

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/28/2012
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NAME OF PROVIDER OR SUPPLIER  SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
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F0000	<p>This visit was for the Investigation of Complaints IN00115413 and IN00118601.</p> <p>Complaint IN00115413-Substantiated. Federal/state deficiencies related to the allegation are cited at F 280 and F 323.</p> <p>Complaint IN00118601-Substantiated. Federal/state deficiencies related to the allegations are cited at F 166, F 223, F 225, and F 226.</p> <p>Survey dates: December 27 &amp; 28, 2012</p> <p>Facility number: 000369 Provider number: 155530 AIM number: 100275190</p> <p>Survey team: Janet Adams, RN</p> <p>Census bed type: SNF/NF: 72 Total: 72</p> <p>Census payor type: Medicare: 6 Medicaid: 64</p>	F0000	F0000Please accept this plan of correction as the facility's credible allegation. This plan of correction does not constitute an admission on the part of South Shore Health & Rehabilitation to the accuracy of the surveyor's findings, nor the conclusions there from. The facility's submission of this plan of correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or any of the deficiencies cited are correctly applied.	

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>Other: 2 Total: 72</p> <p>Sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on January 3, 2012, by Janelyn Kulik, RN.</p>						

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F0166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on record review and interview, the facility failed to ensure a resident's grievance related the attitude of a staff member was promptly and thoroughly addressed for 1 of 1 grievances reviewed related to staff attitude towards residents. (Resident #D) (LPN #2)</p> <p>Findings include:</p> <p>A facility Grievance/Complaint Report dated 9/6/12 was reviewed on 12/27/12 at 1:00 p.m. The report indicated the Social Worker completed the report for Resident #D. The report indicated the resident reported LPN #2 had an attitude with him and he knows he and her will continue to "butt heads" if she works on the unit. The report indicated the facility Administrator received the report on 9/6/12. The "Method of Corrections of Complaint" section on the form indicated "will meet" with Nurse regarding "attitude and care." The "Comments" section on the report was blank. There was no</p>	F0166	<p>Please note that the concerns identified for RD occurred prior to the employment of the current Administrator and Director of Nursing and they were not aware of the resident's concern until the time of survey. 1. The following actions have been taken for residents affected by the alleged deficient practice:a. Upon notification by the surveyors of the incomplete follow through for RD the DON and Social Service Director spoke with RD to determine if there had been any further concerns. No further concerns were noted.b. The SSD spoke with RD and encouraged the resident to contact her if there are any issues. 2. All residents have the potential to be affected by the deficient practice. However, the following has been implemented ensure it does not:a. The SSD and Nursing Management were in-serviced by the Regional Director on the Grievance Policy and Procedure stressing the importance of proper investigation to ensure resident safety on January 3, 2013. (attach A) b. The Activity Director met with the Resident Council on 1/10/2013 and discussed the need to report any</p>	01/27/2013			

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	<p>additional information attached to or on the Grievance/Complaint Report.</p> <p>When interviewed on 12/28/12 at 12:55 p.m., the Director of Nursing indicated she was not acting as the Director of Nursing on above date and was not involved in the follow up to the grievance. The Director of Nursing indicated there was no additional information related to the grievance. The Director of Nursing indicated she reviewed LPN #2's employee file and there was no documentation of the above incident in her file.</p> <p>The record for Resident #D was reviewed on 12/28/12 at 12:00 p.m. The resident's diagnoses included, but were not limited to, depression, anxiety, fever, gastritis, and urinary tract infection. The 9/12 Social Service Progress Notes were reviewed. An entry made on 9/6/12 (no time listed) indicated a weekly behavior meeting was held today and staff reviewed two behavior sheets for the resident. The resident was documented as cursing and being verbally abusive. There was no documentation of the 9/6/12 Grievance of follow up.</p> <p>When interviewed on 12/28/12 at</p>		<p>issues of concern to the SSD, Administrator or AD as soon as they arise. (attach B). 3. The following systemic measures have been implemented to ensure the alleged deficient practice does not recur:a. The Activity Director will review resident concerns monthly during Resident Council meetings on going.b. The Nurse Consultant reviewed the Resident Grievance Form with the SSD and the Administrator to allow better follow thru on resident concerns and discussed the importance of proper documentation of the results of the investigations and findings on 1/3/13.4. To ensure continual compliance of the alleged deficient practice the following Quality Assurance measures have been implemented:a. The Activity director will report all issues brought during the monthly meeting to the Administrator and/or SSD for investigation and follow thru.b. The Administrator will review concerns brought for proper completion and follow up.5. Completion date: 1/27/13</p> <p>Requested Addendum to F 166: Please indicate if the auditing will include any interview with alert and oriented residents or with resident's family members. If so please indicate the number of interviews the frequency and who will be conducting the interviews.</p> <p style="text-align: center;"><b>Social Services/Nursing</b></p>		

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	<p>12:55 p.m., the facility Administrator stated the grievance form should have indicated the follow up to resolving the grievance. The facility Administrator indicated the previous Administrator signed the grievance but there was no further documentation.</p> <p>When interviewed on 12/27/12 at 1:45 p.m., Resident #D would only report that the above concerns had happened awhile ago and no problems now.</p> <p>This federal tag relates to Complaint IN00118601.</p> <p>3.1-7(a)(2)</p>		<p>Management will audit 5 residents and/or family members 2x weekly for one month, then weekly x one month, then monthly for three months, and will be reviewed in QA monthly for issues and trends. (Attachment Y)</p>		

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F0223 SS=D	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to ensure resident's remained free from verbal abuse related to a resident being spoken to in a degrading manner for 1 of 1 substantiated allegations of verbal abuse allegations reviewed. (Resident #F) (CNA #4)</p> <p>Findings include:</p> <p>Facility Abuse allegations were reviewed on 12/28/12 at 11:45 a.m. An allegation dated 9/18/12 indicated Resident #F alleged CNA #4 insulted him and spoke down to him because he urinated on the floor and stated to him he was going to make her kids sick. The facility investigation indicated the CNA was suspended pending the investigation and was then terminated.</p> <p>The facility investigation included written documentation of the previous</p>	F0223	<p>1.The following actions have been taken for those residents affected by the alleged deficient practice:</p> <p>1.The previous Administrator and DON had completed the investigation on the concern provided by RF in September of 2012.</p> <p>2.The SSD spoke with RF and no further concerns were voiced.</p> <p>2. All the residents in the facility have the potential to be affected by the alleged deficient practice. However the following was implemented:</p> <p>1.On 1/3/13 at 1100am the Administrator was in-serviced by the Nurse Consultant, Jacque Whitley, RN, on the Abuse Policy for the facility and steps for completing an investigation. On 1/3/13 the Nurse Consultant, Jacque Whitley, RN, in-serviced the</p>	01/27/2013	

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	<p>Director of Nursing's questioning of the involved CNA. The investigation indicated the Director of Nursing's statement indicated she informed the CNA she was in violation of several Federal regulations including Verbal Abuse. A Mood/Behavior Report Sheet was included in the Investigation forms. The Mood/Behavior Report Sheet was completed by CNA #4 on 9/18/12. The sheet indicated Resident #F had urinated on the floor, uses the urinal and fills it until it runs over. The sheet also indicated "I have asked him to call someone when it's half full and other aids [sic] have asked too. Every time I go in his room I step in piss. Can somebody please talk to him or can we put a diaper on him."</p> <p>The "Investigation of Possible Neglect Abuse" form indicated the resident complained of mistreatment by staff as the CNA spoke to him in a derogatory manner. The corrective action listed on the form indicated the CNA was terminated. There were no statements or interviews obtained from any other staff members who worked with the CNA. There were no other statements obtained from other residents CNA #4 may have taken care of or had contact with to determine if the CNA had interacted</p>		<p>DON, SSD, and the nursing management team on the Abuse Policy and steps for completing an investigation. The need to investigate with residents and staff that may have knowledge of the situation was stressed.</p> <p>3. The following systemic measures have been implemented to ensure the alleged deficient practice does not recur:</p> <p>1.On 1/3/13 the Administrator and DON was provided with an Investigation of Neglect/Abuse form by the Nurse Consultant. This form is to help itemize steps that are needed for investigation (attachment C ).</p> <p>2.On 1/3/13 the Nurse Consultant met with the SSD and the Nursing Management team for review of the Abuse Policy and.was provided with guidelines to reflect the Abuse Prevention Policy, Section-Resident Protection Investigation Procedure on conducting investigations(attachment C ).</p> <p>1.Starting 1/3/13the Administrator and/or DON is to immediately notify the Nurse Consultant of any</p>				

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	<p>with any other residents in the same manner.</p> <p>The record for Resident #F was reviewed on 12/28/12 at 2:45 p.m. The resident's diagnoses included, but were not limited to, psychosis, seizures, anxiety, and renal failure. The 11/15/12 Minimum Data Set (MDS) quarterly assessment indicated the residents BIMS (Brief Interview for Mental Status) score was (15). This indicated the resident's cognitive patterns were intact.</p> <p>The 9/18/12 Social Service Progress Note was reviewed. The note indicated the resident reported the staff member (who completed the green behavior sheet) treated him like a child and feels the staff member is "degrading" to him. The note also indicated the resident told the Social Worker he felt the CNA was "picking on him."</p> <p>The facility "Abuse Prevention Program Facility Policy" was provided by the facility. The policy was reviewed on 12/28/12 at 11:30 a.m. There was no date on the policy. The "Investigation Procedures" section of the Abuse Policy indicated interviews were to be completed with</p>		<p>incident that involves potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property to ensure compliance with F223.</p> <p>2. To ensure the facility completes a thorough investigation, the staff on duty at the time of administrator notification will be informed to make a note of all residents cared for by staff in question at the time of incident which will be included in the investigation as well as the staff on duty. Staff members assigned to complete the investigation will write a summary of the responses of the staff member and others interviewed.</p> <p>3. The Administrator and/or Nurse Consultant will review the investigations completed for thoroughness. Starting 1/10/13 the Administrator and/or the DON will provide the Nurse Consultant with the results of the investigation for review. The Nurse Consultant will provide the Administrator and/or the DON with recommendations as required.</p> <p>1. To ensure continual compliance of the alleged deficient practice the following</p>		

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	<p>other residents to which the accused staff member had regular contact with and also other employees to determine if they have ever witnessed other incidents involving the accused individual.</p> <p>When interviewed on 12/28/12 at 12:30 p.m., the Unit Manager/Restorative Nurse indicated the allegation was first noted when the IDT (Interdisciplinary Team) reviewed the Behavior Form in the morning meeting and the investigation began at this time.</p> <p>When interviewed on 12/28/12 at 12:35 p.m., the Director of Nursing indicated the previous Director of Nursing investigated the above allegation.</p> <p>When interviewed on 12/28/12 at 12:35 p.m., the facility Administrator indicated the previous Administrator and previous Director of Nursing investigated the above allegation. The Administrator indicated interviews should have been obtained from other residents and staff members as per the Abuse Policy.</p> <p>This federal tag relates to Complaint IN00118601.</p>		<p>Quality Assurance measures have been implemented:</p> <p>1.The Administrator will review all abuse investigations immediately to make sure they are completed thoroughly and timely. The Administrator will then present a summary of the findings to the Quality Assurance Committee monthly on going.</p> <p>2.The Administrator will provide staff education on the Abuse Policy as required as identified thru the reviews of the investigations.</p>		

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	3.1-27(b)			

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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 record review and</p>	F0225	1.The following actions have	01/27/2013			

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	<p>interview, the facility failed to thoroughly investigate an allegation of verbal abuse related to obtaining interviews from other staff members and residents for 1 of 1 allegations of verbal abuse reviewed. (Resident #F) (CNA #4)</p> <p>Findings include:</p> <p>Facility Abuse allegations were reviewed on 12/28/12 at 11:45 a.m. An allegation dated 9/18/12 indicated Resident #F alleged CNA #4 insulted him and spoke down to him because he urinated on the floor and stated to him he was going to make her kids sick. The facility investigation indicated the CNA was suspended pending the investigation and was then terminated.</p> <p>The facility investigation included written documentation of the previous Director of Nursing's questioning of the involved CNA. The investigation indicated the Director of Nursing's statement indicated she informed the CNA she was in violation of several Federal regulations including Verbal Abuse. A Mood/Behavior Report Sheet was included in the Investigation forms. The Mood/Behavior Report Sheet was</p>		<p>been taken for those residents affected by the alleged deficient practice:</p> <ol style="list-style-type: none"> <li>1. The previous Administrator and DON had completed the investigation on the concern provided by RF in September of 2012.</li> <li>2. The SSD spoke with RF and no further concerns were voiced.</li> </ol> <p>2. All the residents in the facility have the potential to be affected by the alleged deficient practice. However the following was implemented:</p> <ol style="list-style-type: none"> <li>1. On 1/3/13 at 1100am the Administrator was in-serviced by the Nurse Consultant, Jacque Whitley, RN, on the Abuse Policy for the facility and steps for completing an investigation. On 1/3/13 the Nurse Consultant, Jacque Whitley, RN, in-serviced the DON, SSD, and the nursing management team on the Abuse Policy and steps for completing an investigation. The need to investigate with residents and staff that may have knowledge of the situation was stressed.</li> <li>3. The following systemic measures have been implemented to ensure the alleged deficient practice does not recur: <ul style="list-style-type: none"> <li>1. On 1/3/13 the Administrator and DON was provided with an Investigation of Neglect/Abuse form by the Nurse Consultant. This form is to help itemize steps that are needed for investigation (attachment C ).</li> </ul> </li> </ol>				

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	<p>completed by CNA #4 on 9/18/12. The sheet indicated Resident #F had urinated on the floor, uses the urinal and fills it until it runs over. The sheet also indicated "I have asked him to call someone when it's half full and other aids [sic] have asked too. Every time I go in his room I step in piss. Can somebody please talk to him or can we put a diaper on him."</p> <p>The "Investigation of Possible Neglect Abuse" form indicated the resident complained of mistreatment by staff as the CNA spoke to him in a derogatory manner. The corrective action listed on the form indicated the CNA was terminated. There were no statements or interviews obtained from any other staff members who worked with the CNA. There were no other statements obtained from other residents CNA #4 may have taken care of or had contact with to determine if the CNA had interacted with any other residents in the same manner.</p> <p>The record for Resident #F was reviewed on 12/28/12 at 2:45 p.m. The resident's diagnoses included, but were not limited to, psychosis, seizures, anxiety, and renal failure. The 11/15/12 Minimum Data Set (MDS) quarterly assessment</p>		<p>2. On 1/3/13 the Nurse Consultant met with the SSD and the Nursing Management team for review of the Abuse Policy and was provided with guidelines to reflect the Abuse Prevention Policy, Section-Resident Protection Investigation Procedure on conducting investigations(attachment C ).</p> <p>1. Starting 1/3/13 the Administrator and/or DON is to immediately notify the Nurse Consultant of any incident that involves potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property to ensure compliance with F225.</p> <p>2. To ensure the facility completes a thorough investigation, the staff on duty at the time of administrator notification will be informed to make a note of visitors in the facility and which residents were in close proximity at the time of the incident which will be included in the investigation as well as the staff on duty. Staff members assigned to complete the investigation will write a summary of the responses of the staff member and others interviewed.</p> <p>3. The Administrator and/or Nurse Consultant will review the investigations completed for thoroughness. Starting 1/10/13 the Administrator and/or the DON will provide the Nurse Consultant with the results of the investigation for review. The</p>		

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	<p>indicated the residents BIMS (Brief Interview for Mental Status) score was (15). This indicated the resident's cognitive patterns were intact.</p> <p>The 9/18/12 Social Service Progress Note was reviewed. The note indicated the resident reported the staff member (who completed the green behavior sheet) treated him like a child and feels the staff member is "degrading" to him. The note also indicated the resident told the Social Worker he felt the CNA was "picking on him."</p> <p>The facility "Abuse Prevention Program Facility Policy" was provided by the facility. The policy was reviewed on 12/28/12 at 11:30 a.m. There was no date on the policy. The "Investigation Procedures" section of the Abuse Policy indicated interviews were to be completed with other residents to which the accused staff member had regular contact with and also other employees to determine if they have ever witnessed other incidents involving the accused individual.</p> <p>When interviewed on 12/28/12 at 12:30 p.m., the Unit Manager/Restorative Nurse indicated</p>		<p>Nurse Consultant will provide the Administrator and/or the DON with recommendations as required.</p> <p>1.To ensure continual compliance of the alleged deficient practice the following Quality Assurance measures have been implemented:</p> <p>1.The Administrator will review all abuse investigations immediately to make sure they are completed thoroughly and timely. The Administrator will then present a summary of the findings to the Quality Assurance Committee monthly on going.</p> <p>2.The Administrator will provide staff education on the Abuse Policy as required as identified thru the reviews of the investigations.</p>		

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	<p>the allegation was first noted when the IDT (Interdisciplinary Team) reviewed the Behavior Form in the morning meeting and the investigation began at this time.</p> <p>When interviewed on 12/28/12 at 12:35 p.m., the Director of Nursing indicated the previous Director of Nursing investigated the above allegation.</p> <p>When interviewed on 12/28/12 at 12:35 p.m., the facility Administrator indicated the previous Administrator and previous Director of Nursing investigated the above allegation. The Administrator indicated interviews should have been obtained from other residents and staff members as per the Abuse Policy.</p> <p>This federal tag relates to Complaint IN00118601.</p> <p>3.1-28(d)</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 record review and interview, the facility failed to follow their Abuse policy related to obtaining interviews with staff members and residents during the investigation of 1 of 1 allegations of verbal abuse reviewed.</p> <p>(Resident #F) (CNA #4)</p> <p>Findings include:</p> <p>Facility Abuse allegations were reviewed on 12/28/12 at 11:45 a.m. An allegation dated 9/18/12 indicated Resident #F alleged CNA #4 insulted him and spoke down to him because he urinated on the floor and stated he was going to make her kids sick. The facility investigation indicated the CNA was suspended pending the investigation and was then terminated.</p> <p>The facility investigation included written documentation of the previous Director of Nursing's questioning of the involved CNA. The investigation</p>	F0226	<p>1.The following actions have been taken for those residents affected by the alleged deficient practice:</p> <p>1.On 1/3/13 the Administrator, DON, SSD and the Nursing Management team reviewed the Abuse Prevention Policy and Procedure with the Nurse Consultant to ensure understanding of the policy and procedure including investigations. ( attachment A)</p> <p>2. All the residents in the facility have the potential to be affected by the alleged deficient practice. However the following was implemented:</p> <p>1.On 1/3/13 at 1100am the Administrator was in-serviced by the Nurse Consultant, Jacque Whitley, RN, on the Abuse Policy for the facility and steps for completing an investigation. (attachment A)</p> <p>2.On 1/3/13 the Nurse Consultant, Jacque Whitley, RN, in-serviced the DON, SSD, and the nursing</p>	01/27/2013			

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	<p>indicated the Director of Nursing's statement indicated she informed the CNA she was in violation of several Federal regulations including Verbal Abuse. A Mood/Behavior Report Sheet was included in the Investigation forms. The Mood/Behavior Report Sheet was completed by CNA #4 on 9/18/12. The sheet indicated Resident #F had urinated on the floor, uses the urinal and fills it until it runs over. The sheet also indicated "I have asked him to call someone when it's half full and other aids [sic] have asked too. Every time I go in his room I step in piss. Can somebody please talk to him or can we put a diaper on him."</p> <p>The "Investigation of Possible Neglect Abuse" form indicated the resident complained of mistreatment by staff as the CNA spoke to him in a derogatory manner. The corrective action listed on the form indicated the CNA was terminated. There were no statements or interviews obtained from any other staff members who worked with the CNA. There were no other statements obtained from other residents CNA #4 may have taken care of to determine if the CNA had interacted with any other residents in the same manner.</p>		<p>management team on the Abuse Policy and steps for completing an investigation. The need to investigate with residents and staff that may have knowledge of the situation was stressed (attachment A)</p> <p>3. The following systemic measures have been implemented to ensure the alleged deficient practice does not recur:</p> <p>1.On 1/3/13 the Administrator and DON was provided with an Investigation of Neglect/Abuse form by the Nurse Consultant. This form is to help itemize steps that are needed for investigation (attachment C)</p> <p>1.On 1/3/13 the Nurse Consultant met with the SSD and the Nursing Management team for review of the Abuse Policy and was provided with guidelines to reflect the Abuse Prevention Policy, Section-Resident Protection Investigation Procedure on conducting investigations</p> <p>1.Starting 1/3/13the Administrator and/or DON is to immediately notify the Nurse Consultant of any incident that involves</p>				

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	<p>The facility "Abuse Prevention Program Facility Policy" was provided by the facility. The policy was reviewed on 12/28/12 at 11:30 a.m. There was no date on the policy. The "Investigation Procedures" section of the Abuse Policy indicated interviews were to be completed with other residents to which the accused staff member had regular contact with and other employees to determine if they have ever witnessed other incidents involving the accused individual.</p> <p>When interviewed on 12/28/12 at 12:35 p.m., the facility Administrator indicated the previous Administrator and previous Director of Nursing investigated the above allegation. The Administrator indicated interviews should have been obtained from other residents and staff members as per the Abuse Policy.</p> <p>This federal tag relates to Complaint IN00118601.</p> <p>3.1-28(a)</p>		<p>potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property to ensure compliance with F225.</p> <p>2. To ensure the facility completes a thorough investigation, the staff on duty at the time of administrator notification will be informed to make a note of visitors in the facility and which residents were in close proximity at the time of the incident which will be included in the investigation as well as the staff on duty. Staff members assigned to complete the investigation will write a summary of the responses of the staff member and others interviewed.</p> <p>3.The Administrator and/or Nurse Consultant will review the investigations completed for thoroughness. Starting 1/10/13 the Administrator and/or the DON will provide the Nurse Consultant with the results of the investigation for review. The Nurse Consultant will provide the Administrator and/or the DON with recommendations as required.</p> <p>1.To ensure continual compliance of the alleged deficient practice the following</p>		

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			<p>Quality Assurance measures have been implemented:</p> <p>1.The Administrator will review all abuse investigations immediately to make sure they are completed thoroughly and timely. The Administrator will then present a summary of the findings to the Quality Assurance Committee monthly on going.</p> <p>2.The Administrator will provide staff education on the Abuse Policy as required as identified thru the reviews of the investigations.</p> <p>2.Completion date:1/27/2013</p>		

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F0280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to ensure the resident's plan of care was updated related to interventions after recent falls for 2 of 3 residents reviewed for fall in the sample of 5. (Residents #C and #E)</p> <p>Findings include:</p> <p>1. The record for Resident #E was reviewed on 12/27/12 at 3:10 p.m. The resident's diagnoses included, but were not limited to, cataracts, glaucoma, and intellectual disability. The 12/4/12 Minimum Data Set (MDS) quarterly assessment</p>	F0280	<p>1. For the resident found to be affected by the alleged deficient practice the following corrective actions have been taken: A. RC and RE's, care plans were reviewed and revised to meet the resident's current needs. (attachment I) B. On 1/3/13 the Nursing Management team was in-serviced by the Nurse Consultant regarding the importance of assessing, documenting and care planning resident needs attachment A) 2. Any resident in the facility has the potential to be affected by the alleged deficient practice. However, the following has been implemented: A. The Nursing Management team reviewed</p>	01/27/2013			

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	<p>indicated the resident's BIMS (Brief Interview for Mental Status) score was (1). This indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident was dependent on staff for transfers. A care plan initiated on 6/14/12 indicated the resident was at risk for falls. Interventions listed on the care plan did not include the use of a Dycem in the resident's wheel chair.</p> <p>The 12/2012 Nurses' Notes were reviewed. An entry made on 12/7/12 at 5:30 p.m., indicated the CNA reported the resident was on the floor in her room. The Nurse then observed the resident sitting on the floor next to her bed, The entry also indicated "w/c (wheel chair) @ (at) side." . The resident was alert and verbally responsive and had no complaints of pain or discomfort. A head to toe assessment was obtained and no open or red areas were observed.</p> <p>When interviewed on 12/27/12 at 1:30 p.m., the Unit Manager/Restorative Nurse provided information from the facility Incident Report related to the above fall. The Unit Manager indicated a Dycem was to be applied to the wheelchair after</p>		<p>residents assigned to them to ensure the resident's care plan was accurate. 3. In order to ensure the alleged deficient practice does not recur the facility implemented the following systemic changes: A. Department Heads were assigned residents for review each day to ensure that needs and interventions identified on the resident care plan are addressed appropriately. B. Any changes in resident needs will be included on the 24 hour report and care card. C. A nursing management team member has been assigned to each hall to review resident care and care cards. 4. The following QA Programs were implemented to ensure continual compliance: A. Any issues identified will be reported to the Administrator during the Morning Quality Assurance meeting for discussion of correction actions needed with appropriate facility staff. B. The Administrator will review reports received thru the for trends and will report to the Quarterly Quality Assurance Meetings. 5. Completion Date: 1/27/2013 Requested Addendum to F 280: Please indicate the frequency of the review of the resident care and the care cards.</p> <p><b>A mass audit of care cards will be done with the care plan audit, ten per day, completed by the 1/25/2013. Then Q week per unit manager on assigned unit.</b></p>				

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	<p>the fall as the resident stated she slid forward at the time.</p> <p>When interviewed on 12/28/12 at 11:30 a.m., RN #1 indicated she was assigned to care for Resident #E. The RN indicated she was not sure the resident was to have a Dycem to the wheel chair. The RN then looked at the current Resident Care Sheet for Resident #E and the Dycem was not listed on the sheet.</p> <p>When interviewed on 12/28/12 at 1:15 p.m., the Unit Manager/Restorative Nurse indicated the resident care sheets and care plans should have been updated with the new intervention.</p> <p>2. The record for Resident #C was reviewed on 12/27/12 at 2:00 p.m. The resident's diagnoses included, but were not limited to, Cadasil Syndrome (a neurological disorder), high blood pressure, depression, and generalized weakness. A Fall Risk Assessment completed on 12/14/12 indicated the resident was at risk for falls. A Care Plan initiated on 8/9/12 indicated the resident was at risk for falls. Care plan interventions included for staff to be sure the resident's call light was within reach. Care plan interventions did not</p>		(Attachment X)		

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	<p>include for staff to ensure the resident's urinal was available. The Resident Care Sheets were reviewed. The resident's Resident Care Sheet did not note for the resident to have a urinal available.</p> <p>The 12/1/2012 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status ) score was (2). This indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required limited assistance of staff for transfers, bed mobility, toilet use, and walking.</p> <p>The 12/2012 Nurses' Notes were reviewed. An entry made on 12/15/12 at 12:00 p.m., indicated the resident was found sitting on the bathroom floor. No injury was observed and the resident verbalized no complaints of pain,</p> <p>When interviewed on 12/27/12 at 1:35 p.m., the Unit Manager/Restorative Nurse provided information from the facility Incident Report for the 12/15/12 fall. The Unit Manager indicated the resident was found sitting on the bathroom floor at 9:00 a.m. The resident stated he was attempting to go to the bathroom.</p>				

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	<p>The intervention put in place at that time was to have a urinal available for the resident.</p> <p>When interviewed on 12/28/12 at 1:15 p.m., the Unit Manager/Restorative Nurse indicated the resident care sheets and care plans should have been updated with the new intervention.</p> <p>This federal tag relates to Complaint IN00115413.</p> <p>3.1-35(e)</p>				

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility to provide adequate supervision to prevent accidents for residents at risk for fall related to call lights and personal items not in reach, floor mats not in place, dycem (material to prevent sliding) not in place, non skid footwear not on when transferring a resident, and a resident left alone in the bathroom, for 3 of 3 residents reviewed for falls in the sample of 5. (Residents #B, #C, and #E)</p> <p>Findings include:</p> <p>1. During Orientation Tour on 12/27/12 at 9:20 a.m., Resident #B was observed sitting on the side of his bed. The opposite side of the bed was near the wall. There was no floor mat in place on the side of the bed near the wall. The call light cord was hanging from the wall and the end of the cord with the call button was on the floor and not in the resident's reach. There were no staff members in the resident's room when entering</p>	F0323	<p>1.The corrective action for the alleged deficient practice has been achieved by the following: 1.RB was re-assessed and the Level of Care Card was revised to reflect the needs of the resident To ensure shoes applied prior to transfer, and urinal, floor mats, and alarms intact for resident. The need for the use of shoes, was addressed with the staff on 12/28/12 by the DON. (attachment E) 2.RE was re-assessed and the Level of Care Card was revised to reflect the needs of the resident. The need for a dysom was addressed on the Care Card and with the staff on 12/28/12by the DON. (Attachment F) 3.RC was re-assessed and the Level of Care Card was reviewed and revised to reflect the needs of the resident. The need to make sure the resident has the call light and personal belongings needed within reach was addressed with the staff on 12/28/12 by the DON (attachment G) 2.All residents in the facility have the potential to be affected by the alleged deficient practice. However, due to the</p>	01/27/2013	

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	<p>the room. When interviewed at this time, the Unit Manager indicated the resident had recent falls and was a fall risk.</p> <p>On 12/27/12 at 10:52 a.m., the resident was observed in bed. There was no floor mat on the floor on the resident's right side. A floor mat was observed near the foot of the bed. CNA #1 entered the resident's room at this time. The CNA transferred the resident from the bed to the wheel chair at this time. The resident was not wearing any socks, shoes, or any other type of footwear when the CNA transferred him.</p> <p>The record for Resident #B was reviewed on 12/27/12 at 11:00 a.m. The resident's diagnoses included, but were not limited to, dementia with delusional disorder, seizures, depression, diabetes mellitus, right sided weakness, high blood pressure, and anemia.</p> <p>The 11/7/2012 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (11). A score of (11) indicated the resident's cognitive patterns moderately impaired. The assessment also indicated the resident required extensive</p>		<p>implementation of the following, the alleged deficient practice will not recur:</p> <p>1.The DON in-serviced the nursing staff on 1/11/13 regarding the need to review the Level of Care Cards for residents. (attachment H)</p> <p>2.The Nursing Management team initiated an audit on 1/3/13 of the Level of Care Cards to ensure appropriate directions for care are addressed for the residents .</p> <p>1.The following systemic measures have been implemented to ensure the alleged deficient practice does not recur:</p> <p>1.The DON/designee will audit four Level of Care Cards and the delivery of care to those residents being reviewed weekly for one month and then every other week for two months and then once monthly for four months to ensure accuracy. The Department Heads have been assigned residents for review during rounds.</p> <p>1.The following Quality Assurance programs have been implemented to ensure continued compliance:</p> <p>1.The DON and the department heads will provide the Administrator with information regarding the audits during the morning Quality Assurance Meetings.</p> <p>2.The Administrator will</p>				

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	<p>assistance of one staff person for bed mobility, transfers, and toilet use. The assessment also indicated the resident had functional limitation in range of motion to his upper and lower extremities on one side.</p> <p>Review of the resident's current care plans indicated there was a care plan indicating the resident was at risk for fall related to a history of falls, requiring assistance with transfers and mobility, and a diagnosis of seizure disorder. The care plan was initiated on 2/2/12. The care plan was last updated on 12/4/12. Care plan interventions included for the resident to have wheelchair and seat alarms, floor mats x 2 in place, and to ensure the call light was within reach. Other interventions included to gather information of past falls and attempt to determine the cause of the falls and to anticipate and intervene to prevent recurrence.</p> <p>A Fall Risk Assessment completed on 8/17/12 indicated the resident's total score was (16). A Fall Risk Assessment completed on 9/21/12 indicated the resident's total score was (16). The Fall Risk Assessment form indicated a total score of (10) or above represented a high risk for falls.</p>		<p>report all trends and responses to the Monthly Quality Assurance Committee.</p> <p>1.Completion: 1/27/2013 Requested Addendum to F 323: Please indicate if any observations will be made during the review of the residents to ensure proper interventions are in place to prevent the deficient practice from recurring. If so, please indicate the number of observations and the frequency of the observation.</p> <p><b>All incident reports reviewed from the month of December, interventions/safety devices checked for placement, and the IDT Compliance rounds are to include an audit of the alarms, mats and safety devices utilized by the rooms being checked. (Attachment 2)</b></p>		

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	<p>The 8/2012 Nurses' Notes were reviewed. An entry made on 8/17/12 at 1:00 p.m. indicated the Nurse was informed by staff that the resident had fallen. Upon entering the room the resident was observed sitting on the bathroom floor and no injuries were noted.</p> <p>An entry made on 8/24/12 at 10:50 p.m. indicated the resident pushed the call light and requested the aide to assist him to the bathroom. The resident was assisted to the bathroom and the aid instructed him to call push the call button when finished. The aide was called to the Nurses' station by the Nurse. A loud "thud" was heard and when staff entered the room the resident was on his right side on the floor. No bleeding or bruising noted and the resident verbalized pain only to his right temple. Neurological checks were started and the Physician was called. Orders were obtained to send the resident to the hospital for an evaluation.</p> <p>The 11/2012 Nurses' Notes were reviewed. An entry made on 11/18/12 at 9:20 a.m. indicated the resident had requested staff to put him on the toilet. The Nurse and CNA</p>			

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	<p>requested that the resident put on the call light for assistance.</p> <p>When interviewed on 12/27/12 at 12:30 p.m., the Unit Manager/Restorative Nurse provided information from the facility Incident Report for the above 11/18/12 fall. The Unit Manager indicated an Incident Report was completed on 11/18/12 for the fall which occurred at 9:20 a.m. The Unit Manager indicated the report noted the resident fell on his buttock while attempting to transfer to the wheel chair from the toilet. The Nurses' statement indicated the resident requested to be toileted at 9:15 a.m. and the Nurse and the CNA instructed the resident to pull the call light. Staff returned five minutes later to check on the resident and the resident was found on his buttock.</p> <p>When interviewed on 12/28/12 at 9:20 a.m., the Unit Manager/Restorative Nurse provided information from the facility Incident Report for the above 8/24/12. The Unit Manager indicated the resident fell in the bathroom on 8/24/12 at 10:50 p.m. The Unit Manager indicated he resident was sent to the Emergency Room and returned with a soft cast his arm. The Unit</p>						

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	<p>Manager indicated the resident went to the Orthopedic Physician after the fall and it was determined there was no new fracture. The Unit Manager indicated the Incident Report noted the resident was assisted to the toilet by staff and instructed to flip the switch to call for assistance. The Unit Manager indicated the resident was left alone in the bathroom and fall and was sent to the Emergency Room due to swelling and complaints of pain to the forehead. When interviewed further at this time, the Unit Manager indicated the resident was a fall risk and had a history of transferring himself unassisted with falls occurring. The Unit Manager indicated interventions of alarms and floor mats were in place due to the resident's fall risk.</p> <p>When interviewed on 12/28/12 at 1:15 p.m., the Unit Manager indicated the resident should not have been transferred without shoes.</p> <p>2. On 12/27/12 at 10:45 a.m., Resident #E was observed sitting in wheel chair in her room. CNA #2 entered the resident's room and began to transfer the resident from the wheel chair into the bed. The CNA used a gait belt while</p>			

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	<p>transferring the resident into bed. There was no cushion to the seat of the wheel chair. There was no dycem in place to the seat of the wheel chair.</p> <p>The record for Resident #E was reviewed on 12/27/12 at 3:10 p.m. The resident's diagnoses included, but were not limited to, cataracts, glaucoma, and intellectual disability. The 12/4/12 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (1). This indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident was dependent on staff for transfers. A care plan initiated on 6/14/12 indicated the resident was at risk for falls.</p> <p>The 12/2012 Nurses' Notes were reviewed. An entry made on 2/7/12 at 5:30 p.m., indicated the CNA reported the resident was on the floor in her room. The Nurse then observed the resident sitting on the floor next to her bed, The entry also indicated "w/c (wheel chair) @ (at) side." . The resident was alert and verbally responsive and had no complaints of pain or discomfort. A head to toe assessment was obtained and no open or red areas were observed.</p>				

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	<p>When interviewed on 12/27/12 at 1:30 p.m., the Unit Manager/Restorative Nurse provided information from the facility Incident Report related to the above fall. The Unit Manager indicated a Dycem was to be applied to the wheelchair after the fall as the resident stated she slid forward at the time of the above fall from the wheel chair.</p> <p>When interviewed on 12/28/12 at 11:30 a.m., RN #1 indicated she was assigned to care for Resident #E. The RN indicated she was not sure the resident was to have Dycem to the wheel chair. The RN then looked at the current Resident Care Sheet for Resident #E and the Dycem was not listed on the sheet.</p> <p>When interviewed on 12/28/12 at 1:15 p.m., the Unit Manager/Restorative Nurse indicated the Dycem should have been in place.</p> <p>3. On 12/27/12 at 10:40 a.m., Resident #C was observed in bed. One side of the resident's bed was up against the wall. There were no staff members or visitors in the resident's room at this time. The resident's over bed table was against the wall</p>				

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	<p>between the resident's bed and the television stand. The resident's water pitcher and package of crackers were on the table. Neither of these items were in the resident's reach. There was no urinal on the table or any where in the resident's reach.</p> <p>On 12/27/12 at 2:30 p.m., the resident was observed in a geri chair in the reclined position in his room. The chair was approximately 3 feet away from the resident's bed. The resident's call light was on top of the bed and not in the resident's reach. The resident's over bed table was not in reach either. No urinal was noted in the resident's room. There were no staff members or visitors in the resident's room at this time.</p> <p>On 12/27/12 at 4:15 p.m., the resident was observed in bed. There was no urinal in the resident's reach. There were not staff members or visitors in the resident's room at this time.</p> <p>On 12/28/12 at 7:40 a.m., 8:00 a.m., and 8:35 a.m., the resident was observed in bed. The resident's call light button was on the floor under the resident's bed at the above times. There was no urinal in the resident's room. There were no staff members</p>			

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	<p>or visitors in the room at these above times.</p> <p>The record for Resident #C was reviewed on 12/27/12 at 2:00 p.m. The resident's diagnoses included, but were not limited to, Cadasil Syndrome (a neurological disorder), high blood pressure, depression, and generalized weakness. A Fall Risk Assessment completed on 12/14/12 indicated the resident was at risk for falls. A Care Plan initiated on 8/9/12 indicated the resident was at risk for falls related to a history of falls, decreased strength and endurance, and decreased safety awareness. Care plan interventions included for staff to be sure the resident's call light was in reach.</p> <p>The 12/1/2012 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status ) score was (2). This indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required limited assistance of staff for transfers, bed mobility, toilet use, and walking.</p> <p>The 12/2012 Nurses' Notes were reviewed. An entry made on 12/15/12 at 12:00 p.m., indicated the resident</p>						

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	<p>was found sitting on the bathroom floor. No injury was observed and the resident verbalized no complaints of pain,</p> <p>When interviewed on 12/27/12 at 1:35 p.m., the Unit Manager/Restorative Nurse provided information from the facility Incident Report for the 12/15/12 fall. The Unit Manager indicated the resident was found sitting on the bathroom floor at 9:00 a.m. The resident stated he was attempting to go to the bathroom. The intervention put in place at that time was to have a urinal available for the resident.</p> <p>This federal tag relates to Complaint IN00115413.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>			