

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/20/2015
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NAME OF PROVIDER OR SUPPLIER BROWNSBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 HORNADAY RD BROWNSBURG, IN 46112
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00177598.</p> <p>Complaint IN00177598 - Substantiated, Federal/State deficiencies related to the allegations are cited at F221, F224 and F226.</p> <p>Survey dates: July 16, 20, 2015</p> <p>Facility number: 000113 Provider number: 155206 AIM number: 100287670</p> <p>Census bed type: SNF: 2 SNF/NF: 95 Total: 97</p> <p>Census payor type: Medicare: 11 Medicaid: 47 Other: 39 Total: 97</p> <p>Sample: 3</p> <p>Brownsburg Health Care Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of</p>	F 0000	Submission of this Plan of Correction shall not constitute or be construed as an admission by Brownsburg Healthcare that the allegations contained in the survey report are accurate or reflect the provision of nursing care and services to the residents of Brownsburg Healthcare	

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 0221 SS=A Bldg. 00	<p>Complaint IN00177598.</p> <p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on record review and interview, the facility failed to ensure residents' hands were not physically restrained during medication administration for 2 of 3 residents reviewed for allegations of abuse (Resident's B and C).</p> <p>Findings include:</p> <p>1. A reportable incident, dated 7/9/15, was reviewed on 7/16/15 at 10:15 a.m. The incident indicated Resident B refused prescribed medications and SS (Social Service) staff #1 held the resident's hands down while LPN #2 (Licensed Practical Nurse) administered the medication. The incident report indicated SS #1 was suspended pending investigation of the incident. The facility's investigation, dated 7/9/15, indicated the DON (Director of Nursing) noted documentation in the resident's record by SS #1 indicating she held the resident's hands down because the resident was uncooperative and fought with staff. The investigation indicated</p>	F 0221	<p>Every resident has the right to be free from physical restraints imposed for purposes of discipline or convenience</p> <p>Both incidents were found by DON in SS#1's documentation. SS#1 was immediately suspended pending investigation. Resident's #B and #C were immediately checked for injury and LPN#2 and QMA#3 were interviewed with statements taken about the 2 incidents Both were re-educated on abuse and reporting of abuse with emphasis on physical restraints and on reporting everyone who commits abuse. All nursing staff were inserviced on Abuse and Reporting of Abuse. No other residents have been affected by this practice. SS#1 was terminated. DON/designee continue to check documentation daily</p>	07/20/2015

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	<p>the allegation of abuse was substantiated and the staff member was terminated.</p> <p>The record for Resident B was reviewed on 7/16/15 at 11:10 a.m. Resident B's diagnoses included, but were not limited to, dementia with behavior disturbance, anxiety, and psychosis. Resident B's latest BIMS (Brief Interview of Mental Status) score from the Quarterly MDS (Minimum Data Set) Assessment, dated 4/17/15, indicated she was severely cognitively impaired.</p> <p>A Progress Notes dated 7/8/15 at 2:41 p.m. indicated "Resident refused morning meds [medications]. Nurse requested Director [SS#1] to help by talking to [resident's name]. During attempts to give her medicine, [resident] resisted medication administration aeb [as evidenced by] attempting to hit nurse with hands and elbow, telling nurse to 'blow her nose' and 'I hate you' in hostile tone, and turning head/tightening mouth. Director held [resident's] hands while talking to her and nurse [LPN #2] was able to give meds in pudding. [Resident] calm remainder of morning. Continue to observe."</p> <p>During an interview with LPN #2 on 7/20/15 at 10:40 a.m., she indicated she had attempted to administer Resident B's</p>			

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	<p>medications 3 times that morning unsuccessfully. After the third time, Resident B had propelled herself into the lounge where SS#1 was seated, and SS #1 and Resident B were holding hands so she (LPN #2) approached as SS#1 and the resident were talking, LPN #2 asked for assistance, and SS#1 asked Resident B why she wouldn't take her medications, and Resident B turned her head to LPN #2 with her mouth open and took her medications. LPN #2 indicated she did not report this, as SS #1 was only holding her hands, did not seem to be forcefully doing it, just mutually holding hands. LPN #2 indicated she did not read the documentation until she was called in to the office the next day, and she was unaware it was documented like it was, and the way it was documented, it did sound like Resident B had been abused.</p> <p>2. A reportable incident, dated 7/9/15, was reviewed on 7/16/15 at 10:15 a.m. The incident indicated Resident C refused prescribed medications and indicated SS #1 grabbed the resident's hands and held them down so QMA (Qualified Medication Aide) #3 could administer the medications. The incident report indicated SS #1 was suspended pending investigation of the incident. The facility's investigation, dated 7/9/15, indicated the DON noted documentation</p>			

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	<p>in Resident C's record by SS #1 indicating she held the resident's hands down because the resident was uncooperative and fought with staff. The investigation indicated the allegation of abuse was substantiated and the staff member was terminated.</p> <p>The record for Resident C was reviewed on 7/16/15 at 11:40 a.m. Resident C's diagnoses included, but were not limited to, dementia with delusional features, dementia with behavioral disturbance, psychotic disorder, and anxiety. A Quarterly MDS Assessment, dated 4/30/15, indicated Resident C's BIMS score indicated she was severely cognitively impaired.</p> <p>A Progress Note, dated 7/8/15 at 5:56 p.m. indicated: "Director observed QMA attempting to give [Resident C's name] evening meds. Director intervened when resident attempted to hit QMA. [Resident's name] also squeezed QMA's arm tightly, attempted to bite Director and kicked out into the air. Director held [Resident's] hands down and meds were successfully administered. [Resident] currently walking back and forth in hall but not moving toward anyone in an assertive manner and she has smiled at Director. Continue to observe."</p>			

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	<p>A Progress Note, dated 7/9/15 at 4:38 p.m., indicated "noted dark purple bruise to outside of left hand appears to be new. resident [sic] complained of hand pain."</p> <p>Follow-up Progress Notes, 7/10/15 and 7/11/15, indicated the bruising was fading and Resident C had no complaints of pain.</p> <p>During an interview with QMA #3 on 7/20/15 at 11:20 a.m., she indicated she was passing medications and Resident C kept turning away. She indicated SS #1 came up and grabbed Resident C's hands and said "I'll hold her." QMA #3 indicated she asked SS #1 to release Resident C's hands and indicated she did not immediately report the incident because SS #1 was her immediate supervisor. QMA #3 indicated since that time, she had learned she should have gone to a nurse or the ADON (Assistant DON) or DON or Administrator, that abuse should always be reported no matter who it is. She indicated she worked the evening shift and had not worked until she had been called in to the office the next day.</p> <p>During an interview with the DON on 7/16/15 at 3:30 p.m., she indicated she had found the abuse documentation while doing chart reviews, SS #1 had been</p>			

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	<p>suspended immediately, and LPN #2 and QMA #3 were both called in and both wrote statements and were counseled and both had received an inservice on abuse and reporting. Also provided was an inservice for all staff inservice, dated 7/12/15, reviewing abuse and reporting guidelines.</p> <p>A current facility policy, dated 10/23/13, titled "RESIDENT NEGLECT, ABUSE and MISAPPROPRIATION OF PROPERTY POLICY" was provided by the DON on 7/16/15 at 9:40 a.m. The policy indicated: "Residents will be free from misappropriation of property, and verbal sexual, physical and mental abuse, corporal punishment and involuntary seclusion. DEFINITIONS: Abuse: The willful infliction of injury, unreasonable confinement...PHYSICAL ABUSE:...It also includes controlling behavior through corporal punishment....3) Employees, whether direct care, contract staff, ancillary departments, volunteers, or Consultants, receive instruction/training on neglect, abuse...and the reporting requirements during orientation and periodically during ongoing inservice education. This instruction will include: a) appropriate interventions to deal with aggressive and/or catastrophic reactions of residents</p>			

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F 0224 SS=A Bldg. 00	<p>b) to whom, how and in what time frame staff should report their knowledge related to allegations without fear of reprisal... 6) All alleged incidents...are reported immediately to the Administrator. All employees are responsible to report allegations of abuse immediately...."</p> <p>This federal tag relates to Complaint IN00177598.</p> <p>3.1-3(w)</p> <p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION</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 residents were protected from mistreatment by having their hands physically restrained during medication administration for 2 of 3 residents reviewed for mistreatment (Residents B and C).</p> <p>Findings include:</p> <p>1. A reportable incident, dated 7/9/15,</p>	F 0224	<p>The facility has a written policy and procedure that prohibits mistreatment, neglect, and abuse of residents and misappropriation of property</p> <p>Residents #B and #C were assessed, families and physician were notified of incidents. SS#1 was suspended pending investigation. LPN#2 and QMA#3 were interviewed and statements were taken about the incidents. LPN#2 and QMA#3 were counseled and inserviced on</p>	07/20/2015

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	<p>was reviewed on 7/16/15 at 10:15 a.m. The incident indicated Resident B refused prescribed medications and SS (Social Service) staff #1 held the resident's hands down while LPN #2 (Licensed Practical Nurse) administered the medication. The incident report indicated SS #1 was suspended pending investigation of the incident. The facility's investigation, dated 7/9/15, indicated the DON (Director of Nursing) noted documentation in the resident's record by SS #1 indicating she held the resident's hands down because the resident was uncooperative and fought with staff. The investigation indicated the allegation of abuse was substantiated and the staff member was terminated.</p> <p>The record for Resident B was reviewed on 7/16/15 at 11:10 a.m. Resident B's diagnoses included, but were not limited to, dementia with behavior disturbance, anxiety, and psychosis. Resident B's latest BIMS (Brief Interview of Mental Status) score from the Quarterly MDS (Minimum Data Set) Assessment, dated 4/17/15, indicated she was severely cognitively impaired.</p> <p>A Progress Notes dated 7/8/15 at 2:41 p.m. indicated "Resident refused morning meds [medications]. Nurse requested Director [SS#1] to help by talking to</p>		<p>abuse and reporting of abuse with a heavy emphasis on any holding down of hands(physical restraint) etc, for convenience of staff and that this is abuse no matter who is doing it. All nursing staff have been inserviced on abuse and reporting of abuse. SS#1 was terminated and DON/designee will continue to monitor all documentation. No other resident were affected by this practice</p>	

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	<p>[resident's name]. During attempts to give her medicine, [resident] resisted medication administration and [as evidenced by] attempting to hit nurse with hands and elbow, telling nurse to 'blow her nose' and 'I hate you' in hostile tone, and turning head/tightening mouth. Director held [resident's] hands while talking to her and nurse [LPN #2] was able to give meds in pudding. [Resident] calm remainder of morning. Continue to observe."</p> <p>During an interview with LPN #2 on 7/20/15 at 10:40 a.m., she indicated she had attempted to administer Resident B's medications 3 times that morning unsuccessfully. After the third time, Resident B had propelled herself into the lounge where SS#1 was seated, and SS #1 and Resident B were holding hands so she (LPN #2) approached as SS#1 and the resident were talking, LPN #2 asked for assistance, and SS#1 asked Resident B why she wouldn't take her medications, and Resident B turned her head to LPN #2 with her mouth open and took her medications. LPN #2 indicated she did not report this, as SS #1 was only holding her hands, did not seem to be forcefully doing it, just mutually holding hands. LPN #2 indicated she did not read the documentation until she was called in to the office the next day, and she was</p>			
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	<p>unaware it was documented like it was, and the way it was documented, it did sound like Resident B had been abused.</p> <p>2. A reportable incident, dated 7/9/15, was reviewed on 7/16/15 at 10:15 a.m. The incident indicated Resident C refused prescribed medications and indicated SS #1 grabbed the resident's hands and held them down so QMA (Qualified Medication Aide) #3 could administer the medications. The incident report indicated SS #1 was suspended pending investigation of the incident. The facility's investigation, dated 7/9/15, indicated the DON noted documentation in Resident C's record by SS #1 indicating she held the resident's hands down because the resident was uncooperative and fought with staff. The investigation indicated the allegation of abuse was substantiated and the staff member was terminated.</p> <p>The record for Resident C was reviewed on 7/16/15 at 11:40 a.m. Resident C's diagnoses included, but were not limited to, dementia with delusional features, dementia with behavioral disturbance, psychotic disorder, and anxiety. A Quarterly MDS Assessment, dated 4/30/15, indicated Resident C's BIMS score indicated she was severely cognitively impaired.</p>			

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	<p>A Progress Note, dated 7/8/15 at 5:56 p.m. indicated: "Director observed QMA attempting to give [Resident C's name] evening meds. Director intervened when resident attempted to hit QMA. [Resident's name] also squeezed QMA's arm tightly, attempted to bite Director and kicked out into the air. Director held [Resident's] hands down and meds were successfully administered. [Resident] currently walking back and forth in hall but not moving toward anyone in an assertive manner and she has smiled at Director. Continue to observe."</p> <p>A Progress Note, dated 7/9/15 at 4:38 p.m., indicated "noted dark purple bruise to outside of left hand appears to be new. resident [sic] complained of hand pain."</p> <p>Follow-up Progress Notes, 7/10/15 and 7/11/15, indicated the bruising was fading and Resident C had no complaints of pain.</p> <p>During an interview with QMA #3 on 7/20/15 at 11:20 a.m., she indicated she was passing medications and Resident C kept turning away. She indicated SS #1 came up and grabbed Resident C's hands and said "I'll hold her." QMA #3 indicated she asked SS #1 to release Resident C's hands and indicated she did</p>			

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	<p>not immediately report the incident because SS #1 was her immediate supervisor. QMA #3 indicated since that time, she had learned she should have gone to a nurse or the ADON (Assistant DON) or DON or Administrator, that abuse should always be reported no matter who it is. She indicated she worked the evening shift and had not worked until she had been called in to the office the next day.</p> <p>During an interview with the DON on 7/16/15 at 3:30 p.m., she indicated she had found the documentation while doing chart reviews, SS #1 had been suspended immediately, and LPN #2 and QMA #3 were both called in and both wrote statements and were counseled and both had received an inservice on abuse and reporting. Also provided was an inservice for all staff inservice, dated 7/12/15, reviewing abuse and reporting guidelines.</p> <p>A current facility policy, dated 10/23/13, titled "RESIDENT NEGLECT, ABUSE and MISAPPROPRIATION OF PROPERTY POLICY" was provided by the DON on 7/16/15 at 9:40 a.m. The policy indicated: "Residents will be free from misappropriation of property, and verbal sexual, physical and mental abuse,</p>			

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F 0226 SS=A Bldg. 00	<p>corporal punishment and involuntary seclusion. DEFINITIONS: Abuse: The willful infliction of injury, unreasonable confinement...PHYSICAL ABUSE:...It also includes controlling behavior through corporal punishment...3) Employees, whether direct care, contract staff, ancillary departments, volunteers, or Consultants, receive instruction/training on neglect, abuse...and the reporting requirements during orientation and periodically during ongoing inservice education. This instruction will include: a) appropriate interventions to deal with aggressive and/or catastrophic reactions of residents b) to whom, how and in what time frame staff should report their knowledge related to allegations without fear of reprisal... 6) All alleged incidents...are reported immediately to the Administrator. All employees are responsible to report allegations of abuse immediately...."</p> <p>This federal tag relates to Complaint IN00177598.</p> <p>3.1-28(a)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p>			

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	<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 2 staff implemented policies and procedures for reporting allegations of abuse for 2 of 3 residents reviewed for allegations of abuse (Residents B and C)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. A reportable incident, dated 7/9/15, was reviewed on 7/16/15 at 10:15 a.m. The incident indicated Resident B refused prescribed medications and SS (Social Service) staff #1 held the resident's hands down while LPN #2 (Licensed Practical Nurse) administered the medication. The incident report indicated SS #1 was suspended pending investigation of the incident. The facility's investigation, dated 7/9/15, indicated the DON (Director of Nursing) noted documentation in the resident's record by SS #1 indicating she held the resident's hands down because the resident was uncooperative and fought with staff. The investigation indicated the allegation of abuse was substantiated and the staff member was terminated. <p>The record for Resident B was reviewed</p>	F 0226	<p>The facility has a written policy and procedure that prohibits mistreatment, neglect and abuse of residents LPN#2 and QMA#3 were interviewed with statements taken about the incidents LPN#2 and QMA#3 were counseled and inserviced on abuse and reporting of abuse, with heavy emphasis on physical restraint (holding hands down for convenience) and to report no matter who the person is(ie-director). LPN#2 and QMA#3 both expressed understanding of the policy and procedure and that they are responsible to report immediately and to keep the residents safe. All staff are inserviced on abuse and reporting of abuse on employment and quarterly SS#1 was terminated No other residents were affected by this practice</p>	07/20/2015

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	<p>on 7/16/15 at 11:10 a.m. Resident B's diagnoses included, but were not limited to, dementia with behavior disturbance, anxiety, and psychosis. Resident B's latest BIMS (Brief Interview of Mental Status) score from the Quarterly MDS (Minimum Data Set) Assessment, dated 4/17/15, indicated she was severely cognitively impaired.</p> <p>A Progress Notes dated 7/8/15 at 2:41 p.m. indicated "Resident refused morning meds [medications]. Nurse requested Director [SS#1] to help by talking to [resident's name]. During attempts to give her medicine, [resident] resisted med administration aeb [as evidenced by] attempting to hit nurse with hands and elbow, telling nurse to 'blow her nose' and 'I hate you' in hostile tone, and turning head/tightening mouth. Director held [resident's] hands while talking to her and nurse [LPN #2] was able to give meds in pudding. [Resident] calm remainder of morning. Continue to observe."</p> <p>During an interview with LPN #2 on 7/20/15 at 10:40 a.m., she indicated she had attempted to administer Resident B's medications 3 times that morning unsuccessfully. After the third time, Resident B had propelled herself into the lounge where SS#1 was seated, and SS</p>			

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	<p>#1 and Resident B were holding hands so she (LPN #2) approached as SS#1 and the resident were talking, LPN #2 asked for assistance, and SS#1 asked Resident B why she wouldn't take her medications, and Resident B turned her head to LPN #2 with her mouth open and took her medications. LPN #2 indicated she did not report this, as SS #1 was only holding her hands, did not seem to be forcefully doing it, just mutually holding hands. LPN #2 indicated she did not read the documentation until she was called in to the office the next day, and she was unaware it was documented like it was, and the way it was documented, it did sound like Resident B had been abused.</p> <p>2. A reportable incident, dated 7/9/15, was reviewed on 7/16/15 at 10:15 a.m. The incident indicated Resident C refused prescribed medications and indicated SS #1 grabbed the resident's hands and held them down so QMA (Qualified Medication Aide) #3 could administer the medications. The incident report indicated SS #1 was suspended pending investigation of the incident. The facility's investigation, dated 7/9/15, indicated the DON noted documentation in Resident C's record by SS #1 indicating she held the resident's hands down because the resident was uncooperative and fought with staff. The</p>			

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	<p>investigation indicated the allegation of abuse was substantiated and the staff member was terminated.</p> <p>The record for Resident C was reviewed on 7/16/15 at 11:40 a.m. Resident C's diagnoses included, but were not limited to, dementia with delusional features, dementia with behavioral disturbance, psychotic disorder, and anxiety. A Quarterly MDS Assessment, dated 4/30/15, indicated Resident C's BIMS score indicated she was severely cognitively impaired.</p> <p>A Progress Note, dated 7/8/15 at 5:56 p.m. indicated: "Director observed QMA attempting to give [Resident C's name] evening meds. Director intervened when resident attempted to hit QMA. [Resident's name] also squeezed QMA's arm tightly, attempted to bite Director and kicked out into the air. Director held [Resident's] hands down and meds were successfully administered. [Resident] currently walking back and forth in hall but not moving toward anyone in an assertive manner and she has smiled at Director. Continue to observe."</p> <p>A Progress Note, dated 7/9/15 at 4:38 p.m., indicated "noted dark purple bruise to outside of left hand appears to be new. resident [sic] complained of hand pain."</p>			

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	<p>Follow-up Progress Notes, 7/10/15 and 7/11/15, indicated the bruising was fading and Resident C had no complaints of pain.</p> <p>During an interview with QMA #3 on 7/20/15 at 11:20 a.m., she indicated she was passing medications and Resident C kept turning away. She indicated SS #1 came up and grabbed Resident C's hands and said "I'll hold her." QMA #3 indicated she asked SS #1 to release Resident C's hands and indicated she did not immediately report the incident because SS #1 was her immediate supervisor. QMA #3 indicated since that time, she had learned she should have gone to a nurse or the ADON (Assistant DON) or DON or Administrator, that abuse should always be reported no matter who it is. She indicated she worked the evening shift and had not worked until she had been called in to the office the next day.</p> <p>During an interview with the DON on 7/16/15 at 3:30 p.m., she indicated both the LPN and the QMA who had observed SS #1's actions had been inserviced and counseled as to the need to immediately report SS #1's actions to the administrator.</p>			

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	<p>During an interview with the DON on 7/20/15 at 11:35 a.m., she indicated she was aware LPN #2 still did not feel SS #1 was holding the resident's hands tightly, but restraining her hands to make her take medication was a restraint, and the resident did have the right to refuse her medication.</p> <p>A current facility policy, dated 10/23/13, titled "RESIDENT NEGLECT, ABUSE and MISAPPROPRIATION OF PROPERTY POLICY" was provided by the DON on 7/16/15 at 9:40 a.m. The policy indicated: "Residents will be free from misappropriation of property, and verbal sexual, physical and mental abuse, corporal punishment and involuntary seclusion. DEFINITIONS: Abuse: The willful infliction of injury, unreasonable confinement...PHYSICAL ABUSE:...It also includes controlling behavior through corporal punishment....3) Employees, whether direct care, contract staff, ancillary departments, volunteers, or Consultants, receive instruction/training on neglect, abuse...and the reporting requirements during orientation and periodically during ongoing inservice education. This instruction will include: a) appropriate interventions to deal with aggressive and/or catastrophic reactions of residents</p>			

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