STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155434	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT CONNERSVILLE	2600 N GRAND AVE CONNERSVILLE, IN 47331

(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
F0000	This visit was for the Investigation of Complaint IN00102370. Complaint IN00102370 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-225 and F-226. Survey dates: January 31 and February 1, 2012 Facility number: 000319 Provider number: 155434 AIM number: 100286530 Survey team: Angel Tomlinson RN Census bed type: SNF/NF: 33 Total: 33 Census payor type: Medicare: 4 Medicaid: 18 Other: 11 Total: 33 Sample: 3 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Quality review completed 2/7/12 by Jennie Bartelt, RN.			

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F0225 SS=D	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. 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). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 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.			
	Based on interview and record review, the facility failed to report an allegation of abuse to the administrator immediately, failed to protect residents during an	F0225	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an	03/01/2012

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	investigation of alleged abuse, failed to conduct a thorough investigation of alleged abuse and failed to report allegations of abuse to the state agency in a timely manner for 1 of 3 residents sampled for abuse in a total sample of 3 (Resident #A). Findings include: On 2-1-12 at 9:30 a.m., the Administrator was interviewed and indicated the following: The Administrator indicated the facility did not have specific guidelines for investigating allegations of abuse. The Administrator indicated investigations of abuse were to be complete and thorough. The Administrator indicated on 1-4-11 during morning meeting it was reported to her there was an allegation of abuse regarding Resident #A's fall on 12-27-11. The Administrator indicated she was unsure if the S.S.D. (Social Services Director) or the Activity Director was the one that brought it up in the morning meeting. The Administrator indicated on 1-4-12 she spoke to the S.S.D., CNA's that were working on 12-27-11, the nurse working on 12-27-11 and the resident that found Resident #A on the floor. The Administrator indicated she found the		admisssion that a deficiency exists or that one was cited correctly. This Planof Correction is submitted to meet requirements established by State and Federal law.F 225It is the policy of this facility that all allegations of abuse are reported to the Administrator immediately. In addition, the facility will conduct a thorough investigation of all allegations of abuse, protect residents during the investigation of the alleged abuse, and report the alleged abuse to the state agency in a timely manner.Please note that the Administrator was misquoted in the 2567 regarding specific guidelines for investigating allegation of abuse. When asked by the surveyor if the facility has specific forms used for abuse investigations Administrator stated that no we do not have specific forms, we follow our abuse policy (which had already been provided to the surveyor), and we are expected to do a complete and thorough investigation.Also, the Administrator did provide to the surveyor statement from three residents, seven staff members, and two resident family members related to this incident.Hickory Creek does in fact have an abuse policy which contains guidelines for investigating allegations of abuse which is being placed as attachment F 225-1.1. What corrective action(s) will be accomplished for those residents	

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	allegation of abuse unsubstantiated on 1-4-12. The Administrator indicated the resident that first found Resident #A on the floor had indicated there was no one present in the room except Resident #A when he found her. The Administrator indicated Resident #A had reported an allegation of abuse by the Social Services Director to the Activity Director on 12-27-11. The Administrator indicated she had talked to Resident #A's family member on 1-5-12 and the resident had reported to him that she had been pushed down. The Administrator indicated she was unsure why the family member had not reported it to the facility staff. The Administrator indicated the family member had indicated he did not think much about it until the resident repeated the story again, and then he started wondering about it. The Administrator indicated there were no resident interviews in regard to staff treatment of residents specific to 12-27-11. The Administrator indicated the facility does on-going social interviews with residents. The Administrator indicated the S.S.D. did interviews with residents during Resident		found to have been affected by the deficient practice?The incident involving resident #A was thoroughly investigated. The SSD, Activity Director and LPN have been counseled regarding not following facility abuse policy in regards to not immediately reporting allegations of abuse to the Administrator.All staff was in-serviced on 1/4/12 & 2/7/12 regarding abuse policy, emphasizing the need to report all allegations of abuse immediately to the Administrator. All staff signed an affidavit "Affirmation of NO Observation / Knowledge of Abuse" on 2/7/12 indicating that none of them were aware of any allegations or actual instances of abuse. (See Attachment F 225-2, form HC-ADM 174).All families / responsible parties have been mailed infomation regarding the facility abuse policy and who to contact should they have a concern. Emphasis was placed regarding the need for immediate reporting of any allegation of abuse or concern. A copy of the facility concern form was also included in the letter.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 residents have been interviewed regarding abuse and no other concerns have been noted.If, however, in the future, it the Administrator finds that any	

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	Council. When interviewed as to why there was not an interview with Resident #A specific to the allegation of abuse or staff treatment of the resident, the Administrator indicated she would look for the facility's social interviews. The Administrator indicated the S.S.D. was not suspended from work after the allegation of abuse occurred on 12-27-11. During interview on 2-1-12 at 10:50 a.m., Resident #A's family member indicated when Resident #A told him something, he felt he should believe it. The family member indicated he also felt he needed to believe the facility. The family member indicated he felt that Resident #A was saying things that were not true. The family member indicated Resident #A first told him of the allegation on 12-29-11 when he took her to the dentist to get her tooth fixed. He indicated she told him that on 12-27-11, the S.S.D. had hit her in the face and knocked her down. The family member indicated the resident repeated the same story several times, then as the day went on the resident could not remember parts of the story. The family member indicated he was not sure what to do or how to address the situation. The family member indicated when he brought Resident #A back to the facility from the dentist appointment, he reported the situation to LPN #1. The		allegation of abuse has been made and not reported to her, she will immediately suspend the individual(s) involved and make sure that the resident has been cared for, including caring for any physical or psychosocial needs that are present. Once the resident's status is stable, the Administraotr will begin a thorough investigation into the allegations of abuse and will notify the state agency of the allegations within 24 hours after the initial receipt of the allegations.Once the allegations of abuse are investigated and followed through as indicated by the investigation's results, the Administrator will re-train any staff involved in the incident regarding the facility's policy and procedure for abuse and abuse allegations. She will also render progressive discipline, up to and including, termination of employment for continued noncompliance.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.Through the Guardian Angel program, facility managers will visit their assigned residents at least 5 days a week to make sure that their needs are met and to see if they have any concerns. All concerns expresed during those visits will be transcribed onto Resident Concern forms, and if any concerns allege abuse, the Administrator will be notified	

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	family member indicated LPN #1 assured him there was no way the incident happened. The family member indicated he had attempted to contact the Administrator two times and was not able to get a hold of her. The family member indicated when he did talk to the Administrator, he requested for her to go down and ask the resident what she had reported to him when he took her to the dentist and then go back a second time and ask the resident again to see if she would remember. The family member indicated the Administrator called him back and indicated the resident told her she could not remember. During interview on 2-1-12 at 10:35 a.m., the S.S.D. indicated on 12-27-11, she and the dietary manager were passing the hall breakfast trays. The S.S.D. indicated she assisted Resident #A to her chair and set up her breakfast tray for her. The S.S.D. indicated she went on assisting residents with breakfast. The S.S.D. indicated after breakfast was over, she was coming down the hall, and a male resident told her "there is a lady on the floor." S.S.D. indicated she went to Resident #A's room, the resident was on the floor, and there was a pool of blood. S.S.D. indicated she yelled for help from LPN #1. The S.S.D. indicated on 12-28-11 during lunch time, Resident #A pointed to her lip and said,		immediately.Each allegation of abuse regardless of its source will be followed through as indicated in question #2.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.The Administrator will bring all reports of alleged abuse and subsequent investigations and the results of those investigations to the monthly QA Committee meeting for review and further recommendations. Any committee recommendations will be followed through by the Administrator and pertinent management staff, with results of those recommendations reported back to the committee at the next scheduled QA Committee meeting.This will continue on an ongoing basis.Date of Compliance: 3/1/12	

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	"Look what you did to me." The S.S.D. indicated then the resident said, "You left me and did not give me any silverware." The S.S.D. indicated she told Resident #A that she did set up her tray for her yesterday and gave her silverware. S.S.D. indicated she did not report what the resident said on 12-28-11 to the Administrator. S.S.D. indicated she did tell the Dietary Manager what the resident had said and the Dietary Manager indicated not to worry about it because she was with her on 12-27-11 when she passed the resident's breakfast tray. During the interview on 2-1-12 at 9:30 a.m., the Administrator indicated she first heard of these allegations at the morning meeting on 1-4-12, nine days after the allegation was first reported. Review of the record of Resident #A on 1-31-12 at 1:15 p.m., indicated the resident's diagnoses included, but were not limited to, cerebral vascular accident (CVA - stroke), dementia, glaucoma and anxiety. The Minimum Data Set (MDS) assessment for Resident #A, dated 11-2-11, indicated the following: ability to make self understood- understood, ability to understand others- understands, able to report the correct year- correct,			

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	ability to report correct month- accurate within 5 days, ability to report correct year- incorrect, transfer- limited assistance of one person, ability to walk in room- limited assistance of one person, toilet use- limited assistance of one person, mobility device- walker, urinary and bowel continence- always continent and had the resident had any falls since admission- yes. The nurses note for Resident #A, dated 12-27-11 at 7:50 a.m., indicated the resident was found on the floor in her room sitting on the left hip. There was a moderate amount of blood on the floor. The resident was bleeding from the mouth and nose. Part of the resident front tooth was on the floor. A cold cloth and pressure applied and the bleeding stopped. The resident denied pain. The resident had reopened a 0.5 centimeter (cm) skin tear to the right knee and reopened an 0.5 cm by 0.6 cm by 0.5 cm skin tear of the left knee. All the areas were cleansed with normal saline and a dressing applied. The resident was able to move all extremities without difficulty. The resident's bed was soiled with urine and a brief was on the floor. The resident was aware of the fall and of lost tooth. The resident voiced no concerns related to the event.			

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	The social service note for Resident #A dated 12-27-11 (no time) indicated the resident was found on the floor by the Social Service Director (S.S.D.) and a male resident. Nursing came immediately and cared for resident. The report of dental consultation for Resident #A dated 12-29-11 indicated the resident had a broken tooth from a fall on 12-27-11. Review of the facility's file related to the allegation, provided by the Administrator indicated an interview with Resident #A dated 1-5-12 indicated the resident was asked what happened to her lip. The resident indicated "They tell me I fell but I don't remember." Review of the facility's file related to the allegation, provided by the Administrator, indicated interview with Resident #A's family member dated 1-5-12 indicated the Administrator informed the family member that she had spoken with Resident #A and she could not remember the fall. The Administrator told the family member the resident's fall on 12-27-11 had been investigated and statements had been obtained from staff and there were no concerns of "foul play". The Administrator pointed out to the family member the injuries from 12-27-11 was			

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	consistent with a fall.. Review of the State Reportable Incident provided by the Administrator dated 1-9-12 indicated Resident #A had been found on the floor on 12-27-11 by a resident. The Administrator was informed on 1-4-11 that Resident #A had made a statement on 12-27-11 to the Activity Director that the S.S.D. had been in her room doing an interview and she did not want to be in the interview. Resident #A indicated S.S.D. insisted the resident stay and pushed her off the bed. Review of the State Reportable Incident provided by the Administrator, dated 1-9-12, indicated on 12-27-11 Resident #A was touching her lip and said to the S.S.D. look what you did to me and then said you didn't give me silverware or anything. During interview on 2-1-12 at 11:20 a.m., the Activity Director indicated on 12-27-11 during lunch Resident #A told her that the S.S.D. was doing an interview in her room that morning. Resident #A indicated she did not want to stay for the interview and attempted to leave the room. Resident #A indicated S.S.D. got mad because she did not want to stay and pushed her off her bed. The Activity Director indicated she asked the resident,			

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	"I thought you were going to the bathroom and fell." The Activity Director indicated the resident told her "No, she did not fall going to the bathroom." The Activity Director indicated she did not report what the resident said because she was told in morning meeting on 12-27-11 that Resident #A had said S.S.D. had left her that morning alone with no silverware. The Activity Director indicated she thought the resident was confused. During interview on 2-1-12 at 11:30 a.m., the Dietary Manager indicated on the morning of 12-27-11 she and the S.S.D. were passing hall trays to the residents. The Dietary Manager indicated the S.S.D. assisted Resident #A to her chair. The Dietary Manager indicated she and the S.S.D. set up the resident's breakfast tray for her. The Dietary Manager indicated Resident #A was eating when they left the room. The Dietary Manager indicated Resident #A voiced no complaints or resistance while she was in the room. The Dietary Manager indicated no one had reported an allegation of abuse to her. The Dietary Manager indicated the first time she had heard about the allegation from 12-27-11 was in morning meeting. The Dietary Manager indicated she was not sure of the date of the morning meeting.			

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	During interview with the Administrator on 2-1-12 at 1:00 p.m., indicated the facility reported the allegation of 12-27-11 related to Resident #A on 1-9-11. During interview with LPN #1 on 2-1-12 at 1:20 p.m., indicated Resident #A's family reported to her that Resident #A had told him the S.S.D. had hit her or punched her on 12-27-11. LPN #1 indicated she could not remember the date the family member reported this to her. LPN #1 indicated she told the family member that the resident was confused and that the situation did not happen. LPN #1 indicated she was the nurse caring for Resident #A on 12-27-11 and the resident had told her she was trying to go to the bathroom and fell. LPN #1 indicated Resident #A never reported any abuse to her. LPN #1 indicated on the morning of 12-27-11, a male resident had reported to the S.S.D. that resident #A had fallen. LPN #1 indicated the S.S.D. called for her and she had went and cared for the resident. LPN #1 indicated she did report what the family member had told her to the Administrator, but did not remember the date she reported it. LPN #1 indicated she did not report it the same day the family member had reported it to her. LPN #1 indicated Resident #A had been confused.			

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	The S.S.D. hours worked provided by the Administrator on 2-1-12 at 2:10 p.m., indicated the S.S.D. worked the following hours: 12-27-11- 7.95 hours, 12-28-11- 8.25 hours, 12-29-11- 8 hours, 12-30-11- 7.5 hours, 1-3-12- 7.75 hours and on 1-4-12 worked 5.25 hours. The resident interviews provided by the Administrator on 2-1-12 at 2:10 p.m., indicated two residents were interviewed on 1-4-12 about mistreatment by staff, and both residents reported there had been no witnessed mistreatment of residents by staff. The "Resident Mistreatment, Neglect, Abuse & Misappropriation of Property" policy 9-2010 provided by the Administrator on 2-1-12 at 1:00 p.m. indicated, "Investigation: All reported incidents of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported to the Administrator immediately, investigated and reported per state and federal law (typically within 24 hours of witness/identification)." "All allegations will be thoroughly investigated and measures will be taken to prevent further potential abuse while the investigation is in process." "Immediate			

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT CONNERSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 N GRAND AVE CONNERSVILLE, IN 47331	

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	suspension of the individual accused of the alleged neglect, abuse, misappropriation of resident property, pending the outcome of the investigation of the alleged abuse." This federal tag relates to complaint number IN00102370. 3.1-28(c) 3.1-28(d)			

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F0226 SS=D	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 implement their abuse policy of reporting an allegation of abuse to the administrator immediately, failed to conduct a thorough investigation of alleged abuse, failed to protect residents during an investigation of alleged abuse and failed to report allegations of abuse to the state agency in a timely manner for 1 of 3 residents sampled for abuse in a total sample of 3 (Resident #A). Findings include: Review of the facility's policy for "Resident Mistreatment, Neglect, Abuse & Misappropriation of Property," dated 9-2010, and provided by the Administrator on 2-1-12 at 1:00 p.m., indicated, "Investigation: All reported incidents of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported to the Administrator immediately, investigated and reported per state and federal law (typically within 24 hours of witness/identification)." "All allegations will be thoroughly investigated and measures will be taken to	F0226	F226It is the policy of this facility that all allegations of abuse are reported to the Administrator immediately. In addition, the facility will conduct a thorough investigation of all allegations of abuse, protect residents during the investigation of the alleged abuse, and report the alleged abuse to the state agency in a timely manner.Please note that the Administrator was misquoted in the 2567 regarding specific guidelines for investigating allegation of abuse. When asked by the surveyor if the facility has specific forms used for abuse investigations Administrator stated that no we do not have specific forms, we follow our abuse policy (which had already been provided to the surveyor), and we are expected to do a complete and thorough investigation.Also, the Administrator did provide to the surveyor statement from three residents, seven staff members, and two resident family members related to this incident.Hickory Creek does in fact have an abuse policy which contains guidelines for investigating allegations of abuse which is being placed as attachment F 225-1.1. What corrective action(s) will be accomplished for those residents	03/01/2012

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	prevent further potential abuse while the investigation is in process." "Immediate suspension of the individual accused of the alleged neglect, abuse, misappropriation of resident property, pending the outcome of the investigation of the alleged abuse." The Administrator was interviewed on 2-1-12 at 9:30 a.m., and indicated the following: The Administrator indicated the facility did not have specific guidelines for investigating allegations of abuse. The Administrator indicated investigations of abuse were to be complete and thorough. The Administrator indicated during morning meeting on 1-4-11, it was reported to her there was an allegation of abuse regarding Resident #A's fall on 12-27-11. The Administrator indicated she was unsure if the S.S.D. (Social Servies Director) or the Activity Director was the one that brought it up in the morning meeting. The Administrator indicated on 1-4-12 she spoke to the S.S.D., CNA's that were working on 12-27-11, the nurse working on 12-27-11 and the resident that found Resident #A on the floor. The Administrator indicated she found the allegation of abuse unsubstantiated on 1-4-12.		found to have been affected by the deficient practice?The incident involving resident #A was thoroughly investigated. The SSD, Activity Director and LPN have been counseled regarding not following facility abuse policy in regards to not immediately reporting allegations of abuse to the Administrator.All staff was in-serviced on 1/4/12 & 2/7/12 regarding abuse policy, emphasizing the need to report all allegations of abuse immediately to the Administrator. All staff signed an affidavit "Affirmation of NO Observation / Knowledge of Abuse" on 2/7/12 indicating that none of them were aware of any allegations or actual instances of abuse. (See Attachment F 225-2, form HC-ADM 174).All families / responsible parties have been mailed infomation regarding the facility abuse policy and who to contact should they have a concern. Emphasis was placed regarding the need for immediate reporting of any allegation of abuse or concern. A copy of the facility concern form was also included in the letter.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 residents have been interviewed regarding abuse and no other concerns have been noted.If, however, in the future, it the Administrator finds that any	

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	The Administrator indicated the resident that first found Resident #A on the floor had indicated there was no one present in the room except Resident #A when he found her. The Administrator indicated Resident #A had reported an allegation of abuse by the S.S.D. to the Activity Director on 12-27-11. The Administrator indicated she had talked to Resident #A's family member on 1-5-12, and the resident had reported to the family memeber that she had been pushed down. The Administrator indicated she was unsure why the family member had not reported it to the facility staff. The Administrator indicated the family member had indicated he did not think much about it until the resident repeated the story again, and then he started wondering about it. The Administrator indicated there were no resident interviews in regard to staff treatment, specific to 12-27-11. The Administrator indicated the facility does on-going social interviews with residents. The Administrator indicated the S.S.D. did interviews with residents during Resident Council. When interviewed as to why there was not an interview with		allegation of abuse has been made and not reported to her, she will immediately suspend the individual(s) involved and make sure that the resident has been cared for, inclluding caring for any physical or psychosocial needs that are present. Once the resident's status is stable, the Administraotr will begin a thorough investigation into the allegations of absue and will notify the state agency of the allegations within 24 hours after the initial receipt of the allegations.Once the allegations of abuse are investigated and followed through as indicated by the investigation's results, the Administrator will re-train any staff involved in the incident regarding the facility's policy and procedure for abuse and abuse allegations. She will also render progressive disciipline, up to and including, termination of employment cor continued noncompliance.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.Through the Guardian Angel program, facility managers will visit their assigned residents at least 5 days a week to make sure that their needs are met and to see if they have any concerns. All concerns expresed during those visits will be transcribed onto Resident Concern forms, and if any concerns allege abuse, the Administrator will be notified	

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	Resident #A specific to the allegation of abuse or staff treatment of resident, the Administrator indicated she would look for the facility's social interviews. The Administrator indicated the S.S.D. was not suspended from work after the allegation of abuse occurred on 12-27-11. During interview on 2-1-12 at 10:50 a.m., Resident #A's family member indicated when Resident #A told him something he felt he should believe it. The family member indicated he also felt he needed to believe the facility. The family member indicated he felt that Resident #A was saying things that were not true. The family member indicated Resident #A first told him of the allegation on 12-29-11, when he took her to the dentist to get her tooth fixed. The family member said the resident told him that on 12-27-11, the S.S.D. had hit her in the face and knocked her down. The family member indicated the resident repeated the same story several times, then as the day went on, the resident could not remember parts of the story. The family member indicated he was not sure what to do or how to address the situation. The family member indicated when he brought Resident #A back to the facility from the dentist appointment, he reported the situation to LPN #1. The family member indicated LPN #1 assured him		immediately.Each allegation of abuse regardless of its source will be followed through as indicated in question #2.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.The Administrator will bring all reports of alleged abuse and subsequent investigations and the results of those investigations to the monthly QA Committee meeting for review and further recommendations. Any committee recommendations will be followed through by the Administrator and pertinent management staff, with results of those recommendations reported back to the committee at the next scheduled QA Committee meeting.This will continue on an ongoing basis.Date of Compliance: 3/1/12	

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	there was no way the incident happened. The family member indicated he had attempted to contact the Administrator two times and was not able to get a hold of her. The family member indicated when he did talk to the Administrator, he requested for her to go down and ask the resident what she had reported to him when he took her to the dentist and then go back a second time and ask the resident again to see if she would remember. The family member indicated the Administrator called him back and indicated the resident told her she could not remember. During interview 2-1-12 at 10:35 a.m., the S.S.D. indicated on 12-27-11, she and the Dietary Manager were passing the hall breakfast trays. S.S.D. indicated she assisted Resident #A to her chair and set up her breakfast tray for her. S.S.D. indicated she went on assisting residents with breakfast. S.S.D. indicated after breakfast was over, she was coming down the hall, and a male resident said "there is a lady on the floor." The S.S.D. indicated she went to Resident #A's room, the resident was on the floor, and there was a pool of blood. The S.S.D. indicated she yelled for help from LPN #1. The S.S.D. indicated on 12-28-11 during lunch time, Resident #A pointed to her lip and said, "Look what you did to me." S.S.D.			

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	indicated then the resident said, "You left me and did not give me any silverware." S.S.D. indicated she told Resident #A that she did set up her tray for her yesterday and gave her silverware. S.S.D. indicated she did not report what the resident said on 12-28-11 to the Administrator. S.S.D. indicated she did tell the Dietary Manager what the resident had said, and the Dietary Manager indicated not to worry about it, because she was with her on 12-27-11 when she passed the resident's breakfast tray. During the interview on 2-1-12 at 9:30 a.m., the Administrator indicated she first heard of these allegations at the morning meeting on 1-4-12, nine days after the allegation was first reported. Review of the record of Resident #A on 1-31-12 at 1:15 p.m., indicated the resident's diagnoses included, but were not limited to, Cerebral Vascular Accident (CVA) (stroke), Dementia, glaucoma and anxiety. The Minimum Data Set (MDS) assessment for Resident #A dated 11-2-11, indicated the following: ability to make self understood- understood, ability to understand others- understands, able to report the correct year- correct, ability to report correct month- accurate			

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	within 5 days, ability to report correct year- incorrect, transfer- limited assistance of one person, ability to walk in room- limited assistance of one person, toilet use- limited assistance of one person, mobility device- walker, urinary and bowel continence- always continent and had the resident had any falls since admission- yes. The nurses note for Resident #A dated 12-27-11 at 7:50 a.m., indicated the resident was found on the floor in her room sitting on the left hip. There was a moderate amount of blood on the floor. The resident was bleeding from the mouth and nose. Part of the resident's front tooth was on the floor. A cold cloth and pressure was applied, and the bleeding stopped. The resident denied pain. The resident had reopened a 0.5 centimeter (cm) skin tear to the right knee and reopened an 0.5 cm by 0.6 cm by 0.5 cm skin tear of the left knee. All the areas were cleansed with normal saline and a dressing applied. The resident was able to move all extremities without difficulty. The resident's bed was soiled with urine, and a brief was on the floor. The resident was aware of the fall and of the lost tooth. The resident voiced no concerns related to the event. The Social Service Note for Resident #A			

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	dated 12-27-11 (no time) indicated the resident was found on the floor by the Social Service Director (S.S.D.) and a male resident. Nursing came immediately and cared for resident. The report of Dental Consultation for Resident #A dated 12-29-11 indicated the resident had a broke tooth from a fall on 12-27-11. Review of the facility's file related to the allegation, provided by the Administrator, indicated an interview with Resident #A dated 1-5-12 indicated the resident was asked what happened to her lip. The resident indicated, "They tell me I fell but I don't remember." Review of the facility's file related to the allegation, provided by the Administrator indicated interview with Resident #A's family member dated 1-5-12 indicated the Administrator informed the family member that she had spoken with Resident #A and she could not remember the fall. The Administrator told the family member the resident's fall on 12-27-11 had been investigated and statements had been obtained from staff and there were no concerns of "foul play". The Administrator pointed out to the family member the injuries from 12-27-11 was consistent with a fall..			

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	Review of the State Reportable Incident provided by the Administrator dated 1-9-12 indicated Resident #A had been found on the floor on 12-27-11 by a resident. The Administrator was informed on 1-4-11 that Resident #A had made a statement on 12-27-11 to the Activity Director that the S.S.D. had been in her room doing an interview and she did not want to be in the interview. Resident #A indicated S.S.D. insisted the resident stay and pushed her off the bed. Review of the State Reportable incident provided by the Administrator dated 1-9-12 indicated on 12-27-11 Resident #A was touching her lip and said to the S.S.D. look what you did to me and then said you didn't give me silverware or anything. During interview with the Activity Director on 2-1-12 at 11:20 a.m., indicated on 12-27-11 during lunch Resident #A told her that the S.S.D. was doing an interview in her room that morning. Resident #A indicated she did not want to stay for the interview and attempted to leave the room. Resident #A indicated S.S.D. got mad because she did not want to stay and pushed her off her bed. The Activity Director indicated she asked the resident " I thought you were			

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	going to the bathroom and fell". The Activity Director indicated the resident told her no she did not fall going to the bathroom. The Activity Director indicated she did not report what the resident said because she was told in morning meeting on 12-27-11 that Resident #A had said S.S.D. had left her that morning alone with no silverware. The Activity Director indicated she thought the resident was confused. During interview on 2-1-12 at 11:30 a.m., the Dietary Manager indicated on the morning of 12-27-11, she and the S.S.D. were passing hall trays to the residents. The Dietary Manager indicated the S.S.D. assisted Resident #A to her chair. The Dietary Manager indicated she and the S.S.D. set up the resident's breakfast tray for her. The Dietary Manager indicated Resident #A was eating when they left the room. The Dietary Manager indicated Resident #A had not voiced any complaints or resistance while she was in the room. The Dietary Manager indicated no one had reported an allegation of abuse to her. The Dietary Manager indicated the first time she had heard about the allegation from 12-27-11 was in morning meeting. The Dietary Manager indicated she was not sure of the date of the morning meeting.			

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	During interview on 2-1-12 at 1:00 p.m., the Administrator indicated the facility reported the allegation of the 12-27-11 incident related to Resident #A on 1-9-11. During interview on 2-1-12 at 1:20 p.m., LPN #1 indicated Resident #A's family reported to her that Resident #A had told him the S.S.D. had hit her or punched her on 12-27-11. LPN #1 indicated she could not remember the date the family member reported this to her. LPN #1 indicated she told the family member that the resident was confused and that the situation did not happen. LPN #1 indicated she was the nurse caring for Resident #A on 12-27-11, and the resident had told her she was trying to go to the bathroom and fell. LPN #1 indicated Resident #A never reported any abuse to her. LPN #1 indicated on the morning of 12-27-11, a male resident had reported to the S.S.D. that Resident #A had fallen. LPN #1 indicated the S.S.D. called for her and she had gone and cared for the resident. LPN #1 indicated she did report what the family member had told her to the Administrator, but did not remember the date she reported it. LPN #1 indicated she did not report it the same day the family member had reported it to her. LPN #1 indicated Resident #A had been confused. The S.S.D. hours worked provided by the			

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	Administrator on 2-1-12 at 2:10 p.m., indicated the S.S.D. worked the following hours: 12-27-11- 7.95 hours, 12-28-11- 8.25 hours, 12-29-11- 8 hours, 12-30-11- 7.5 hours, 1-3-12- 7.75 hours and on 1-4-12 worked 5.25 hours. The resident interviews provided by the Administrator on 2-1-12 at 2:10 p.m., indicated two residents were interviewed on 1-4-12 about mistreatment by staff and both residents reported there had been no witnessed mistreatment of residents by staff. This federal tag relates to Complaint IN00102370. 3.1-28(a)			