right thing by reporting any concerns and assured them any concerns were followed up. Noted that another charge nurse was on duty at that time...[Family member's name] then asked if this writer was aware of any comments of the sexual nature made by [CNA #1's name]. When this writer denied knowledge of such she [family member's name] stated that she had been told by another employee that [CNA #1's name] had made comments about the women and used the word 'pu-y.' She further stated she had been told these conversations had taken place in her [family member's name] room. [Family member's name] declined to name the employee who had shared this information. This writer assured the family we would take their concerns seriously and would investigate.</p> <p>February 9, 2011 (sic) Investigative Findings: Notified [DON's name] Director of Nursing Services immediately after speaking with the [family member's name]. ...None of the employees contacted were aware of any inappropriate comments made by the employee. The family declined to name any employee who had shared the comments with them. Given this lack of substantiating</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN 47553
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>information the investigation failed to reveal any inappropriate conduct by [CNA #1's name] at this time."</p> <p>The investigation indicated that on 2/9/12, the DON was able to contact CNA # 2 and during interview CNA # 2 indicated that on Friday, 2/3/2012 she had worked with CNA #1 and he had made inappropriate comments about women's pubic areas in the presence of CNA # 2 while in the room with Resident A.</p> <p>The investigation also included, "She (CNA #2) said he (CNA #1) was talking to her (co-worker and comment was not directed at resident) [CNA #2] states she does not believe comment was made to try and hurt resident. [CNA #2] did state she and [CNA #1] were in [Resident A's] room at the time. [CNA #2] stated she had reported the conversation to her charge nurse and the charge nurse reported to Social Services Director. [CNA #2] said she did talk with [Social Services Directors name] about this but denied talking with anyone else or the family about the incident. [CNA #2] denied anyone else hearing the conversation. Given [CNA #2's name] report, it does appear that [CNA #1's name] may have said something to another employee however with [CNA #1's name] resignation it is not possible to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOGOOTE, IN 47553
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>obtain a statement from him at this time.</p> <p>This incident does not appear to be a state reportable incident under the guidelines of the ISDH but does seem to have warranted further investigation if [CNA #1's] name were still employed at the facility....."</p> <p>Review of Resident A's clinical record on 02/28/12 at 9:45 a.m. indicated the following:</p> <p>Resident A had diagnoses, which included but were not limited to, Diabetes and Progressive Alzheimer's disease.</p> <p>A most recent MDS (minimum data set) assessment, dated 12/16/11, indicated Resident A had severe cognitive impairment and required total assistance of staff for personal hygiene and bathing and the resident was incontinent of bowel and bladder.</p> <p>An policy titled "Resident Safety Abuse Statement (not dated) was provided by the facility on 02/27/12. The policy indicated, "It is the intent of this facility to maintain a work and living environment that is professional and free from threat and/or occurrence of harassment, abuse (verbal, physical, mental or sexual), neglect, corporal punishment, involuntary</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN 47553
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>seclusion or misappropriation of property....Our facility promotes an atmosphere of sharing with residents and staff without fear of retribution. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers....Any suspected, observed or reported violation of this resident safety policy will be reported immediately to the supervisor, the D.O.N. and/or Executive Director per facility policy...The supervisor on duty shall IMMEDIATELY report any alleged violation of this resident safety policy to the DON and/or Executive Director or designee. The D.O.N. or the designee will notify the Executive Director if they are the first contact....The Quality Assurance Coordinator and/or the supervisor on duty will assess the resident....and properly document the date, time, and location of the reported or suspected incident..The supervisor will ensure that the resident is protected from harm during the investigation....The Executive Director or designee shall determine if notification should be made to appropriate regulatory enforcement agencies...."</p> <p>The facility did not provide any documentation supporting Social Services Department had documented any</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOGOOTE, IN 47553
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>concerns regarding this incident.</p> <p>This Federal/State tag relates to Complaint IN00103975.</p> <p>3.1-28(a)</p>			