

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155608	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2015
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NAME OF PROVIDER OR SUPPLIER  WITTENBERG LUTHERAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00172644 and IN00174479.</p> <p>Complaint IN00172644- Substantiated. Federal/State deficiencies related to the allegations are cited at F225 and F226.</p> <p>Complaint IN00174479- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: June 11 &amp; 12, 2015</p> <p>Facility number: 000515 Provider number: 155608 AIM number: 100290820</p> <p>Census bed type: SNF: 17 SNF/NF: 117 Total: 134</p> <p>Census payor type: Medicare: 24 Medicaid: 66 Other: 44 Total: 134</p> <p>Sample: 10</p>	F 0000		
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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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F 0225 SS=D Bldg. 00	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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</p>			

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	<p>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 interview, the facility failed to thoroughly investigate allegations of abuse and report an allegation of abuse to the Administrator and/or Abuse Coordinator in a timely manner for 3 of 3 residents reviewed for allegations of staff to resident Abuse in the sample of 10. (Residents #D, #K, and #L)</p> <p>Findings include:</p> <p>1. The record for Resident #K was reviewed on 6/11/15 at 2:40 p.m. The resident's diagnoses included, but were not limited to, depression, high blood pressure, and anemia.</p> <p>The 5/13/15 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (15). A score of (15) indicated the resident's cognitive patterns were intact.</p> <p>Review of a 5/17/15 Incident Report Form indicated an incident occurred on</p>	F 0225	<p><b>F225</b></p> <p>-□□□□□□<b>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>Residents D, K and L were assessed at time of the alleged incident. Residents have been re-assessed to ensure no adverse physical or emotional affects.</p> <p>-□□□□□□<b>how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</b></p> <p>Facility reviewed 24 hour reports, allegations of abuse and incident reports for last 60 days.</p> <p>-□□□□□□<b>what measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Interdisciplinary team to include: Human resources, Executive Director, DON (or designee of nursing administration), social service</p>	07/06/2015

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	<p>5/16/15 at 8:45 p.m. The report indicated staff noted discoloration to Resident #K's left upper arm. The area of discoloration measured 6 cm (centimeters) x 3 cm. The report also indicated, Resident #K indicated she received the bruise during a transfer into bed by the CNA the previous night and the CNA was rough during the transfer. The form identified CNA #1 as the staff member the resident referred to.</p> <p>Review of the facility investigation forms indicated report of the incident was completed on 5/17/15. The report indicated the resident was noted with discoloration to the left upper arm of unknown origin. The report also indicated an investigation was started and a CNA was placed on leave. A Narrative Nursing Note completed by RN #1 was included in the investigation. This Nursing Note indicated the RN was called to the the resident's room related to the resident's complaints of pain and a bruise on the resident's left upper arm. The note also indicted the resident stated "She did it when she put me to bed last night."</p> <p>A statement completed by Nurse #1 related to the incident was included in the facility investigation. The statement was not dated. The statement indicated Resident #K said a staff member grabbed</p>		<p>has been developed to review conclusion and investigations of all reportable events.</p> <p>Administratortnotification date and time added to investigative tools (see attached)</p> <p>New investigative tool has beendeveloped to guide a consistent investigative process: (See attached)</p> <p>Allpotential interviewers will be re-in serviced on new protocol.</p> <p>Re-inservicefacility staff on reporting guidelines for Abuse/Neglect allegations</p> <p>-□□□□□□how the corrective action(s) willbe monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place; and</p> <p>- All state reportableinvestigations will be reviewed by DON (or designee) for accuracy, completion, clearconclusion and Administrator notification. Findings will be reported at QualityAssurance meeting for 90 days or until no deficiencies are identified.</p> <p>- Abuse Coordinator/Designee willreview 5 incidents per week for abuse/neglect indicators and reporting findingsat Quality assurance meeting for 90 days or</p>	

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	<p>her arm and the staff member was not nice.</p> <p>A written statement completed by Nursing Supervisor #2 was reviewed. There was no date on the statement. The statement indicated Resident #K stated the CNA was mean, rough, and aggressive with care and the CNA was sent home. The statement also indicated there had been other complaints in regards to the same CNA. The first complaint indicated another female resident reported the CNA stripped her down naked and left her cold instead of putting her pants on first. A second complaint indicated another female resident complained the CNA was rough when putting her to bed. The third complaint indicated a male resident complained and the CNA was moved off the hall the resident resided on.</p> <p>When interviewed on 6/11/15 at 2:55 p.m., the Director of Nursing indicated RN#1 reported the bruise and the resident's statement to Nursing Supervisor #3 on 5/16/15 at 8:45 p.m. The Director of Nursing indicated the incident occurred on the evening of 5/15/15 and was first reported to staff on 5/16/15 at 8:45 p.m. The Director of Nursing indicated there had not been interviews completed of any other staff</p>		<p>until no deficiencies are identified</p> <p>-</p> <p>-□□□□□□ by what date the systemic changes will be completed.</p> <p>July 6, 2015</p>		

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	<p>members who had worked on 5/15/15.</p> <p>2. The record for Resident #L was reviewed on 6/11/15 at 1:55 p.m. The resident's diagnoses included, but were not limited to, dementia, anemia, and diabetes mellitus. The 3/27/15 Minimum Data Set (MDS) admission assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (11). A score of (11) indicated the resident's cognitive patterns were moderately impaired. The assessment also indicated the resident required extensive assistance (resident involved in activity, staff provide weight-bearing support) of two or more persons.</p> <p>Review of an Incident Investigation Form, dated 04/23/15, indicated the incident occurred on 04/23/15 at 6:30 p.m. The form indicated RN #2 notified LPN #3 that the resident had a scratch to the left cheek related to a transfer and Resident #L could not tell the nurse what had happened. The form indicated the Nurse Supervisor was notified at 6:40 p.m. on 04/23/15.</p> <p>A hand written, undated note, written by LPN #3, indicated, "This Nurse asked CNA involved how the scratch happened on the (L) (left) cheek. CNA stated to this nurse, '(Resident Name) scratched herself c/ (with) her hand!'"</p>			

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	<p>A hand written note, dated 04/23/15 at 6:30 p.m., and signed by RN #2, indicated, "...resident in sit to stand sling-put on by CNA (CNA #2). When applying sit to stand straps RN noted CNA being rough c/ (with) resident. This RN attempted multiple attempts to correct behavior from CNA-verbally &amp; physically rushing resident...In the process of CNA applying straps to sit to stand-CNA strongly pulling on (lt) (left) side strap...RN noted blood to CNA's hand, inquired what happened then noticed residents (sic) (Lt) side of cheek was slightly bleeding c/ what appeared to be a friction burn...This RN notified resident's nurse in regards to abrasion to (LT) cheek..."</p> <p>Review of an Investigation Form for Suspected Abuse/Neglect, dated 04/30/15, indicated, "Res. (Resident) (Resident #L) reported to NP (Nurse Practitioner) about rough treatment. Nurse confirmed this statement/allegation." The form indicated the resident had an abrasion to the cheek and it was determined no mistreatment occurred and the abrasion was likely from the sit to stand lift strap.</p> <p>A signed statement by RN #2, dated 04/24/15, indicated, "... (Supervisor</p>				

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	<p>Name) said I need statements...Leave it for (Day Supervisor Name) on her desk so she can do it in the morning...Res was already up in lift when (CNA #2 Name) started pulling on her. Kept telling res to shut up. Attempted to correct behavior. Res. was upset..."</p> <p>A signed statement by CNA #2, dated 04/24/15, indicated, "I entered room with (RN #1's Name) with the sit to stand lift. (RN #1) asked why I brought the lift in, I replied to transfer her to the bed. (RN #1) then informed me that (Resident Name) had been changed to a 2 assist by therapy. We use (sic) a gait belt to 2 assist her to bed. I noticed the area to her face while she was in bed and also noted blood to her left thumb...Did you pull on Resident? No Did you ever tell resident to shut up or be quiet? No..."</p> <p>The Nurse Practitioner's Progress Note, dated 04/24/15, indicated the resident was seen for an acute injury and was visibly upset about last nights ordeal. The Progress note indicated the resident had a left cheek bruise from an inappropriate sit to stand lift and the resident was upset and crying. The Progress Note further indicated, "...4/23/15, staff (RN #2) states (CNA #2) had (Resident Name) improperly suspended in hoyer lift. Was 'yanking</p>			

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	<p>(Resident Name) around' (Resident Name) states aid (sic) was 'mean, rough and hurt me.' States she kept telling aide to 'not use the lift' but was told repeatly (sic) 'to be quiet' Bruise noted to (L) (left) cheek from improper hoyer placement per staff. Pt (patient) visibly upset..."</p> <p>During an interview on 06/12/15 at 11:07 a.m., the DoN (Director of Nursing) indicated she had notified the Nurse Practitioner on 06/12/15 at 7:45 a.m. and the Nurse Practitioner indicated the above Progress Note was primarily a recap of the information provided by RN #2. The Nurse Practitioner indicated when she saw the resident, the resident was tearful but had not mentioned nor recalled how the abraised area on the cheek had occurred and the resident had not voiced any concerns regarding care.</p> <p>A signed statement by the Nursing Supervisor, dated 04/24/15, indicated, "...She did not say anything that made me feel like there was anything else wrong other than the abrasion on her face..."</p> <p>A signed statement by LPN #3, dated 04/24/15, indicated, "...not under the impression anything inappropriate had happened. (RN #2) did say (CNA #2) kept saying 'Come on...' and did say</p>						

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	<p>(CNA #2's) demeanor was brusks (sic) and that she was pulling the sit-to-stand sling on (l) side to hook it to lift..."</p> <p>During an interview on 06/11/15 at 1:37 p.m., the Director of Nursing (DoN) indicated, RN #2 had not followed proper procedure and had not reported the rough treatment. The DoN indicated they found the allegation when the incident report was reviewed and found the statement of RN #2, which indicated CNA #2 was rough with the resident. She indicated the CNA had denied the rough treatment.</p> <p>During interviews on 06/11/15 at 2:10 p.m., the Administrator indicated the Social Service Director was the Abuse Coordinator and she was the one who investigated allegations of abuse. The Social Service Director then indicated she had not documented her investigation of the allegation, but she had spoke with the resident and the resident indicated she had spoke with the Nurse Practitioner about her concerns. She indicated the resident stated, "no" when she was asked if she had any concerns with her care.</p> <p>During an interview on 06/12/15 at 10:01 a.m., CNA #2 indicated the resident had not been transferred with the lift. She indicated the resident was transferred with a gait belt and two assistance on the</p>			

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	<p>evening of 04/23/15. CNA #2 indicated she had seen the area on the resident's cheek prior to transferring her. She indicated she completed the rest of the shift, which was until 7 p.m. was not scheduled to work the week-end and was then placed on Administrative Leave.</p> <p>3. The record for Resident #D was reviewed on 6/11/15 at 6:15 a.m. The resident's diagnoses included, but were not limited to, vascular dementia, diabetes mellitus, and osteoporosis.</p> <p>Review of the 5/14/15 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was 14. A score of (14) indicated the resident's cognitive patterns were intact. The assessment also indicated the resident required extensive assistance of two staff members for bed mobility and transfers. The assessment also indicated the resident required extensive assistance of one staff member for dressing and personal hygiene.</p> <p>Review of an Internal Investigation Form for suspected Abuse/Neglect, dated 04/30/15, indicated the alleged abuse/neglect occurred on 04/23/15 during the afternoon and was reported on 04/24/15 at 2:30 p.m. The form indicated</p>			

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	<p>Resident #D's family member reported CNA #4 had spoken rudely towards Resident #D and the family member. The form indicated, "After interviewing staff-no mistreatment occurred."</p> <p>A handwritten statement, signed by Nursing Supervisor #5, indicated on 04/23/15 around 6:40 a.m. (sic should be p.m.), she was notified Resident #D's family had a complaint. The statement indicated, " (Resident #D's family) states she believes (Resident #D) is afraid of (CNA #4)...I asked her to take (Resident #D) to restroom, et (and) she just kept walking...turned call light on...(CNA #4) came in et (and) said I told you I have to take care of the resident I was helping, then I would take care of (Resident #D)...she felt (CNA #4) was rude. (Resident #D's family) said (CNA #4) did go get the nurse...to help her toilet (Resident #D)...Around 7 p.m., returned to room. (Resident #D's family) states (Resident #D) told her she feels threaten (sic). I ask (Resident #D) do you feel threaten (sic)...said no-very plain..."</p> <p>Interviews with other staff indicated: LPN #6-04/27/15, indicated, CNA #4 will act frustrated, roll her eyes and acts disgruntled when asked to do something.</p> <p>LPN #7-04/27/15, indicated CNA #4</p>			

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	<p>could be rude and short with others.</p> <p>QMA #8-04/27/15, indicated she had seen CNA #4 be rude to a resident. Examples written were, "I just took you bathroom (sic)", or "you have to wait" or "I'm busy". Negative about things.</p> <p>RN #9- 04/27/15- indicated CNA #4 was "blunt".</p> <p>CNA #10-04/27/15- indicated CNA #4 was negative and never had a positive attitude.</p> <p>During an interview on 06/12/15 at 11:07 a.m., the Assistant Director of Nursing indicated the rudeness to the other residents had not been reported. She indicated there were no specifics given and further questioning of the statements had not been included in the investigation. She indicated she had informed the staff this should have all been reported.</p> <p>This Federal tag relates to Complaint IN00172644.</p> <p>3.1-28(c) 3.1-28(d)</p>			

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F 0226 SS=D Bldg. 00	<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 ensure the facility's abuse policy was followed related to not immediately reporting an allegation of abuse to the Administrator of the facility and not thoroughly investigating allegations of abuse for 3 of 3 residents reviewed for abuse allegations in a total sample of 10. (Residents #D, #K, and #L)</p> <p>Findings include:</p> <p>1. The record for Resident #K was reviewed on 6/11/15 at 2:40 p.m. The resident's diagnoses included, but were not limited to, depression, high blood pressure, and anemia.</p> <p>Review of a 5/17/15 Incident Report Form indicated an incident occurred on 5/16/15 at 8:45 p.m. The report indicated staff noted discoloration to Resident #K's left upper arm. The area of discoloration measured 6 cm (centimeters) x 3 cm. The report also indicated the Resident #K indicated she received the bruise during a transfer into bed by the CNA the previous</p>	F 0226	<p><b>F225 - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> Residents D, K and L were assessed at time of the alleged incident. Residents have been re-assessed to ensure no adverse physical or emotional affects. - <b>how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</b> Facility reviewed 24 hour reports, allegations of abuse and incident reports for last 60days. - <b>what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Interdisciplinary team to include: Human resources, Executive Director, DON (or designee of nursing administration), social service has been developed to review conclusion and investigations of all reportable events. Administrator notification date and time added to investigative tools (see attached) New investigative tool has been developed to guide a</p>	07/06/2015			

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	<p>night and the CNA was rough during the transfer. The form identified CNA #1 as the staff member the resident referred to.</p> <p>Review of the facility investigation forms indicated report of the incident was completed on 5/17/15. The report indicated the resident was noted with discoloration to the left upper arm of unknown origin. The report also indicated an investigation was started and a CNA was placed on leave. A Narrative Nursing Note completed by RN #1 was included in the investigation. This Nursing Note indicated the RN was called to the the resident's room related to the resident's complaints of pain and a bruise on the resident's left upper arm. The note also indicted the resident stated "She did it when she put me to bed last night."</p> <p>A written statement completed by Nursing Supervisor #2 was reviewed. There was no date on the statement. The statement indicated Resident #K stated the CNA was mean, rough, and aggressive with care and the CNA was sent home. The statement also indicated there had been other complaints in regards to the same CNA. The first complaint indicated another female resident reported the CNA stripped her down naked and left her cold instead of</p>		<p>consistent investigative process: (See attached) Allpotential interviewers will be re-in serviced on new protocol. Re-inservice facility staff on reporting guidelines for Abuse/Neglect allegations - <b>how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and</b> _ All state reportable investigations will be reviewed by DON (or designee) for accuracy, completion, clear conclusion and Administrator notification. Findings will be reported at Quality Assurance meeting for 90 days or until no deficiencies are identified. _ Abuse Coordinator/Designee will review 5 incidents per week for abuse/neglect indicators and reporting findings at Quality assurance meeting for 90 days or until no deficiencies are identified - <b>by what date the systemic changes will be completed.</b> July 6, 2015</p>	

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	<p>putting her pants on first. A second complaint indicated another female resident complained the CNA was rough when putting her to bed. The third complaint indicated a male resident complained and the CNA was moved off the hall the resident resided on.</p> <p>When interviewed on 6/11/15 at 2:55 p.m., the Director of Nursing indicated RN#1 reported the bruise and the resident's statement to Nursing Supervisor #3 on 5/16/15 at 8:45 p.m. The Director of Nursing indicated the incident occurred on the evening of 5/15/15 and was first reported to staff on 5/16/15 at 8:45 p.m. The Director of Nursing indicated there had not been interviews completed of any other staff members who had worked on 5/15/15.</p> <p>2. The record for Resident #L was reviewed on 6/11/15 at 1:55 p.m. The resident's diagnoses included, but were not limited to, dementia, anemia, and diabetes mellitus. The 3/27/15 Minimum Data Set (MDS) admission assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (11). A score of (11) indicated the resident's cognitive patterns were moderately impaired. The assessment also indicated the resident required extensive assistance (resident involved in</p>			

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	<p>activity, staff provide weight- bearing support) of two or more persons.</p> <p>Review of an Incident Investigation Form, dated 04/23/15, indicated the incident occurred on 04/23/15 at 6:30 p.m. The form indicated RN #2 notified LPN #3 that the resident had a scratch to the left cheek related to a transfer and Resident #L could not tell the nurse what had happened. The form indicated the Nurse Supervisor was notified at 6:40 p.m. on 04/23/15.</p> <p>A hand written note, dated 04/23/15 at 6:30 p.m., and signed by RN #2, indicated, "...resident in sit to stand sling-put on by CNA (CNA #2). When applying sit to stand straps RN noted CNA being rough c/ (with) resident. This RN attempted multiple attempts to correct behavior from CNA-verbally &amp; physically rushing resident...In the process of CNA applying straps to sit to stand-CNA strongly pulling on (lt) (left) side strap...RN noted blood to CNA's hand, inquired what happened then noticed residents (sic) (Lt) side of cheek was slightly bleeding c/ what appeared to be a friction burn...This RN notified resident's nurse in regards to abrasion to (LT) cheek..."</p> <p>During an interview on 06/11/15 at 1:37</p>			

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	<p>p.m., the Director of Nursing indicated, RN #2 had not followed proper procedure and had not reported the rough treatment. The DoN indicated they found the allegation when the incident report was reviewed and found the statement of RN #1, which indicated CNA #2 was rough with the resident. She indicated the CNA had denied the rough treatment.</p> <p>3. The record for Resident #D was reviewed on 6/11/15 at 6:15 a.m. The resident's diagnoses included, but were not limited to, vascular dementia, diabetes mellitus, and osteoporosis.</p> <p>Review of the 5/14/15 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was 14. A score of (14) indicated the resident's cognitive patterns were intact. The assessment also indicated the resident required extensive assistance of two staff members for bed mobility and transfers. The assessment also indicated the resident required extensive assistance of one staff member for dressing and personal hygiene.</p> <p>Review of an Internal Investigation Form for suspected Abuse/Neglect, dated 04/30/15, indicated the alleged abuse/neglect occurred on 04/23/15</p>			

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	<p>during the afternoon and was reported on 04/24/15 at 2:30 p.m. The form indicated the Resident #D's family member reported CNA #4 had spoken rudely towards Resident #D and the family member. The form indicated, "After interviewing staff-no mistreatment occurred."</p> <p>A handwritten statement, signed by Nursing Supervisor #5, indicated on 04/23/15 around 6:40 a.m. (sic should be p.m.), she was notified Resident #D's family had a complaint. The statement indicated, " (Resident #D's family) states she believes (Resident #D) is afraid of (CNA #4)...I asked her to take (Resident #D) to restroom, et she just kept walking...turn call light on...(CNA #4) came in et said I told you I have to take care of the resident I was helping, thin I would take care of (Resident #D)...she felt (CNA #4) was rude. (Resident #D's family) said (CNA #4) did go get the nurse...to help her toilet (Resident #D)...Around 7 p.m., returned to room. (Resident #D's family) states (Resident #D) told her she feels threaten (sic). I ask (Resident #D) do you feel threaten (sic)...said no-very plain..."</p> <p>Interviews with other staff indicated: LPN #6-04/27/15, indicated, CNA #4 will act frustrated, roll her eyes and acts</p>			

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	<p>disgruntled when asked to do something.</p> <p>LPN #7-04/27/15, indicated CNA #4 could be rude and short with others.</p> <p>QMA #8-04/27/15, indicated she had seen CNA #4 be rude to a resident. Examples written were, "I just took you bathroom (sic)", or "you have to wait" or "I'm busy". Negative about things.</p> <p>RN #9- 04/27/15- indicated CNA #4 was "blunt".</p> <p>CNA #10-04/27/15- indicated CNA #4 was negative and never had a positive attitude.</p> <p>During an interview on 06/12/15 at 11:07 a.m., the Assistant Director of Nursing indicated the rudeness to the other residents had not been reported. She indicated there were no specifics given and further questioning of the statements had not been included in the investigation. She indicated she had informed the staff the this should have all been reported.</p> <p>The facility policy titled "Abuse and Neglect of a Resident" was reviewed on 6/11/15 at 6:00 a.m. The policy had a revised date of 6/19/14. The Director of Nursing provided the policy and</p>			

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	<p>indicated the policy was current. The policy indicated the residents had the right to be free from verbal, physical, sexual, and mental abuse. The policy identified Verbal Abuse as "using insulting names, threatening, shouting at, using demeaning language, curt replies, sarcasm, and sighs that convey disgust or irritation. The policy defined Physical Abuse as "the use of physical force that may result in bodily injury, physical pain, or impairment such as: kicking, slapping, hitting, shoving, shaking, striking with or without an object, pinching, kicking, burning, physical punishment, confinement, or unlawful use of restraints, corporal punishment." The policy also indicated "Injuries of unknown origin including bruises (even small ones) and skin tears (even minor ones) should be reported as potential physical abuse."</p> <p>Continued review of the facility policy indicated staff members were required to report any allegations immediately to the direct supervisor and/ or the Coordinator of Abuse Prevention. The Supervisor was required to inform the Abuse Prevention Coordinator who was then required to immediately inform the facility Administrator.</p> <p>This Federal tag relates to Complaint</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/02/2015  
FORM APPROVED  
OMB NO. 0938-0391

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