STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155535	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CROSSING HEALTH & REHABILITATION CENTER	3550 CENTRAL AVE COLUMBUS, IN 47203

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F0000	This visit was for the Investigation of Complaint IN00110725 and IN00111334. Complaint IN00110725 -- Substantiated. Federal/State deficiencies related to the allegations are cited at F155, F224, F226 and F241. Complaint IN00111334 -- Substantiated. Federal/State deficiency related to the allegations is cited at F279, F323 and F498. Survey dates: July 17 and 18, 2012 Facility number: 000572 Provider number: 155535 AIM number: 100267710 Survey team: Penny Marlatt, RN Census bed type: SNF: 13 SNF/NF: 41 NF: 10 Total: 64 Census payor type: Medicare: 13 Medicaid: 41 Other: 10 Total: 64	F0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

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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	Sample: 3 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed 7/26/12 Cathy Emswiller RN			

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F0155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.			
	Based on interview and record review, the facility failed to ensure a resident's right to refusal of care was honored as evidenced by a resident pulling away and trying to hit and bite the nurse during attempts to obtain a blood sugar and to administer medication. This deficient practice affected 1 of 3 residents reviewed for neglect and abuse in a total sample of 3. (Resident #B) Findings include: Resident #B's clinical record was reviewed on 7-17-12 at 2:07 p.m. Her diagnoses included, but were not limited to diabetes, high blood pressure, Alzheimer's disease, depression and anxiety. Her most recent Minimum Data Set (MDS) assessment, dated 4-30-12, indicated she has significant cognitive impairment, does not ambulate independently, but requires assistance of 1 person with mobility and uses a walker or wheelchair for mobility. On 7-17-12 at 1:52 p.m., the	F0155	F155 Requires the facility to ensure a resident's right to refusal of care is honored. The facility will ensure this requirement is met through the following: 1. Resident #B was not harmed. 2. All residents have the potential to be affected. See below for corrective measures. 3. The Resident Right policy and procedure was reviewed with no changes made. (See Attachment A). The staff was inserviced on the above procedure. 4. The DON or her designee will conduct daily rounds to ensure that all resident's rights are being honored even the right for refusal of care. The DON or her designee will use the nursing monitoring tool to help conduct their rounds daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until compliance is maintained. (See Attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly if warranted. 5. The above corrective measures will be completed on or before July 23,	07/23/2012

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	Administrator provided a copy of an incident the facility reported to the Indiana State Department (ISDH) Long Term Care Division on 6-24-12 with a follow up report sent to the ISDH on 6-25-12. This report indicated an anonymous caller left a message on the corporate hotline in which it alleged a nurse and a CNA held down Resident #B's arms during a medication administration on 6-24-12 at 12:30 p.m. This report indicated the Administrator was notified immediately and an investigation was initiated. The staff members involved, LPN #3 and CNA #4 were suspended, pending results of the investigation. This report indicated the facility did not find evidence of abuse. It indicated inservice education was provided to the two staff members, as well as all other employees and contractual employees regarding a resident's right to refuse care or treatment. LPN #3 and CNA #4 were reinstated. In interview with LPN #3 on 7-18-12 at 12:04 p.m., she indicated she was working with Resident #B on 6-24-12. She indicated Resident #B had "not had a good 24 hours prior to when there was a problem. The night before, she'd kept her roommate up looking for the children. Obviously, there were no children." She indicated on 6-24-12 before lunch, she		2012.	

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	was in the dining room attempting to explain to Resident #B that she needed to obtain her blood sugar and the resident appeared agitated to her. She indicated the resident was trying to grab the nurse's hand and stick it in her mouth to bite her. She indicated after 4 attempts, the resident allowed her to obtain the blood sugar. She indicated CNA #4 attempted to assist her in calming the resident by saying, 'Just let her get the blood sugar,' but was unsuccessful. She indicated during this time, the resident was swinging her other arm and attempting to bite LPN #3. She indicated after she obtained the blood sugar, she attempted to administer an "as needed" dose of Ativan (used to calm or decrease anxiety of a person). She indicated at this time, the resident would close her mouth and turn her head away from LPN #3. She then indicated she asked RN #5 to attempt to administer the Ativan, but she also was unsuccessful. She then indicated approximately 5 minutes later she asked LPN #6 to attempt to administer the medication, but she also was unsuccessful. She indicated at this point, CNA #4 then served Resident #B's lunch tray to her. She indicated when CNA #4 asked her what type of dressing she would like for her salad, the resident swung at CNA #4. She indicated after that, CNA #4 then assisted the resident to the			

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	activities room, across the hall from the dining room and in full view of the dining room, in order to have a quieter environment. She indicated once Resident #B was in the activities room, "She kept swinging at us." She indicated the resident did finally open her mouth for the medication, but then clamped down on the plastic spoon and nearly broke it. She indicated the resident then "Spit it out all over me and [name of CNA #4.]" She indicated the resident never did take the Ativan. She indicated the resident remained in the activities room for lunch. She indicated she was informed by LPN #6 "She ended up eating and smiling and was happy after that." She indicated she was suspended, pending the investigation for an allegation of abuse. She indicated she was reinstated on the evening of 6-25-12. She indicated she was educated on the right to refuse (care) and conducting a blood sugar test in the dining room. She indicated, "Looking back, like I told [name of the Director of Nursing], I would have done things differently. For starters, after the first time she refuse, I should have just left her alone and then come back later. She has dementia and she may not have understood what I was trying to do." On 7-17-12 at 1:52 p.m., the Administrator provided a copy of a			

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	document entitled, "Working with residents who refuse care, medications. [sic]" This document indicated, "Specifically when working with residents who refuse any type of medication, treatment, activities or anything directly relating to them, always remember: The resident has the right to refuse. Period...Residents have the right to direct their own care. This includes medication, daily living activities and therapies. If a resident refuses something that we as a facility are attempting to achieve, example a medication administration, there are alternatives that may achieve the same result. We never, ever force a resident by holding them down, forcing medications, isolating them or in someway that is stripping them of their dignity." This Federal tag relates to Complaint IN00110725. 3.1-4(d)			

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F0224 SS=A	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN 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 implemented the policies and procedures developed which prohibit mistreatment, neglect and abuse of residents as evidenced by an abuse allegation of staff to resident abuse of a resident who pulled away, tried to bite and hit staff during blood sugar testing and medication administration. This deficient practice affected 1 of 3 residents reviewed for neglect and abuse in a total sample of 3. (Resident #B) Findings include: Resident #B's clinical record was reviewed on 7-17-12 at 2:07 p.m. Her diagnoses included, but were not limited to diabetes, high blood pressure, Alzheimer's disease, depression and anxiety. Her most recent Minimum Data Set (MDS) assessment, dated 4-30-12, indicated she has significant cognitive impairment, does not ambulate independently, but requires assistance of 1 person with mobility and uses a walker or	F0224	F224 Requires the facility to implement policies and procedures developed which prohibit mistreatment, neglect and abuse of residents . The facility has ensured this requirement was met through the following measures: 1. Resident #B did not suffer a negative effect as a result of this incident. Once brought to the facility's attention, immediate suspension of the employee pursued and investigation was initiated, as per facility policy. 2. All residents have the potential to be affected. See below for corrective measures. 3. The policy and procedure for Abuse Prohibition was reviewed with no changes made. (See Attachment C) The staff was inserviced on the above procedure. 4. In an effort to ensure ongoing compliance with facility policy, the facility will continue to inserviced new employees upon hire and quarterly on the Abuse Prohibition policy and procedure. As means of quality assurance, the facility will continue to follow its policy and administrative staff shall continue to conduct investigation	07/23/2012

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	wheelchair for mobility. On 7-17-12 at 1:52 p.m., the Administrator provided a copy of an incident the facility reported to the Indiana State Department (ISDH) Long Term Care Division on 6-24-12 with a follow up report sent to the ISDH on 6-25-12. This report indicated an anonymous caller left a message on the corporate hotline in which it alleged a nurse and a CNA held down Resident #B's arms during a medication administration on 6-24-12 at 12:30 p.m. This report indicated the Administrator was notified immediately and an investigation was initiated. The staff members involved, LPN #3 and CNA #4 were suspended, pending results of the investigation. This report indicated the facility did not find evidence of abuse. It indicated inservice education was provided to the two staff members, as well as all other employees and contractual employees regarding a resident's right to refuse care or treatment. LPN #3 and CNA #4 were reinstated. In interview with LPN #3 on 7-18-12 at 12:04 p.m., she indicated she was working with Resident #B on 6-24-12. She indicated Resident #B had "not had a good 24 hours prior to when there was a problem. The night before, she'd kept her		of each allegations of abuse, reporting to ISDH (as occurred in this incident), in an effort to ensure residents remain free of abuse. All incidents and corrective measures taken shall be reported to the quality assurance committee during quarterly meetings in an effort to verify ongoing compliance. The DON or her designee will conduct rounds specifically being alert to employee burnout and behaviors that may need to be addressed to ensure appropriate workplace delivery of services daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until compliance is maintained. (See Attachment B) 5. The above corrective measures will be completed on or before July 23, 2012.	

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	roommate up looking for the children. Obviously, there were no children." She indicated on 6-24-12 before lunch, she was in the dining room attempting to explain to Resident #B that she needed to obtain her blood sugar and the resident appeared agitated to her. She indicated the resident was trying to grab the nurse's hand and stick it in her mouth to bite her. She indicated after 4 attempts, the resident allowed her to obtain the blood sugar. She indicated CNA #4 attempted to assist her in calming the resident by saying, 'Just let her get the blood sugar,' but was unsuccessful. She indicated during this time, the resident was swinging her other arm and attempting to bite LPN #3. She indicated after she obtained the blood sugar, she attempted to administer an "as needed" dose of Ativan (used to calm or decrease anxiety of a person). She indicated at this time, the resident would close her mouth and turn her head away from LPN #3. She then indicated she asked RN #5 to attempt to administer the Ativan, but she also was unsuccessful. She then indicated approximately 5 minutes later she asked LPN #6 to attempt to administer the medication, but she also was unsuccessful. She indicated at this point, CNA #4 then served Resident #B's lunch tray to her. She indicated when CNA #4 asked her what type of dressing she would			

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	like for her salad, the resident swung at CNA #4. She indicated after that, CNA #4 then assisted the resident to the activities room, across the hall from the dining room and in full view of the dining room, in order to have a quieter environment. She indicated once Resident #B was in the activities room, "She kept swinging at us." She indicated the resident did finally open her mouth for the medication, but then clamped down on the plastic spoon and nearly broke it. She indicated the resident then "Spit it out all over me and [name of CNA #4.]" She indicated the resident never did take the Ativan. She indicated the resident remained in the activities room for lunch. She indicated she was informed by LPN #6 "She ended up eating and smiling and was happy after that." She indicated during this entire event, the resident did not yell or scream. She indicated she was suspended, pending the investigation for an allegation of abuse. She indicated she was reinstated on the evening of 6-25-12. She indicated she was educated on the right to refuse (care) and conducting a blood sugar test in the dining room. She indicated, "Looking back, like I told [name of the Director of Nursing], I would have done things differently. For starters, after the first time she refuse, I should have just left her alone and then come back later. She has dementia and			

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	she may not have understood what I was trying to do. I shouldn't have been doing the blood sugar in the dining room, but I was in a hurry." On 7-17-12 at 1:52 p.m., the Administrator provided a copy of a document entitled, "Working with residents who refuse care, medications. [sic]" This document indicates, "Specifically when working with residents who refuse any type of medication, treatment, activities or anything directly relating to them, always remember: The resident has the right to refuse. Period...Residents have the right to direct their own care. This includes medication, daily living activities and therapies. If a resident refuses something that we as a facility are attempting to achieve, example a medication administration, there are alternatives that may achieve the same result. We never, ever force a resident by holding them down, forcing medications, isolating them or in someway that is stripping them of their dignity." On 7-17-12 at 11:10 a.m., the Administrator provided a copy of a document entitled, "Abuse Prohibition, Reporting and Investigation Policy and Procedure." This document indicated, "It is the policy of [name of the corporation]			

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	that reports of abuse will be communicated to and thoroughly investigated by, the correct authority. [Name of the corporation] will not permit residents to be subjected to abuse by anyone...will ensure that all alleged violations, including mistreatment, neglect or abuse...are reported immediately to the administrator of the facility." This Federal tag relates to Complaint IN00110725. 3.1-28(a)			

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F0226 SS=A	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 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 implemented the policies and procedures developed which prohibit mistreatment, neglect and abuse of residents as evidenced by an abuse allegation of staff to resident abuse of a resident who pulled away, tried to bite and hit staff during blood sugar testing and medication administration. This deficient practice affected 1 of 3 residents reviewed for neglect and abuse in a total sample of 3. (Resident #B) Findings include: Resident #B's clinical record was reviewed on 7-17-12 at 2:07 p.m. Her diagnoses included, but were not limited to diabetes, high blood pressure, Alzheimer's disease, depression and anxiety. Her most recent Minimum Data Set (MDS) assessment, dated 4-30-12, indicated she has significant cognitive impairment, does not ambulate independently, but requires assistance of 1 person with mobility and uses a walker or wheelchair for mobility.	F0226	F226 Requires the facility to implement policies and procedures developed which prohibit mistreatment, neglect and abuse of residents . The facility has ensured this requirement was met through the following measures: 1. Resident #B did not suffer a negative effect as a result of this incident. Once brought to the facility's attention, immediate suspension of the employee pursued and investigation was initiated, as per facility policy. 2. All residents have the potential to be affected. See below for corrective measures. 3. The policy and procedure for Abuse Prohibition was reviewed with no changes made.(See Attachment C) The staff was inserviced on the above procedure. 4. In an effort to ensure ongoing compliance with facility policy, the facility will continue to inserviced new employees upon hire and quarterly on the Abuse Prohibition policy and procedure. As means of quality assurance, the facility will continue to follow its policy and administrative staff shall continue to conduct investigation of each allegations of abuse,	07/23/2012

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	On 7-17-12 at 1:52 p.m., the Administrator provided a copy of an incident the facility reported to the Indiana State Department (ISDH) Long Term Care Division on 6-24-12 with a follow up report sent to the ISDH on 6-25-12. This report indicated an anonymous caller left a message on the corporate hotline in which it alleged a nurse and a CNA held down Resident #B's arms during a medication administration on 6-24-12 at 12:30 p.m. This report indicated the Administrator was notified immediately and an investigation was initiated. The staff members involved, LPN #3 and CNA #4 were suspended, pending results of the investigation. This report indicated the facility did not find evidence of abuse. It indicated inservice education was provided to the two staff members, as well as all other employees and contractual employees regarding a resident's right to refuse care or treatment. LPN #3 and CNA #4 were reinstated. In interview with LPN #3 on 7-18-12 at 12:04 p.m., she indicated she was working with Resident #B on 6-24-12. She indicated Resident #B had "not had a good 24 hours prior to when there was a problem. The night before, she'd kept her roommate up looking for the children.		reporting to ISDH (as occurred in this incident), in an effort to ensure residents remain free of abuse. All incidents and corrective measures taken shall be reported to the quality assurance committee during quarterly meetings in an effort to verify ongoing compliance. The DON or her designee will conduct rounds specifically being alert to employee burnout and behaviors that may need to be addressed to ensure appropriate workplace delivery of services daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until compliance is maintained. (See Attachment B) 5. The above corrective measures will be completed on or before July 23, 2012.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155535	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/18/2012
NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3550 CENTRAL AVE COLUMBUS, IN 47203	

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	Obviously, there were no children." She indicated on 6-24-12 before lunch, she was in the dining room attempting to explain to Resident #B that she needed to obtain her blood sugar and the resident appeared agitated to her. She indicated the resident was trying to grab the nurse's hand and stick it in her mouth to bite her. She indicated after 4 attempts, the resident allowed her to obtain the blood sugar. She indicated CNA #4 attempted to assist her in calming the resident by saying, 'Just let her get the blood sugar,' but was unsuccessful. She indicated during this time, the resident was swinging her other arm and attempting to bite LPN #3. She indicated after she obtained the blood sugar, she attempted to administer an "as needed" dose of Ativan (used to calm or decrease anxiety of a person). She indicated at this time, the resident would close her mouth and turn her head away from LPN #3. She then indicated she asked RN #5 to attempt to administer the Ativan, but she also was unsuccessful. She then indicated approximately 5 minutes later she asked LPN #6 to attempt to administer the medication, but she also was unsuccessful. She indicated at this point, CNA #4 then served Resident #B's lunch tray to her. She indicated when CNA #4 asked her what type of dressing she would like for her salad, the resident swung at			

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	CNA #4. She indicated after that, CNA #4 then assisted the resident to the activities room, across the hall from the dining room and in full view of the dining room, in order to have a quieter environment. She indicated once Resident #B was in the activities room, "She kept swinging at us." She indicated the resident did finally open her mouth for the medication, but then clamped down on the plastic spoon and nearly broke it. She indicated the resident then "Spit it out all over me and [name of CNA #4.]" She indicated the resident never did take the Ativan. She indicated the resident remained in the activities room for lunch. She indicated she was informed by LPN #6 "She ended up eating and smiling and was happy after that." She indicated during this entire event, the resident did not yell or scream. She indicated she was suspended, pending the investigation for an allegation of abuse. She indicated she was reinstated on the evening of 6-25-12. She indicated she was educated on the right to refuse (care) and conducting a blood sugar test in the dining room. She indicated, "Looking back, like I told [name of the Director of Nursing], I would have done things differently. For starters, after the first time she refuse, I should have just left her alone and then come back later. She has dementia and she may not have understood what I was			

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	trying to do. I shouldn't have been doing the blood sugar in the dining room, but I was in a hurry." On 7-17-12 at 1:52 p.m., the Administrator provided a copy of a document entitled, "Working with residents who refuse care, medications. [sic]" This document indicates, "Specifically when working with residents who refuse any type of medication, treatment, activities or anything directly relating to them, always remember: The resident has the right to refuse. Period...Residents have the right to direct their own care. This includes medication, daily living activities and therapies. If a resident refuses something that we as a facility are attempting to achieve, example a medication administration, there are alternatives that may achieve the same result. We never, ever force a resident by holding them down, forcing medications, isolating them or in someway that is stripping them of their dignity." On 7-17-12 at 11:10 a.m., the Administrator provided a copy of a document entitled, "Abuse Prohibition, Reporting and Investigation Policy and Procedure." This document indicated, "It is the policy of [name of the corporation] that reports of abuse will be			

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	communicated to and thoroughly investigated by, the correct authority. [Name of the corporation] will not permit residents to be subjected to abuse by anyone...will ensure that all alleged violations, including mistreatment, neglect or abuse...are reported immediately to the administrator of the facility." This Federal tag relates to Complaint IN00110725. 3.1-28(a)			

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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.			
	Based on interview and record review, the facility failed to ensure a resident's dignity was maintained as evidenced by a resident pulling away and trying to hit and bite the nurse during attempts to obtain a blood sugar in public area in potential view of others and to administer medication. This deficient practice affected 1 of 3 residents reviewed for neglect and abuse in a total sample of 3. (Resident #B) Findings include: Resident #B's clinical record was reviewed on 7-17-12 at 2:07 p.m. Her diagnoses included, but were not limited to diabetes, high blood pressure, Alzheimer's disease, depression and anxiety. Her most recent Minimum Data Set (MDS) assessment, dated 4-30-12, indicated she has significant cognitive impairment, does not ambulate independently, but requires assistance of 1 person with mobility and uses a walker or wheelchair for mobility. On 7-17-12 at 1:52 p.m., the	F0241	F241 Requires the facility to ensure a resident's dignity is maintained. The facility will ensure this requirement is met through the following: 1. Resident #B was not harmed. 2. All residents have the potential to be affected. See below for corrective measures. 3. The Resident's Right policy and procedure was reviewed and no changes were made. (See Attachment A). The staff was inserviced on the above policy focusing on privacy and dignity. 4. The DON or her designee will conduct rounds to ensure that resident's privacy and dignity is maintained daily times four weeks, weekly times four weeks, then every two weeks times two months, then quarterly thereafter until compliance is maintained. (See Attachment B). The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly. 5. The above corrective measures will be completed on or before July 23, 2012.	07/23/2012

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	Administrator provided a copy of an incident the facility reported to the Indiana State Department (ISDH) Long Term Care Division on 6-24-12 with a follow up report sent to the ISDH on 6-25-12. This report indicated an anonymous caller left a message on the corporate hotline in which it alleged a nurse and a CNA held down Resident #B's arms during a medication administration on 6-24-12 at 12:30 p.m. This report indicated the Administrator was notified immediately and an investigation was initiated. The staff members involved, LPN #3 and CNA #4 were suspended, pending results of the investigation. This report indicated the facility did not find evidence of abuse. It indicated inservice education was provided to the two staff members, as well as all other employees and contractual employees regarding a resident's right to refuse care or treatment. LPN #3 and CNA #4 were reinstated. In interview with LPN #3 on 7-18-12 at 12:04 p.m., she indicated she was working with Resident #B on 6-24-12. She indicated Resident #B had "not had a good 24 hours prior to when there was a problem. The night before, she'd kept her roommate up looking for the children. Obviously, there were no children." She indicated on 6-24-12 before lunch, she			

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	was in the dining room attempting to explain to Resident #B that she needed to obtain her blood sugar and the resident appeared agitated to her. She indicated the resident was trying to grab the nurse's hand and stick it in her mouth to bite her. She indicated after 4 attempts, the resident allowed her to obtain the blood sugar. She indicated CNA #4 attempted to assist her in calming the resident by saying, 'Just let her get the blood sugar,' but was unsuccessful. She indicated during this time, the resident was swinging her other arm and attempting to bite LPN #3. She indicated after she obtained the blood sugar, she attempted to administer an "as needed" dose of Ativan (used to calm or decrease anxiety of a person). She indicated at this time, the resident would close her mouth and turn her head away from LPN #3. She then indicated she asked RN #5 to attempt to administer the Ativan, but she also was unsuccessful. She then indicated approximately 5 minutes later she asked LPN #6 to attempt to administer the medication, but she also was unsuccessful. She indicated at this point, CNA #4 then served Resident #B's lunch tray to her. She indicated when CNA #4 asked her what type of dressing she would like for her salad, the resident swung at CNA #4. She indicated after that, CNA #4 then assisted the resident to the			

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	activities room, across the hall from the dining room and in full view of the dining room, in order to have a quieter environment. She indicated once Resident #B was in the activities room, "She kept swinging at us." She indicated the resident did finally open her mouth for the medication, but then clamped down on the plastic spoon and nearly broke it. She indicated the resident then "Spit it out all over me and [name of CNA #4.]" She indicated the resident never did take the Ativan. She indicated the resident remained in the activities room for lunch. She indicated she was informed by LPN #6 "She ended up eating and smiling and was happy after that." She indicated during this entire event, the resident did not yell or scream. She indicated she was suspended, pending the investigation for an allegation of abuse. She indicated she was reinstated on the evening of 6-25-12. She indicated she was educated on the right to refuse (care) and conducting a blood sugar test in the dining room. She indicated, "Looking back, like I told [name of the Director of Nursing], I would have done things differently. For starters, after the first time she refuse, I should have just left her alone and then come back later. She has dementia and she may not have understood what I was trying to do. I shouldn't have been doing the blood sugar in the dining room, but I			

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	was in a hurry." On 7-18-12 at 3:05 p.m., the Director of Nursing provided a copy of a document entitled, "Inservice Record, " dated 2-10-12 and indicated one of the topics of inservice was, "General Overview on Survey Preparedness." This inservice record indicated, "No injections or glucose checks can be done in public view." This inservice record included LPN #3's signature of attendance. The Director of Nursing indicated in interview on 7-18-12 at 3:05 p.m., "After this incident with [name of Resident #B], [name of LPN #3] received a verbal warning about doing the blood sugar in the dining room." On 7-17-12 at 12:25 p.m., the Administrator provided a copy of a document entitled, Rights of Nursing Home Residents Educational Program." This document indicated, "Quality of Life: (a) Dignity: A facility must care for its 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." On 7-17-12 at 1:52 p.m., the Administrator provided a copy of a document entitled, "Working with residents who refuse care, medications.			

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	[sic]" This document indicates, "Specifically when working with residents who refuse any type of medication, treatment, activities or anything directly relating to them, always remember: The resident has the right to refuse. Period...Residents have the right to direct their own care. This includes medication, daily living activities and therapies. If a resident refuses something that we as a facility are attempting to achieve, example a medication administration, there are alternatives that may achieve the same result. We never, ever force a resident by holding them down, forcing medications, isolating them or in someway that is stripping them of their dignity." This Federal tag relates to Complaint IN00110725. 3.1-3(t)			

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F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on interview and record review, the facility failed to ensure the specialty left foot pedal/leg extension for the wheelchair of a resident with left hemiplegia was addressed in the resident's plan of care prior to the resident being transported down the hallway in the wheelchair, resulting in the resident's left foot dropping down onto the floor and then causing the resident to be propelled forward onto the floor which resulted in the resident sustaining a fracture to the left clavicle (collarbone), a sprain to the left ankle and a hematoma to the head.	F0279	F279 Requires the facility to ensure that specialty equipment for a wheelchair for a resident is addressed in the resident's plan of care prior to a resident being transported. The facility will ensure this requirement is met through the following: 1. Resident #A was treated by the physician and a sling was ordered for her left arm. 2. All residents have the potential to be affected. Resident's plan of care was reviewed and all equipment that is to be applied to the wheelchair was placed on the care plan. See below for corrective measures. 3. The Care Plan policy and	07/23/2012

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	This deficient practice affected 1 of 3 residents reviewed for accidents in a total sample of 3. (Resident #A) Findings include: Resident #A's clinical record was reviewed on 7-17-12 at 11:05 a.m. Her diagnoses included, but were not limited to cerebrovascular accident (CVA or stroke), depression, anxiety, Alzheimer's disease, arthritis and osteoporosis. Her most recent Minimum Data Set (MDS) assessment, dated 6-21-12, indicated she has moderate cognitive impairment, requires extensive assistance of 1 person with ambulation and transfers and uses a walker or wheelchair for mobility. In interview with Resident #A on 7-17-12 at 10:55 a.m., she indicated, "Not long ago, my aide was pushing me down the hall to the dining room...She forgot the foot pedals of my wheelchair. My [left] foot drug on the floor and I pitched forward. Hurt my shoulder; showed me the xray of my collarbone [in the emergency room]...[and] my left ankle got sprained. I had a stroke about 5 years ago and have little use of my left side. My shoulder aches all the time." Review of the resident's plan of care for falls, mobility, assistance with routine		procedure was reviewed with no changes made.(See Attachment D) The staff was inserviced on the above procedure. 4. The DON or her designee will conduct rounds to ensure all equipment that is to be placed on the resident's wheelchair is present to ensure safety. The DON or her designee will utilize the nursing monitoring tool to conduct the rounds daily times four weeks, weekly times four weeks, then every two weeks times two months, then quarterly thereafter until compliance is maintained. (See Attachment B) The audits will be reviewed during the facility's quarterly assurance meetings and the plan of action will be adjusted accordingly. 5. The above corrective measures will be completed on or before July 23, 2012.	

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	activities of daily living and issues related to her previous stroke and osteoporosis did not indicate to have the placement of the specialty foot pedal/leg extension on the wheelchair for the safety of the resident. The care plans did indicate the addition of the foot pedal/leg extension for the wheelchair on 6-18-12, after the fall occurred. Additionally, this was added to the monthly recapitulation orders as this was indicated by a physician's written order on 6-16-12 at 7:00 p.m. which indicated, "Foot pedals to w/c [wheelchair] at all times when up in w/c." This Federal tag relates to Complaint IN00111334. 3.1-35(a) 3.1-35(b)(1)			

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F0323 SS=G	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 interview and record review, the facility failed to ensure the specialty left foot pedal was in place on the wheelchair of a resident with left hemiplegia prior to transporting the resident down the hallway in the wheelchair, resulting in the resident's left foot dropping down onto the floor and then causing the resident to be propelled forward onto the floor which resulted in the resident sustaining a fracture to the left clavicle (collarbone), a sprain to the left ankle and a hematoma to the head. This deficient practice affected 1 of 3 residents reviewed for accidents in a total sample of 3. (Resident #A) Findings include: Resident #A's clinical record was reviewed on 7-17-12 at 11:05 a.m. Her diagnoses included, but were not limited to cerebrovascular accident (CVA or stroke), depression, anxiety, Alzheimer's disease, arthritis and osteoporosis. Her most recent Minimum Data Set (MDS) assessment, dated 6-21-12, indicated she has moderate cognitive impairment,	F0323	F323 Requires the facility to ensure that specialty equipment is placed on the wheelchair prior to a resident being transported. The facility will ensure this requirement is met through the following: 1. Resident #A was treated by the physician and a sling was ordered for her left arm. 2. All residents have the potential to be affected. Resident's plan of care was reviewed and all equipment that is to be applied to the wheelchair was placed on the resident's wheelchair. See below for corrective measures. 3. The Fall Management policy and procedure was reviewed with no changes made.(See Attachment E) The staff was inserviced on the above procedure and to ensure all wheelchair equipment is placed on the wheelchair prior to the resident being transported. 4. The DON or her designee will conduct rounds to ensure all equipment that is to be placed on the resident's wheelchair is present to ensure safety when a resident is being transported. The DON or her designee will utilize the nursing monitoring tool to conduct the rounds daily times four weeks, weekly times four	07/23/2012

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NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3550 CENTRAL AVE COLUMBUS, IN 47203	

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	requires extensive assistance of 1 person with ambulation and transfers and uses a walker or wheelchair for mobility. In interview with Resident #A on 7-17-12 at 10:55 a.m., she indicated, "Not long ago, my aide was pushing me down the hall to the dining room...She forgot the foot pedals of my wheelchair. My [left] foot drug on the floor and I pitched forward. Hurt my shoulder; showed me the xray of my collarbone [in the emergency room]...[and] my left ankle got sprained. I had a stroke about 5 years ago and have little use of my left side. My shoulder aches all the time." In interview with CNA #1 on 7-18-12 at 10:50 a.m., she indicated she was providing care to Resident #A on the evening of 6-16-12. She indicated she assisted her in transferring from the recliner into the wheelchair without any difficulty. She indicated she was unaware the resident required the extension and foot pedal added to the wheelchair. She indicated she had recently switched from the night shift to the evening shift. She indicated she could not recall if the aide assignment sheet had anything about the foot pedal on it prior to the accident. She indicated the resident did not say anything to her in regard to putting the foot pedal on the wheelchair. She indicated she was		weeks, then every two weeks times two months, then quarterly thereafter until compliance is maintained.(See Attachment B) The audits will be reviewed during the facility's quarterly assurance meetings and the plan of action will be adjusted accordingly. 5. The above corrective measures will be completed on or before July 23, 2012.	

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	in the process of pushing the resident down the hall toward the dining room, "No problems until got near the DON's (Director of Nursing) office. Her foot dropped and she just went forward. I screamed and she screamed. All kinds of people showed up. Her head hit and you could hear it hit. First thing I did was check her head...She said her arm and leg or knee hurt. A nurse and 2 or 3 CNA's responded. [Name of resident] seemed to be alert and oriented." In interview with LPN #2 on 7-18-12 at 11:34 a.m., she indicated she did not witness the accident, but "heard it happen." She indicated she had seen CNA #1 walk past the nurse's station with Resident #A. She indicated she did not recall the CNA's walking pace to be unusually fast, "Just a normal pace." She indicated that "Right after she went by, I heard it." She indicated she found the resident lying on her left side with her legs entangled in the wheelchair and, "Generally, she had a pedal on the left side [of the wheelchair] and I immediately noted it was missing." She indicated she assessed the resident and the resident was sent to the local emergency room. She indicated after the resident was sent to the emergency room, she then spoke with CNA #1. She indicated CNA #1 "Told me she was new to the evening shift from			

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	nights and didn't know the pedal was suppose to be there. She thought the pedals weren't being used anymore." She indicated, "I don't think the aide assignment sheets said anything about her foot pedal." In interview with the DON on 7-17-12 at 12:17 p.m., she indicated, "Wheelchair pedals should have been on the wheelchair prior to the accident." She indicated she was unsure why the foot pedal was not in place. In interview with the DON on 7-18-12 at 8:12 a.m., she indicated she was not sure if the CNA assignment sheet for Resident #A would have reflected the need for the foot pedal prior to her accident on 6-16-12. She indicated, "Typically, I wouldn't necessarily put things like foot pedals or a leg extension [for a wheelchair] on there unless it would be new or as a result of an incident. On 7-18-12 at 9:35 a.m., the DON provided a copy of the CNA assignment sheet which indicated it had been updated on 6-15-12 for Resident #A. It did not include any information about a foot pedal or leg extension for her wheelchair. Review of the emergency room visit documentation indicated Resident #A arrived via ambulance at 7:05 p.m. on 6-16-12 with a large "lump [to the] left			

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	side [of] head starting to bruise" with the left shoulder painful and swollen. The findings of the emergency room physician, upon discharge the same evening, were a left clavicle fracture, a contusion to the left ankle and a left scalp hematoma. These findings were based upon physical examination, a CT scan of the head and xray's of the shoulder and ankle. The recommendations included a follow up appointment with an orthopedist and to wear a left arm sling until seen by the specialist. Review of the orthopedist's recommendations on 6-26-12 was consistent with the emergency room findings. He advised the sling to be worn for comfort and to treat conservatively. He recommended a follow up appointment and xray of the clavicle in 4 weeks. On 7-18-12 at 9:35 a.m., the DON provided a copy of "Occupational Therapy Progress Notes," dated 9-4-09 through 9-11-09. This document indicated Resident #A's wheelchair has a left foot "Box-trough" type of foot pedal/leg extension for the wheelchair. The DON indicated this foot pedal/leg extension had not changed since this note was written in 2009. This Federal tag relates to Complaint IN00111334.			

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	3.1-45(a)(2)			

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F0498 SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Based on interview and record review, the facility failed to ensure a CNA was knowledgeable regarding the placement of a specialty left foot pedal on the wheelchair of a resident with left hemiplegia prior to transporting the resident down the hallway in the wheelchair, resulting in the resident's left foot dropping down onto the floor and then causing the resident to be propelled forward onto the floor which resulted in the resident sustaining a fracture to the left clavicle (collarbone), a sprain to the left ankle and a hematoma to the head. This deficient practice affected 1 of 3 residents reviewed for accidents in a total sample of 3. (Resident #A, CNA #1) Findings include: Resident #A's clinical record was reviewed on 7-17-12 at 11:05 a.m. Her diagnoses included, but were not limited to cerebrovascular accident (CVA or stroke), depression, anxiety, Alzheimer's disease, arthritis and osteoporosis. Her	F0498	F498 Requires the facility to ensure a CNA is knowledgeable regarding the placement of specialty equipment on the wheelchair of a resident. The facility will ensure this requirement is met through the following: 1. Resident #A was treated by the physician and a sling was ordered for her left arm. 2. All residents have the potential to be affected. The CNA assignment sheets were reviewed to ensure all specialty equipment that is be be placed on a resident's wheelchair is addressed on the CNA assignment sheet. See below for corrective measures. 3. The Fall Management policy and procedure was reviewed with no changes made.(See Attachment E) The staff was inserviced on the above procedure and that the staff is to check their assignment sheets to ensure all equipment is on the wheelchair prior to transporting the resident. 4. The DON or her designee will review the CNA assignment sheets to ensure all equipment that is to be placed on the resident's wheelchair is addressed on the	07/23/2012

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	most recent Minimum Data Set (MDS) assessment, dated 6-21-12, indicated she has moderate cognitive impairment, requires extensive assistance of 1 person with ambulation and transfers and uses a walker or wheelchair for mobility. In interview with Resident #A on 7-17-12 at 10:55 a.m., she indicated, "Not long ago, my aide was pushing me down the hall to the dining room...She forgot the foot pedals of my wheelchair. My [left] foot drug on the floor and I pitched forward. Hurt my shoulder; showed me the xray of my collarbone [in the emergency room]...[and] my left ankle got sprained. I had a stroke about 5 years ago and have little use of my left side. My shoulder aches all the time." In interview with CNA #1 on 7-18-12 at 10:50 a.m., she indicated she was providing care to Resident #A on the evening of 6-16-12. She indicated she assisted her in transferring from the recliner into the wheelchair without any difficulty. She indicated she was unaware the resident required the extension and foot pedal added to the wheelchair. She indicated she had recently switched from the night shift to the evening shift. She indicated she could not recall if the aide assignment sheet had anything about the foot pedal on it prior to the accident.		sheets so staff is knowledgeable of the specialty equipment needing to be placed on the resident's wheelchair prior to being transported. The DON or her designee will utilize the nursing monitoring tool to conduct the audit daily times four weeks, weekly times four weeks, then every two weeks times two months, then quarterly thereafter until compliance is maintained. (See Attachment B) The audits will be reviewed during the facility's quarterly assurance meetings and the plan of action will be adjusted accordingly. 5. The above corrective measures will be completed on or before July 23, 2012.	

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	In interview with LPN #2 on 7-18-12 at 11:34 a.m., she indicated she did not witness the accident, but "heard it happen." She indicated after the resident was sent to the emergency room, she then spoke with CNA #1. She indicated CNA #1 "Told me she was new to the evening shift from nights and didn't know the pedal was suppose to be there. She thought the pedals weren't being used anymore." She indicated, "I don't think the aide assignment sheets said anything about her foot pedal." In interview with the DON on 7-17-12 at 12:17 p.m., she indicated, "Wheelchair pedals should have been on the wheelchair prior to the accident." She indicated she was unsure why the foot pedal was not in place. In interview with the DON on 7-18-12 at 8:12 a.m., she indicated she was not sure if the CNA assignment sheet for Resident #A would have reflected the need for the foot pedal prior to her accident on 6-16-12. She indicated, "Typically, I wouldn't necessarily put things like foot pedals or a leg extension [for a wheelchair] on there unless it would be new or as a result of an incident. On 7-18-12 at 9:35 a.m., the DON provided a copy of the CNA assignment sheet which indicated it had been updated on 6-15-12 for Resident #A.			

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	It did not include any information about a foot pedal or leg extension for her wheelchair. Review of the Indiana State Department of Health's Division of Long Term Care Nurse Aide Training Program Manual (July 1998), under the heading of "Initial Steps," it indicated "1. Ask nurse about resident's needs, abilities and limitations, if necessary." It indicated to do this under "Rationale: 1. Prepares you to provide the best possible care to resident." This Federal tag relates to Complaint IN00111334. 3.1-14(i)			