

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155402	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/19/2012
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NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906
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F0000	<p>This visit was for the Investigation of Complaint IN00111749.</p> <p>Complaint IN00111749 - Substantiated. Federal/state deficiencies related to the allegations are cited at F 241, F 312, F314.</p> <p>Survey dates: July 18 and 19, 2012</p> <p>Facility number: 000271 Provider number: 155402 AIM number: 100291260</p> <p>Survey team: Michelle Hosteter RN-TC</p> <p>Census bed type: SNF/NF: 76 Total: 76</p> <p>Census payor type: Medicare: 12 Medicaid : 56 Other: 8 Total: 76</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 7/24/12 by Suzanne</p>	F0000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Heritage Healthcare desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on August 18, 2012. We are requesting paper compliance effective 8/18/12.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	Williams, RN			

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F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on record review and interview, the facility failed to maintain dignity for a resident with incontinence. This affected 1 of 1 resident reviewed for dignity in a sample of 3. [Resident B]</p> <p>Findings include:</p> <p>The clinical record of Resident B was reviewed on 7/19/12 at 6:20 A.M. Diagnoses included, but were not limited to, CHF (Congestive Heart Failure), diabetes, chronic kidney disease and depression. The resident resided on Ross Hall.</p> <p>A care plan for Resident B dated 3/4/11, with a revision date of 7/11/12, indicated for incontinence, "...has frequent episodes of urinary incontinence related to loss of bladder control, CHF, chronic kidney disease, and diabetes...Skin will remain intact without reddened or open areas r/t incontinence through next review..."</p> <p>The Executive Director offered information regarding Resident B</p>	F0241	<p>It is the policy of this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 1. <i>What corrective action will be done by the facility?</i> An investigation was completed following this alleged incident. Staff members involved in the incident were retrained on following resident's plan of care for toileting and position changes, and corrective action was given. After the alleged incident resident B had a 3 day bladder diary completed and was referred to therapy for bladder retraining and pelvic floor strengthening. Resident B was placed on an every hour prompted toileting regimen to include one hour checks through the night. Resident B's care plan was reviewed and updated. 2. <i>How will the facility identify other residents having the potential to be affected by the same practice?</i> 100% of residents' bowel and bladder function will be reassessed and ensured they are placed on appropriate program for toileting and incontinence</p>	08/18/2012			

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	<p>involving an investigation they did for an incident that occurred on 7/2/12, on 7/18/12 at 10 A.M. The family of Resident B was upset due to a recliner being soaked with urine and not cleaned in a timely fashion.</p> <p>A schedule dated July 2, 2012, indicated CNA #2 and LPN #1 were working on Ross Hall where the resident resided.</p> <p>CNA #2 indicated in an undated statement, "...On Monday July 2nd ...worked Ross hall/Stuart hall . I went into the resident's room at 10:15 P.M. I was passing ice water. She (resident) stated she was reading (and) not ready for bed yet. I went back at 11:00 P.M., she was still reading. I then told her that I'd check on her in a bit. About an hour later, (12:00 A.M.) i checked on her and she had fallen asleep. She was alert (sign for and) oriented and had her call light pinned to her chair. The nurse, told me she would call with her call light when she needed something. At 5:00 A.M. i went in to get roommate up. Resident woke up and yelled at me for a few mins. (minutes) , and then had me get her a fluffy blanket because she was cold. She never once asked me to put her to bed that night. I asked resident if she would like to speak to a nurse, and she said no."</p>		<p>management by nursing department. This will be completed by 8/18/12. Upon admission resident's bowel and bladder function will be assessed and they will be placed on appropriate program for toileting and incontinence management.</p> <p>3. <i>What measures will be put in place to ensure this practice does not recur?</i> A mandatory nursing staff in-service will be performed on 8/07/2012 by Staff Development Coordinator. This in-service will include that all residents are to be checked at least every two hours for position change, toileting needs/ incontinent care, skin care, and call light response time. This in-service will also review resident dignity and respect. Walking rounds have been implemented with off going and on going shifts giving and receiving report while observing the residents on the unit. Staff will perform routine rounds every 2 hours on even hours to include licensed nurse. Issues noted during rounds will be written on a the C.N.A. Observation Tool reviewed by nursing administration to be follow up on with resident and staff members involved. Licensed Nursing will perform C.N.A. Observation Tool each shift for two weeks, then daily for 2 weeks, then weekly for 4 weeks. Audit tool will monitor that residents are checked at least every two hours for position</p>		

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	<p>The investigation by the Executive Director, dated 7/3/12, indicated, "...Resident was offered assistance to go to bed, and it was her choice to remain in her recliner, where she fell asleep. Staff did not wake the resident when this was noted at 2:00 A.M. At 5:00 A.M. resident woke up when the C.N.A. (Certified Nursing Aide) was caring for her roommate. Resident was upset for being left in the chair all night...Resident called and alerted the staff that she needed to be toileted around 8:30 A.M., and staff informed resident that they were passing breakfast and would return with help. When C.N.A.s returned, the resident had been incontinent to the point of saturating her brief, pad, and chair..."</p> <p>In an interview with LPN #1, on 7/19/12 at 10:30 A.M., she indicated she worked night shift on July 2, 2012. She indicated CNA #2 was not new to being a nurses' aide, but that she had never worked Ross Hall before. She indicated she went in around 11:00 P.M. to check on Resident B's roommate. She indicated the resident was still up and did not want to go to bed. The resident's call light was in reach and she did not use it all shift. She indicated that she would expect a CNA to try to toilet someone who usually uses their call light and hadn't. However, the CNA was new to that unit, and may not have</p>		<p>change, toileting needs/ incontinent care, and call light response time. Five residents will be interviewed weekly for six weeks to confirm that staff has offered to toilet or perform incontinence care as needed. Residents will also be asked about call light response time. 4. <i>How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place?</i> The DON or designee will bring results from the C.N.A. Observation Tool, issues identified in resident interviews, as well as any corrective action that was required to the monthly Performance Improvement Committee meeting for 90 days so that the members may review the results and provide recommendations for any process improvement.</p>				

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	<p>known to offer to wake resident up as she usually sleeps in bed and uses the call light.</p> <p>In an interview with Resident B on 7/19/12 at 8:35 A.M., she indicated on 7/2/12, she was left sitting in her recliner all night and she saw an aid in her room three times, once about 10 or 11 P.M., once at about 2:00 A.M. and then at 5:00 A.M., and they did not take her to the bathroom. Also, no one cared for her until after breakfast. She indicated she used call light three times and no one answered during the night. She indicated it took the girls who helped her after breakfast 45 minutes to an hour to answer the light. She indicated when they did, the chair was soaked, and she was embarrassed to be that wet. She explained the old recliner was ruined so she had a new one.</p> <p>This federal tag relates to complaint IN00111749.</p> <p>3.1-3(t)</p>				

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F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on record review and interview, the facility failed to provide assistance for toileting for a resident who had frequent urine incontinence. This affected 1 of 1 resident reviewed for toileting in a sample of 3. [Resident B]</p> <p>Findings include:</p> <p>The clinical record of Resident B was reviewed on 7/19/12 at 6:20 A.M. Diagnoses included, but were not limited to, CHF (Congestive Heart Failure), diabetes, chronic kidney disease and depression. The resident resided on Ross Hall.</p> <p>An MDS (Minimum Data Set) assessment dated 5/24/12 indicated the resident was noted to be alert and oriented to person, time and place and she needed assistance with toileting.</p> <p>A care plan for Resident B, dated 3/4/11 with a revision date of 7/11/12, indicated for incontinence, "...has frequent episodes of urinary incontinence related to loss of bladder control, CHF, chronic kidney</p>	F0312	<p>It is the policy of this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. <i>1. What corrective action will be done by the facility?</i></p> <p>An investigation was completed following this alleged incident. Staff members involved in the incident were retrained on following resident's plan of care for toileting and position changes, and corrective action was given. After the alleged incident resident B had a 3 day bladder diary completed and was referred to therapy for bladder retraining and pelvic floor strengthening. Resident B was placed on an every hour prompted toileting regimen to include one hour checks through the night. Resident B's care plan was reviewed and updated. <i>2. How will the facility identify other residents having the potential to be affected by the same practice?</i></p> <p>100% of residents' bowel and bladder function will be reassessed and ensured they are placed on appropriate program for toileting and incontinence management by nursing</p>	08/18/2012			

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	<p>disease, and diabetes...Skin will remain intact without reddened or open areas r/t incontinence through next review...to use bedpan at night if resident requests...Encourage resident to call for assistance with toileting...Increase fluid consumption during day and limited fluid consumption in evening hours, Change soiled clothing after each incontinent episode..."</p> <p>On 7/18/12 at 10 A.M. the Executive Director (ED) offered information regarding Resident B involving an investigation they did for an incident that occurred on 7/2/12. The family of Resident B was upset due to a recliner being soaked with urine and not cleaned in a timely fashion.</p> <p>The investigation by the Executive Director, dated 7/3/12, indicated, "...Resident was offered assistance to go to bed, and it was her choice to remain in her recliner, where she fell asleep. Staff did not wake the resident when this was noted at 2:00 A.M. At 5:00 A.M. resident woke up when the C.N.A. (Certified Nursing Aide) was caring for her roommate. Resident was upset for being left in the chair all night...Resident called and alerted the staff that she needed to be toileted around 8:30 A.M., and staff informed resident that they were passing</p>		<p>department. This will be completed by 8/18/12. Upon admission resident's bowel and bladder function will be assessed and they will be placed on appropriate program for toileting and incontinence management.</p> <p>3. <i>What measures will be put in place to ensure this practice does not recur?</i> A mandatory nursing staff in-service will be performed on 8/07/2012 by Staff Development Coordinator. This in-service will include that all residents are to be checked at least every two hours for position change, toileting needs/ incontinent care, skin care, and call light response time. This inservice will also review resident dignity and respect. Walking rounds have been implemented with off going and on going shifts giving and receiving report while observing the residents on the unit. Staff will perform routine rounds every 2 hours on even hours to include licensed nurse. Issues noted during rounds will be written on a the C.N.A. Observation Tool reviewed by nursing administration to be follow up on with resident and staff members involved. Licensed Nursing will perform C.N.A. Observation Tool each shift for two weeks, then daily for 2 weeks, then weekly for 4 weeks. Audit tool will monitor that residents are checked at least every two hours for position change, toileting needs/</p>				

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	<p>breakfast and would return with help. When C.N.A.s returned, the resident had been incontinent to the point of saturating her brief, pad, and chair..."</p> <p>A schedule dated July 2, 2012, indicated CNA #2 and LPN #1 were working on Ross Hall where the resident resided.</p> <p>CNA #2 indicated in an undated statement, "...On Monday July 2nd ...worked Ross hall/Stuart hall . I went into the resident's room at 10:15 P.M. I was passing ice water. She (resident) stated she was reading (and) not ready for bed yet. I went back at 11:00 P.M., she was still reading. I then told her that I'd check on her in a bit. About an hour later, (12:00 A.M.) i checked on her and she had fallen asleep. She was alert (sign for and) oriented and had her call light pinned to her chair. The nurse, told me she would call with her call light when she needed something. At 5:00 A.M. I went in to get roommate up. Resident woke up and yelled at me for a few mins. (minutes)..."</p> <p>In an interview with Resident B on 7/19/12 at 8:35 A.M., she indicated on 7/2/12 she was left sitting in her recliner all night and she saw an aid in her room three times, once about 10 or 11 P.M., once at about 2:00 A.M. and then at 5:00</p>		<p>incontinent care, and call light response time. Five residents will be interviewed weekly for six weeks to confirm that staff has offered to toilet or perform incontinence care as needed. Residents will also be asked about call light response time. 4. <i>How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place?</i> The DON or designee will bring results from the C.N.A. Observation Tool, issues identified in resident interviews, as well as any corrective action that was required to the monthly Performance Improvement Committee meeting for 90 days so that the members may review the results and provide recommendations for any process improvement.</p>				

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	<p>A.M., and they did not take her to the bathroom. Also, no one cared for her until after breakfast. She indicated she used call light three times to use the restroom and no one answered during the night. She indicated it took the girls who helped her after breakfast 45 minutes to an hour to answer the light..</p> <p>In an interview with LPN #1 on 7/19/12 at 10:30 A.M., she indicated she worked night shift on July 2, 2012. She indicated CNA #2 was not new to being a nurses' aide, but she had never worked Ross Hall before. She indicated she went in around 11:00 P.M. to check on Resident B's roommate. She indicated the resident was still up and did not want to go to bed. The resident's call light was in reach and she did not use it all shift. She indicated that she would expect a CNA to try to toilet someone who usually uses their call light and didn't\). However, the CNA was new to that unit , and may not have known to offer to wake resident up as she usually sleeps in bed and uses the call light.</p> <p>In an interview with Resident B's roommate on 7/19/12 at 10:45 A.M., she indicated staff offered to put Resident B to bed around 6:30-7:00 P.M. and she refused. She stated she got up around 3:00 A.M. and got ready for the day and saw Resident B asleep in recliner. She</p>						

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	<p>indicated Resident B gets cold easy so she asked the CNA to put a blanket on her, which she did. She stated that is all she can recall.</p> <p>This federal tag relates to complaint IN00111749.</p> <p>3.1-41(a)(2)</p>				

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F0314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on record review and interview, the facility failed to provide interventions to prevent a resident from acquiring a pressure area. This affected 1 of 1 resident reviewed for pressure areas in a sample of 3. [Resident B]</p> <p>Findings include:</p> <p>The clinical record of Resident B was reviewed on 7/19/12 at 6:20 A.M. Diagnoses included, but were not limited to, CHF (Congestive Heart Failure), diabetes, chronic kidney disease and depression. The resident resides on Ross Hall.</p> <p>A care plan for Resident B dated 3/4/11, with a revision date of 7/11/12, indicated for incontinence, "...has frequent episodes of urinary incontinence related to loss of bladder control, CHF, chronic kidney disease, and diabetes...Skin will remain</p>			F0314	<p>It is the policy of this facility to ensure a resident who enters the facility without pressure sores does not develop pressure sores unless the individuals clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. 1. <i>What corrective action will be done by the facility?</i> An investigation was completed following this alleged incident. Staff members involved in the incident were retrained on following resident's plan of care for toileting and position changes, and corrective action was given. After the alleged incident resident B had a 3 day bladder diary completed and was referred to therapy for bladder retraining and pelvic floor strengthening. Resident B was placed on an every hour prompted toileting regimen to include one hour checks through the night.</p>		08/18/2012

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	<p>intact without reddened or open areas r/t incontinence through next review...to use bedpan at night if resident requests...Encourage resident to call for assistance with toileting...Increase fluid consumption during day and limited fluid consumption in evening hours, Change soiled clothing after each incontinent episode..." Her care plan for skin indicated, "...Assist with reposition every 2 hours and as needed...Cleanse perineal area with soap and water following each urination..."</p> <p>A MDS (Minimum Data Set) assessment dated 5/24/12, indicated the resident was noted to be alert and oriented to person, time and place and she needed assistance of one with toileting. It also indicated the resident was at risk for pressure ulcers.</p> <p>On 7/18/12 at 10 A.M. the Executive Director (ED) offered information regarding Resident B involving an investigation they did. The family of Resident B was upset due to a recliner being soaked with urine and not cleaned in a timely fashion.</p> <p>The investigation by Executive Director, dated 7/3/12, indicated, "...Resident was offered assistance to go to bed, and it was her choice to remain in her recliner, where she fell asleep. Staff did not wake the</p>		<p>Resident B's care plan was reviewed and updated. The 1.5 X 1.0 cm open area noted two days after the incident was completely healed by 7/09/12. 2. <i>How will the facility identify other residents having the potential to be affected by the same practice?</i> 100% of residents' bowel and bladder function will be reassessed and ensured they are placed on appropriate program for toileting and incontinence management by nursing department. This will be completed by 8/18/12. Upon admission resident's bowel and bladder function will be assessed and they will be placed on appropriate program for toileting and incontinence management. Skin sheets will be completed weekly by licensed nursing staff. Skin will be observed daily by direct care staff. 3. <i>What measures will be put in place to ensure this practice does not recur?</i> A mandatory nursing staff in-service will be performed on 8/07/2012 by Staff Development Coordinator. This in-service will include that all residents are to be checked at least every two hours for position change, toileting needs/ incontinent care, skin care, and call light response time. This inservice will also review resident dignity and respect. Walking rounds have been implemented with off going and on going shifts giving and receiving report while observing the residents on the unit. Staff</p>		

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	<p>resident when this was noted at 2:00 A.M. At 5:00 A.M. resident woke up when the C.N.A. (Certified Nursing Aide) was caring for her roommate. Resident was upset for being left in the chair all night...Resident called and alerted the staff that she needed to be toileted around 8:30 A.M., and staff informed resident that they were passing breakfast and would return with help. When C.N.A.'s returned, the resident had been incontinent to the point of saturating her brief, pad, and chair..."</p> <p>A schedule dated July 2, 2012 indicated CNA #2 and LPN #1 were working on Ross Hall where the resident resided.</p> <p>CNA #2 indicated in an undated statement that "...On Monday July 2nd ...worked Ross hall/Stuart hall . I went into the residents room .at 10:15 P.M. I was passing ice water. She (resident) stated she was reading (and) not ready for bed yet. I went back at 11:00 P.M., she was still reading. I then told her that I'd check on her in a bit. About an hour later, (12:00 A.M.) I checked on her and she had fallen asleep. She was alert (and) oriented and had her call light pinned to her chair The nurse, told me she would call with her call light when she needed something., At 5:00 A.M. I went in to get roommate up. Resident woke up and</p>		<p>will perform routine rounds every 2 hours on even hours to include licensed nurse. Issues noted during rounds will be written on a the C.N.A. Observation Tool reviewed by nursing administration to be follow up on with resident and staff members involved. Licensed Nursing will perform C.N.A. Observation Tool each shift for two weeks, then daily for 2 weeks, then weekly for 4 weeks. Audit tool will monitor that residents are checked at least every two hours for position change, toileting needs/ incontinent care, and call light response time. Five residents will be interviewed weekly for six weeks to confirm that staff has offered to toilet or perform incontinence care as needed. Residents will also be asked about call light response time. Facility Skin Integrity program will be reviewed with all licensed nurses by 8/11/12 by Staff Development Coordinator or designee with emphasis placed on skin sheet documentation weekly, and when an open area has been noted. 4. How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place? The DON or designee will bring results from the C.N.A. Audit Tool, issues identified in resident interviews, as well as any corrective action that was required to the monthly Performance Improvement</p>				

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	<p>yelled at me for a few mins. (minutes)..."</p> <p>In a fax, dated 7/5/12, to the physician, the following information was indicated, "Open area to buttock 1.5 x 1 cm..."</p> <p>Physician's orders indicated 7/5/12, "Open area to buttock Cleanse (with) NS (normal saline) pat dry apply Tegaderm et (and) cover (with) bandaid dly (daily) re eval (re-evaluate) in 7 days."</p> <p>Progress notes dated 7/5/12 4:58 P.M. indicated, "...new pinpoint area noted to buttock, cleanse with NS pat dry and apply bandaid for 7 days then re evaluate. MD notified.... " A note dated 7/10/12 at 11:30 P.M., indicated, "...Skin assessment noted without any new areas, and treated areas healing. Wound nurse assessed areas also and area to buttocks has healed and remains intact."</p> <p>A request was made to the ED on 7/19/12 at 11:00 A.M. for all skin sheets from 7/1/12 through 7/18/12. In reviewing the skin sheets offered by ED, there were no skin sheets dated 7/5/12 through 7/12/12 for the open coccyx area provided.</p> <p>In an interview with LPN #1 on 7/19/12 at 10:30 A.M., she indicated she worked night shift on July 2, 2012. She indicated CNA #2 was not new to being a nurses'</p>		Committee meeting for 90 days so that the members may review the results and provide recommendations for any process improvement.				

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	<p>aide, but she had never worked Ross Hall before. She indicated she went in around 11:00 P.M. to check on Resident B's roommate. She indicated the resident was still up and did not want to go to bed. The resident's call light was in reach and she did not use it all shift. She indicated that she would expect a CNA to try to toilet someone who usually uses their call light and hadn't. However, the CNA was new to that unit, and may not have known to offer to wake resident up as she usually sleeps in bed and uses the call light.</p> <p>In an interview with Resident B on 7/19/12 at 8:35 A.M., she indicated on 7/2/12 she was left sitting in her recliner all night and that she saw an aid in her room three times, once about 10 or 11 P.M., once at about 2:00 A.M. and then at 5:00 A.M., and they did not take her to the bathroom. Also, no one cared for her until after breakfast. She indicated she used the call light three times and no one answered during the night. She indicated it took the girls who helped her after breakfast 45 minutes to an hour to answer the light.</p> <p>This federal tag relates to complaint IN00111749.</p> <p>3.1-40(a)(1)</p>			

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