

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2014
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NAME OF PROVIDER OR SUPPLIER  WOODLAND HILLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025
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F000000	<p>This visit was for the Investigation of Complaint IN00142655.</p> <p>Complaint IN00142655 - Substantiated. Federal/state deficiencies related to the allegations are cited at F223, F224, F225, and F226.</p> <p>Unrelated deficiencies are cited.</p> <p>Dates of survey: February 11, 12, 13, 14, 15, 16, and 17, 2014</p> <p>Facility number: 000022 Provider number: 155061 AIMS number: 100274510</p> <p>Survey team: Diana Sidell RN, TC Sunny Jungclaus RN Julie Dover (February 13 and 14, 2014)</p> <p>Census bed type: SNF/NF: 45 Total: 45</p> <p>Census payor type: Medicare: 5 Medicaid: 37 Other: 3 Total: 45</p>	F000000	<p>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.</p> <p>The 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. Should additional information be necessary to confirm said compliance, feel free to contact me.</p>	
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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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F000223 SS=J	<p>Sample: 12</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>This report was reviewed on February 20, 2014 by Cheryl Fielden RN.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure a resident was free from verbal and physical abuse in that a facility nurse yelled at a resident and roughly handled her while trying to pry her hands off a walker resulting in a fractured vertebrae and death. This affected 1 of 4 residents reviewed for abuse in a sample of 10. (Resident #A)</p>	F000223	F223 Requires the facility to ensure a resident is free from verbal and physical abuse. The involved resident is expired, and the involved staff member is no longer employed, thus, no further corrective action can be taken relative to the specific resident/incident. All residents have the potential to be affected, thus the following actions shall be taken. As means to ensure no other concerns of physical/ verbal abuse, all interviewable residents will be identified and interviewed	02/18/2014			

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	<p>This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy was identified on 2/14/14, and began on 12/20/13. The Administrator, Director of Nursing, Corporate Nurse Consultant, and Regional Director of Operations were notified of the Immediate Jeopardy, related to verbal and physical abuse, at 10:53 a.m. on 2/14/14. The Immediate Jeopardy was removed on 2/17/14, but the facility remained out of compliance at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy because not all staff had been re-inserviced on the abuse policy.</p> <p>Findings include:</p> <p>The Probable Cause Affidavit dated February 4, 2014, was received on February 13, 2014, reviewed on February 14, 2014 and indicated an interview with Resident #D's family member on December 31, 2013. "[Name of family member] advised that she was at Woodland Hills Care center on December 20, 2013 visiting [name of Resident #D]. [Name of family member] advised</p>		<p>in regards to staff interaction with emphasis on resident abuse, and each resident again educated as to the need to immediately report should any concern (i.e. abuse) be identified. All Allegations made by a resident (whether the resident is considered interviewable or non-interviewable) will be investigated using the same policy. An investigation will be initiated in follow up to any allegation of abuse made by the resident. Additionally, all residents are are monitored by staff to ensure that any potential non-verbal indicators of abuse are immediately reported should a concern be identified. (e.g., changes in behavior, withdrawal when being touched or/and care being provided, sudden change in participation in activities or social events, etc.). The facility will also conduct weekly skin assessments monitoring for any bruising and/or injury of unknown origin. If a concern is identified, the administrator will immediately initiate a thorough investigation as per policy and the same be documented. All residents (interviewable and non-interviewable) have the means to report allegations of abuse immediately. All residents and legal representatives are appraised of the ability to notify the nurse on duty, department supervisor or administrator directly of any concerns.</p>				

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	while she was there she observed [name of LPN#1] come into the room to care for and assist her mother's roommate [name of Resident #A]. [Name of family member] advised she was behind the curtain and believed [name of LPN #1] did not see her when she entered the room. Shortly after [name of LPN #1] entered the room she heard [name of LPN #1] yelling at [name of Resident #A]. [Name of family member] advised [name of LPN #1] seemed angry and she looked out from the curtain to see what was transpiring. [Name of family member] advised when she looked out from the curtain she observed [name of LPN #1] to have hold of [name of Resident #A] shoulder area violently jerking [name of Resident #A] back and forth attempting to get her to release her walker. After observing [name of LPN #1] jerking [name of Resident #A] she observed [name of LPN #1] and [name of Resident #A] to be in the restroom that was in the room. While they were in the restroom she could hear commotion and [name of LPN #1] yelling at [name of Resident #A]. [Name of family member] stated she then yelled over and asked [name of LPN #1] if she needed anything and shortly after		Additionally, the facility conducts quarterly interviews with all residents and/or legal representatives that address abuse prohibition, including provision of verbal education/reminder as to how to report abuse immediately and means in place in which to do so (e.g., report to staff in charge, administrative staff, use of hotline, etc.). All incident/accident reports since December 2013, as well as report of concerns, will be reviewed to ensure any injury of unknown origin and/or allegation of abuse was thoroughly investigated and the same documentation with necessary subsequent actions taken. All staff will again be educated prior to their next tour of duty as to abuse prohibition, and the mandate to immediately report to the administrator should there be an allegation of abuse of any type. All supervisory staff shall again be educated prior to their next tour of duty as to the mandatory immediate suspension of any employee against whom an allegation of abuse is reported in an effort to immediately protect/safeguard residents during investigation. In effort to ensure ongoing compliance, administrative staff shall be responsible to report any allegation of abuse to the Regional Director upon receipt and confirm appropriate		

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	<p>[name of LPN #1] and [name of Resident #A] came out of the restroom. [Name of family member] advised she looked back out of the curtain and observed [name of LPN #1] with [name of Resident #A] and [name of Resident #A] was seated possibly on the bed. [Name of family member] stated [name of Resident #A] was staring up with her mouth and eyes wide open. [Name of family member] advised she believed [name of Resident #A] was possibly dying or dead. "</p> <p>The Probable Cause Affidavit dated February 4, 2014 indicated a second interview on January 3, 2014 between [name of Detective] and [name of family member]. "In the interview, [name of family member] described her observations and demonstrated how [name of LPN #1] shook [name of family member]. In the demonstration, [name of family member] explained that [name of Resident #A] was using her walker and had a hold of it with her hands. [Name of family member] advised that [name of LPN #1] was attempting to remove [name of Resident #A] from the walker to assist [name of Resident #A]. [Name of family member] advised that [name of Resident #A] was not</p>		<p>measures were immediately initiated, including immediate suspension of an employee against whom an allegation is made. The Regional Director shall confirm thorough investigation is conducted as per policy and the same documented. As means of quality assurance, the full written record of any investigation shall be reviewed during at least weekly visits by the assigned nurse consultant. Should any concern be identified relative to the following of facility policy regarding abuse prohibition, the same shall be immediately addressed, including disciplinary action and/or re-education, as warranted. All allegations, investigations and resolution shall again be reported and reviewed during each quarterly Quality Assurance meeting. The facility requests that this citation be submitted for Independent Informal Dispute Resolution Review. A complete packet of IDR Rationale and corresponding supporting documentation was delivered to ISDH on Friday, March 7th, due to the volume of materials submitted. A brief overview is provided below: IDR Rationale for F223F223 states, "The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion."Woodland Hills Care Center upholds this right. The</p>				

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	<p>cooperating with [name of LPN #1] and would not let go of the walker. [Name of family member] explained and demonstrated how [name of LPN #1] got behind [name of Resident #A] and [name of LPN #1] placed her arms under [name of Resident #A] shoulders, in [name of Resident #A] armpits, and pulled up on [name of Resident #A] in a violent manner several times in an attempt to remove [name of Resident #A] from the walker."</p> <p>The Probable Cause Affidavit dated February 4, 2014 indicated an interview on January 3, 2014 between the (name of Detective) and (Resident #D) at Woodland Hills Care center. "Upon walking into Room ... I observed [name of Resident's #D's] curtains to be open where she could see who entered her room. Directly across from [name of Resident's #D's] bed was the bed of [name of Resident #A] who was her roommate. The Detective spoke with [name of Resident #D] about the incident involving [name of LPN #1] and [name of Resident #A]. [Name of Resident #D] advised while the family member was there [name of LPN #1] came in to assist [name of Resident #A] to the restroom. While</p>		<p>facility affirms there were (and are) policies in place that adhere to this right, including taking preventative measures through hiring practices and ongoing education, and implementing immediate reactive measures when notified of an allegation of abuse. The facility contends it followed its policy in an effort to prevent abuse when notified of an allegation of abuse on 12/23/13. When evaluating the facility's compliance with F223, one must consider the date/time when the allegation of abuse was voiced which would warrant implementation of the aforementioned facility policy to ensure residents remain free from verbal, sexual, physical and mental abuse. The 2567 repeatedly references the "Probable Cause Affidavit" dated February 4, 2014. While the facility remains strongly concerned with the content of the affidavit, the determination of facility compliance with F223 must be made solely on the information of which the facility was privy as of the date on which that information was reported. The affidavit includes interviews conducted with the reporting visitor/family member on 12/31/13 and 1/3/14. One must not only consider the later dates of these interviews, but also whether the visitor/family member provided the information stated in the affidavit to</p>				

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	<p>[name of LPN #1] was assisting [name of Resident #A], [name of family member] advised she could hear [name of LPN #1] saying in a mean voice get up, get up I told you for the last time get up and she observed [name of family member] watching out from the curtain. [Name of Resident #D] stated [name of LPN #1] was very mean and angry sounding while speaking with [name of Resident #A]. [Name of Resident #D] advised she heard [name of LPN #1] being rough and mean with [name of Resident #A] while in the restroom. [Name of Resident #D] advised she thought then [name of Resident #A] wouldn't be coming back out. [Name of Resident #D] then overheard [name of LPN #1] attempting to wake [name of Resident #A] up and heard her counting chest compressions trying to wake her up. [Name of Detective] asked [name of Resident #D] to tell him what she believed happened and [name of Resident #D] stated I think [name of LPN #1] killed [name of Resident #A]."</p> <p>The Probable Cause Affidavit dated February 4, 2014 indicated "On February 3, 2014, your affiant received the completed final report from [name of local county</p>		<p>facility administrative staff during prior reporting. The question relative to compliance would be, "Did the facility follow its policy and respond appropriately to the allegation and/or information provided in an effort to safeguard residents from abuse?" Per the 2567 (page 2), "Based on interview and record review, the facility failed to ensure a resident was free from verbal and physical abuse in that a facility nurse yelled at a [Resident A] and roughly handled her while trying to pry her hands off a walker resulting in a fractured vertebrae and death." The facility remains fully cooperative with the investigation of the unfortunate death of [Resident A]. One should note the death certificate of Resident A] states as cause of death "Hypertensive Atherosclerosis and Sudden Cardiac Death" (see Attachment # ____). The death certificate lists as the date certified "1/06/2014." The 2567 does not acknowledge the death certificate nor cause of death listed, and although there has been no trial, the 2567 states the alleged verbal and physical abuse was such that the actions "resulted in a fractured vertebrae and death." The facility respectfully questions this determination made on the basis of the Probable Cause Affidavit and autopsy, but prior to a legal proceeding (i.e., trial) to</p>				

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	<p>pathologist] in regards to the autopsy of [name of Resident #A]. [Name of local county pathologist] report shows when he examined the exterior of [name of resident #A] he observed no bruising or defensive marks on her body or any abnormalities on her back. [Name of county pathologist] internal examination notes a rather large fracture involving the vertebral column. The fracture is located at approximately the T8 vertebral body. The fracture extends through the entire thickness of the bony vertebral body, and the vertebral column can be moved with a hinge type motion on either side of the fracture. [Name of county pathologist] noted the adjacent bone is very hard and when the fracture is opened, it shows prominent displacement of the upper edge of the fracture, dissecting under the thoracic pleura. [Name of county pathologist] final diagnosis on the cause of death it blunt force injury of the thoracic spine. Based on the information provided by investigators it is [name of county pathologist] opinion the manner of [Resident #A ' s] death is homicide."</p> <p>A Probable Cause Affidavit dated February 4, 2014 indicated "on</p>		<p>determine the guilt or innocence of [LPN #1]. Further, the facility has been verbally notified to anticipate an amended autopsy report from the coroner's office. The facility remains respectful of the information listed within the Probable Cause Affidavit, yet contends facility administration was not informed of the alleged actions of the nurse as described in the later interviews held with the same visitor/daughter who initially reported to the Director of Nursing and Administrator on 12/23/13. Further, one should note additional details are recalled/alleged with each interview conducted, yet not listed in the prior interview. Each interview with the family member has revealed more information than the prior. The accounts of "violent jerking" were known to the facility only upon independent acquisition of the Probable Cause Affidavit on February 5th, 2014. As of that date, 1.) the residents had been interviewed with questions pertaining to any type of abuse; the interview included the question, "Has any resident or staff member ever physically harmed you?"; 2.) the facility had previously reviewed prior incident/accident reports in an effort to identify any concerns with pattern of injury of unknown etiology, and 3.) the resident was deceased, LPN#1 was no longer employed and all staff members</p>				

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	<p>January 10, 2014, ...[name of Doctor at local university pathology lab] examined the backbone and advised that the only cause of the break would have been a movement back and forth from front to back, not a movement side to side ...On January 26, 2014 ...the completed final report from pathologist ...the microscopic examination confirms that the bone matrix is normal in that there is no pathologic change such as metastatic cancer or access to have caused pathologic fracture. There is acute bleeding without inflammatory reaction within the marrow fat, and within the fragmented cortex. He further states that in his opinion with medical certainty, that this fracture occurred before the death of [name of Resident #A] and that it occurred at or near the time of her death. That this fracture would have produced significant respiratory distress and may have produced contusion or damage of the spinal cord. The mechanism of this injury is a violent hyper-extension of the back, and could not be the result of chest compressions or CPR. This injury did not result from positioning the body for CPR, since there is no skin injury associated with the fracture. Transporting or moving the dead</p>		<p>had been re-educated as to abuse prohibition. The facility was cooperating fully with the investigation of local authorities. The facility had not been informed of an allegation of physical abuse until reading the affidavit, and the alleged actions of the nurse were already under full investigation. The facility did not lodge an additional report with ISDH in an effort to report the allegation(s) listed on the affidavit. The facility respectfully disagrees with the statement, "the facility failed to ensure a resident was free from verbal and physical abuse in that a facility nurse yelled at a [Resident A] and roughly handled her while trying to pry her hands off a walker resulting in a fractured vertebrae and death." and requests this citation be deleted.</p>		

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	<p>body would not cause this injury. There is no evidence of any other medical condition that did cause the death of [name of Resident #A]. The cause of death is blunt force injury of the chest (thoracic spine) and the manner of death, relying on information provided by the Investigators is homicide.</p> <p>Resident #A's closed record was reviewed on 2/11/14 at 4:20 p.m. Physician's orders, dated 12/1/13 through 12/31/13, indicated Resident #A was admitted with diagnoses that included, but were not limited to, high blood pressure, chronic liver disease, cirrhosis of the liver, enlarged spleen, anemia, protein deficiency, kyphosis (curved spine), hypothyroidism, high blood fats, and gastroesophageal reflux disease.</p> <p>A quarterly Minimum Data Set Assessment, dated 12/18/13, indicated Resident #A was independent, decisions consistent/reasonable in cognitive skills for daily decision making, hearing was adequate, wore no hearing aids, had no behaviors, required supervision and set up for bed mobility, transfers, walking in corridor, dressing, eating, toilet use,</p>				

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	<p>and personal hygiene, had no impairment in range of motion, used a walker for mobility, was always incontinent of bowel and bladder, and experienced pain almost constantly in the last 5 days of the assessment, at the intensity of 8 (on a zero to ten scale, with zero being no pain, and 10 as the worst pain).</p> <p>A history and physical, dated 8/13/13, indicated Resident #A had a past medical history of backache and kyphosis, with "...severe pain with this...."</p> <p>Nurse's notes, dated 12/20/13 at 12:00 p.m., and signed by LPN #1, indicated: "Went to resident room &amp; resident asked writer to walk her to the bathroom, walking [with] unsteady gait. Color pale [with] resp. (respirations) easy. Talking to staff abd (abdomen) soft and distended [with] [decreased bowel sounds] X 4 q (quads). Had sm (small) form[ed] BM (bowel movement). Refused food took carton of milk."</p> <p>Nurse's notes, dated 12/20/13 at 12:20 p.m., and signed by LPN #1, indicated: "Called a code [no] pulse [no] resp[irations]. 2 staff (former DoN and LPN #1) doing CPR in bed</p>			

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	<p>on board...[Physician] called [with] order to send to [local hospital] ER for TX &amp; evaluation...."</p> <p>Nurse's notes, dated 12/20/13 at 12:50 p.m., and signed by LPN #1, indicated: "911 stretcher [with] 02 on P (pulse) 48 R (respirations) 10 - 02 sat 68% [with] 02 on. Resp[irations] Cheynes Stoke. (sic) to [local hospital] ER for TX &amp; Eval. Color cyanotic [with] resp labored."</p> <p>Nurse's notes, dated 12/20/13 at 1:50 p.m., and signed by LPN #1, indicated: "Called from [local hospital] ER. Deceased. [Name of resident's contact] called."</p> <p>A facility "Incident Report Form" was provided by the Administrator on 2/13/14 at 2:40 p.m. The incident report form indicated the initial report date was 12/23/13, with a follow up report on 12/27/13. The report indicated an incident occurred between Resident #A and LPN #1, and indicated: "Brief description of incident: Family member voiced an allegation of a nurse yelling at resident and prying her hands off of her walker. This was the first report to administration regarding this allegation. Type of injury/injuries: none. Immediate Action Taken:</p>			

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	<p>Nurse suspended immediately and investigation initiated. Preventive measures taken: Investigation indicated residents felt that the nurse in question was abrupt with them on more than one occasion. Nurse has been terminated effective 12/27/13. Residents will be addressed at next resident council meeting regarding immediate reporting of any staff member who speaks to them inappropriately/abusively. Staff will again be inserviced on abuse prohibition and immediate reporting of any concerns voiced by residents. Newly hired staff will continue to receive abuse prohibition inservice training upon hire and periodically thereafter. Allegations of abuse will continue to be investigated when reported, as per facility policy."</p> <p>Attached to the facility's investigation indicated an "Abuse Investigation Worksheet." The worksheet indicated: "Date of incident: 12/20/13. Time: 1:00 p.m. Resident involved: [Resident #A] Other party involved: Resident [#D], staff: [LPN #1], Family: [Family member]...Description of Allegation: Yelling @ Resident - prying her hands off of walker. Tone of voice inappropriate. Allegation reported</p>			

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	<p>by: [family member], Date: 12/23/13 Time: 4:00 p.m. Immediate action taken to protect resident: When mgmt (management) was notified by family immediately suspended nurse involved - reported to State and started investigation...Plan of action to prevent further recurrence: Talk [with] staff on when and how to report abuse. Staff member did not feel like family was voicing a concern of abuse...Conclusion of Investigation/Final action taken: Nurse terminated 12/27/13 due to tone of voice used when speaking with residents...."</p> <p>During an interview on 2/13/14, at 8:37 p.m., a family member indicated she was at the facility the day an incident happened. The family member it was on 12/20/13 at "12:10 p.m. or so" she thought [Resident #A] died that day, but she died at the hospital. . She said LPN#1 "wasn't screaming, but her tone was bad" and LPN #1 was "behind Resident #A with both of her arms up underneath Resident #A's arms, jerking her to the right saying let go [resident's name], let go." The family member indicated "the activity [aide] came in and started talking while they were listening [to LPN #1], and the activity [aide] started</p>			

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	<p>listening. [LPN #1] was saying 'let go [Resident #A], let go'. [LPN #1] left the room and came back 10 minutes later. The activity [aide] listened and the family member thought she heard what she was hearing". The family member indicated she didn't report it because she "was so upset and wanted to get to [a scheduled engagement] and was hoping nothing sinister happened to LPN #1 harming Resident #A." The family member indicated she thought she would go to the DoN and talk to her, and the DoN asked if there was something she wanted to tell them, she said yes and the DoN got the Administrator. The family member indicated she told them "to talk to the activity aide, so they did, and fired [LPN #1] on the spot." She said "it was very, very alarming, guess I should have told the police."</p> <p>During an interview, on 2/14/14, at 5:20 p.m., CNA #6 indicated she "was present during the whole thing" then declined to say anything further about the events that day.</p> <p>During an interview, on 2/15/14 at 3:18 p.m., CNA #4 indicated she had left the floor at 11:45 a.m. to 12:15 p.m. and " when I got back,</p>			

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	<p>[LPN #1] called me to the bathroom. [LPN #1] had [Resident #A] on the toilet; [Resident #A] was unresponsive, they [Former DoN and LPN #1] put her on the walker and transferred her to her bed. Then [LPN#1] had the other CNA [CNA #6] get all the staff in the room and the DoN started chest compressions. The respiratory therapy was called because she [Resident #A] was vomiting a small trickle out of the corner of her mouth. " CNA #4 then indicated she rode to the hospital with [Resident #A] after the ambulance got there.</p> <p>During an interview, on 2/14/14 at 12:10 p.m., Activity Aide #3 indicated she went in to see [Resident #D] on 12/20/13, and her [family member] was there. The [family member] turned to [Resident #D] and said something, then [LPN #1] was speaking loudly; "[Resident #A] open your eyes, speak to me [Resident #A]." [Name of family member] said "would you listen to her, how she is talking to her, she should be fired" , then [LPN #1] yelled "I need help, call 911" and staff started running. Activity Aide #3 said she was going to leave so she wouldn't be in the way, and left.</p>			

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	<p>She also indicated the voices she heard " started a moment after that, it was quiet when I entered the room." She said "I said to the [family member], there is an emergency situation going on."</p> <p>During a confidential interview, in a confidential time and date, a resident indicated he has heard "loud yelling and cursing" that occurs "not every day but quite often, when there is no upper staff here."</p> <p>During an interview, on 2/14/14 at 10:46 a.m., the Corporate Nurse Consultant indicated the activity aide thought it was panic in her nurse's tone and not abuse, and that was why the physical abuse was not reported. She indicated the "Statements they got from the first investigation covered the physical abuse, the nurse was terminated, the resident died, it was in the hands of police and they didn't have anything else to go back and look at."</p> <p>During an interview, on 2/14/14 at 10:46 a.m., the Administrator indicated January 3, 2014, after the police arrived at the facility regarding this incident, was the first they knew of any physical abuse; of any</p>			

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	<p>jerking, the family member just said LPN #1 was loud and prying [Resident #A's] hands off the walker, was never told anything about the physical abuse, just said she was removing her fingers from the walker. She indicated they did not know what happened, there wasn't any physical abuse, the family member didn't say anything about [LPN #1] being rough with [Resident #A], just that it was "her tone of voice." The Administrator indicated [LPN #1] worked the rest of her shift on 12/20/13, and on 12/23/13, was clocked out at 5:17 p.m. The Administrator also indicated they did not "feel the need to investigate the physical [abuse allegation] any further, they had already looked at the abuse protocol with the investigation of the verbal abuse, and they did not report the physical abuse to the ISDH."</p> <p>On 2/13/14, at 11:56 a.m., the County Coroner indicated Resident #A had a fractured vertebrae, at the T-8 level (thoracic level - where ribs attach), which was "consistent with a blunt force trauma to the back." The County Coroner also indicated [name of Forensic Pathologist] said she "would have had to place her knee in the back and pull forcefully."</p>				

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	<p>A policy and procedure for "Abuse Prohibition, reporting and investigation", dated 11/2012, was provided by the Director of Nurses on 2/11/14 at 2:04 p.m. The policy indicated, but was not limited to, "It is the policy of this facility that reports of abuse will be communicated to, and thoroughly investigated by, the correct authority.</p> <p>1. This facility will not permit residents to be subjected to abuse by anyone, including employees, other residents, consultants, volunteers, staff or personnel of other agencies serving the resident, family members, legal guardians, sponsors, friends or other individuals.</p> <p>An Immediate Jeopardy was identified on 2/14/14. The Immediate Jeopardy began on 12/20/13 when a nurse was not immediately reported for verbal and physical abuse and continued to work, residents were not protected while the nurse was working, and there was no thorough investigation of the occurrence of physical and verbal abuse. The Administrator, Director of Nursing, Corporate Nurse Consultant, and Regional Director of Operations were notified of the</p>			
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	<p>Immediate Jeopardy, related to verbal and physical abuse, at 10:53 a.m. on 2/14/14. The Immediate Jeopardy was removed on 2/17/14, when through observations, interviews and record reviews, it was determined the facility had implemented the plan of action to remove the Immediate Jeopardy and that steps taken removed the immediacy of the problem. LPN #1 had been terminated, the Administrator began inservicing staff on the abuse policy. Even though the facility's corrective actions removed the Immediate Jeopardy, the facility remained out of compliance at a reduced scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>This Federal tag relates to Complaint IN00142655.</p> <p>3.1-27(a)(1) 3.1-27(b)</p>			

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F000225 SS=L	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F000225	F225 Requires the facility to	02/18/2014			

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	<p>Based on record review and interview, the facility failed to immediately report and thoroughly investigate an allegation of verbal and physical abuse that lead to the death of Resident A. This affected 1 of 4 residents reviewed who met the criteria for abuse and had the potential to affect all 45 residents in the facility.</p> <p>This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy was identified on 2/14/14, and began on 12/20/13. The Administrator, Director of Nursing, Corporate Nurse Consultant, and Regional Director of Operations were notified of the Immediate Jeopardy, related to verbal and physical abuse, at 10:53 a.m., on 2/14/14. The Immediate Jeopardy was removed on 2/17/14, but the facility remained out of compliance at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy because not all staff had been re-inserviced on the abuse policy.</p> <p>Findings include:</p> <p>During an interview on 2/13/14, at</p>		<p>immediately report and thoroughly investigate an allegation of verbal and physical abuse. The involved resident is expired and the involved staff member is no longer employed, thus, no further corrective action can be taken relative to the specific resident/incident. As all residents could be affected, the following actions shall be taken: As means to ensure all verbal/physical abuse is reported immediately and thoroughly investigated, all interviewable residents will be identified and interviewed in regard to staff interaction with emphasis on resident abuse, and each resident again educated as to the need to immediately report should any concern (i.e. abuse) be identified. All allegations made by a resident (whether the resident is considered interviewable or non-interviewable) will be investigated using the same policy. An investigation will be initiated in follow up to any allegation of abuse made by the resident. Additionally, all residents are are monitored by staff to ensure that any potential non-verbal indicators of abuse are immediately reported should a concern be identified. (e.g., changes in behavior, withdrawal when being touched or/and care being provided, sudden change in participation in activities or social events, etc.). The facility will also conduct weekly skin assessments</p>		

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	8:37 p.m., a family member indicated she was at the facility the day an incident happened. The family member indicated that it was on 12/20/13 at "12:10 p.m., or so" and indicated she thought [Resident #A] died that day, but she died at the hospital. She said LPN #1 "wasn't screaming, but her tone was bad" and LPN #1 was "behind Resident #A with both of her arms up underneath Resident #A's arms, jerking her to the right saying let go [resident's name], let go." The family member indicated "the activity [aide] came in and started talking while they were listening [to LPN #1], and the activity [aide] started listening. [LPN #1] was saying 'let go [Resident #A], let go'. [LPN #1] left the room and came back 10 minutes later. The activity [aide] listened and the family member thought she heard what she was hearing". The family member indicated she didn't report it because she "was so upset and wanted to get to [a scheduled engagement] and was hoping nothing sinister happened to LPN #1 harming Resident #A." The family member indicated she thought she would go to the DoN and talk to her, and the DoN asked if there was something she wanted to tell them, she said		monitoring for any bruising and/or injury of unknown origin. If a concern is identified, the administrator will immediately initiate a thorough investigation as per policy and the same be documented. All residents (interviewable and non-interviewable) have the means to report allegations of abuse immediately. All residents and legal representatives are appraised of the ability to notify the nurse on duty, department supervisor or administrator directly of any concerns. Additionally, the facility conducts quarterly interviews with all residents and/or legal representatives that address abuse prohibition, including provision of verbal education/reminder as to how to report abuse immediately and means in place in which to do so (e.g., report to staff in charge, administrative staff, use of hotline, etc.) If any allegations are made through these interviews, the facility will report the allegation to the Indiana State Department of Health immediately. All staff will again be educated prior to their next tour of duty as to abuse prohibition, and to mandate to immediately report to the administrator should there be an allegation of abuse of any type. Upon staff reporting any allegation of abuse, the administrator as well will report the allegation to the Indiana State				

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	<p>yes and the DoN got the Administrator. The family member indicated she told them "to talk to the activity aide, so they did, and fired [LPN #1] on the spot." She said "it was very, very alarming, guess I should have told the police."</p> <p>During an interview, on 2/14/14 at 12:10 p.m., Activity Aide #3 indicated she went in to see [Resident #D] on 12/20/13, and her [family member] was there. The [family member] turned to [Resident #D] and said something, then [LPN #1] was speaking loudly; "[Resident #A] open your eyes, speak to me [Resident #A]." [Name of family member] said "would you listen to her, how she is talking to her, she should be fired" , then [LPN #1] yelled "I need help, call 911" and staff started running. Activity Aide #3 said she was going to leave so she wouldn't be in the way, and left. She also indicated the voices she heard " started a moment after that, it was quiet when I entered the room." She said " I said to the [family member], there is an emergency situation going on."</p> <p>During an interview, on 2/14/14 at 10:46 a.m., the Administrator indicated January 3, 2014, after the</p>		<p>Department of Health. The administrator will immediately investigate the allegation thoroughly as well as notify the Regional Director in which the Regional Director will also ensure that the allegation is reported immediately to the Indiana State Department of Health and documentation reflects that a thorough investigation is completed. In an effort to ensure ongoing compliance and quality assurance, the full written record of any investigation shall be reviewed during at least weekly visits by the assigned nurse consultant to ensure a thorough investigation was completed and the allegation was reported timely. Should any concern be identified relative to the following of facility policy regarding abuse prohibition, complete investigation or reporting in a timely manner, the same shall be immediately addressed, including disciplinary action and/ or re-education, as warranted. All allegations, investigations, reporting and resolution shall again be reported and reviewed during each quarterly Quality Assurance meeting. The facility requests that this citation be submitted for Independent Informal Dispute Resolution Review. A complete packet of IDR Rationale and corresponding supporting documentation was delivered to ISDH on Friday, March 7th, due to the volume of materials</p>				

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	<p>police arrived at the facility regarding this incident, was the first they knew of any physical abuse; of any jerking, the family member just said LPN #1 was loud and prying [Resident #A's] hands off the walker, was never told anything about the physical abuse, just said she was removing her fingers from the walker. She indicated they did not know what happened, there wasn't any physical abuse, the family member didn't say anything about [LPN #1] being rough with [Resident #A], just that it was "her tone of voice." The Administrator indicated [LPN #1] worked the rest of her shift on 12/20/13, and on 12/23/13, was clocked out at 5:17 p.m. The Administrator also indicated they did not "feel the need to investigate the physical [abuse allegation] any further, they had already looked at the abuse protocol with the investigation of the verbal abuse, and they did not report the physical abuse to the ISDH."</p> <p>On 2/14/14 at 10:46 a.m., the Corporate Nurse Consultant indicated the activity aide thought it was panic in her nurse's tone and not abuse, and that's why the physical abuse was not reported. She indicated the "Statements they</p>		<p>submitted. A brief overview is provided below:F225 states, "Thefacility must not employ individuals who have been-- (A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or (B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and (iii) 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 theState nurse aide registry or licensing authorities. 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). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and</p>		

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	<p>got from the first investigation covered the physical abuse, the nurse was terminated, the resident died, it was in the hands of police and they didn't have anything else to go back and look at."</p> <p>An " Employee Termination Report " was included with the investigation done on 12/23/13, and indicated: " Date: 12-27-13. Employee Name: [name of LPN #1] ...Last Day Worked: 12-23-13. Rehire: No [this had a checkmark on the line]. Reason for termination, Be Specific!!!: inattention to duty/neglect causing fear in resident /abuse yelling at residents/abuse. " This document was signed by the former DoN.</p> <p>During an interview, on 2/14/14, at 5:20 p.m., CNA #6 indicated she "was present during the whole thing " then declined to say anything further about the events that day.</p> <p>During an interview, on 2/15/14 at 3:18 p.m., CNA #4 indicated she had left the floor at 11:45 a.m. to 12:15 p.m. and "when I got back, [LPN #1] called me to the bathroom. [LPN #1] had [Resident #A] on the toilet; [Resident #A] was unresponsive, they [Former DoN</p>		<p>certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken."Woodland Hills Care Center upholds this directive.The facility affirms there are policies in place that mandate immediate reporting and investigation of verbal and physical abuse. The facility contends it followed its policy in an effort to prevent abuse when notified of an allegation of abuse on 12/23/13.Per the 2567 (page 15), "Based on record review and interview, the facility failed to immediately report and thoroughly investigate an allegation of verbal and physical abuse that lead to the death of [Resident A]." The facility respectfully disagrees with this statement. The facility acknowledges the concerns documented in the referenced Probable Cause Affidavit. However, one should note the death certificate of [ResidentA] does indicate verbal and physical abuse lead to the death of [Resident A],as stated on the 2567.The facility respectfully disagrees with the statement, "the facility failed to immediately report and thoroughly investigate an allegation of verbal and physical abuse that lead to the death of [Resident A]." and requests this citation be deleted.</p>				

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	<p>and LPN #1] put her on the walker and transferred her to her bed. Then [LPN#1] had the other CNA [CNA #6] get all the staff in the room and the DoN started chest compressions. The respiratory therapy was called because she [Resident #A] was vomiting a small trickle out of the corner of her mouth." CNA #4 then indicated she rode to the hospital with [Resident #A] after the ambulance got there.</p> <p>A facility "Incident Report Form", was provided by the Administrator on 2/13/14 at 2:40 p.m. The incident report form indicated the initial report date was 12/23/13, with a follow up report on 12/27/13. The report indicated an incident occurred between Resident #A and LPN #1, and indicated: "Brief description of incident: Family member voiced an allegation of a nurse yelling at resident and prying her hands off of her walker. This was the first report to administration regarding this allegation. Type of injury/injuries: none. Immediate Action Taken: Nurse suspended immediately and investigation initiated. Preventive measures taken: Investigation indicated residents felt that the nurse in question was abrupt with them on more than one occasion.</p>			

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	<p>Nurse has been terminated effective 12/27/13. Residents will be addressed at next resident council meeting regarding immediate reporting of any staff member who speaks to them inappropriately/abusively. Staff will again be inserviced on abuse prohibition and immediate reporting of any concerns voiced by residents. Newly hired staff will continue to receive abuse prohibition inservice training upon hire and periodically thereafter. Allegations of abuse will continue to be investigated when reported, as per facility policy."</p> <p>Attached to the "Incident Report Form" was the facility investigation which included, but was not limited to, an "Abuse Investigation Worksheet". The worksheet indicated: "Date of incident: 12/20/13. Time: 1:00 p.m. Resident involved: [Resident #A] Other party involved: Resident [#D], staff: [LPN #1], Family: [Family member]...Description of Allegation: Yelling @ Resident - prying her hands off of walker. Tone of voice inappropriate. Allegation reported by: [family member], Date: 12/23/13 Time: 4:00 p.m. Immediate action taken to protect resident: When mgmt (management) was notified by</p>			

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	<p>family immediately suspended nurse involved - reported to State and started investigation...Plan of action to prevent further recurrence: Talk [with] staff on when and how to report abuse. Staff member did not feel like family was voicing a concern of abuse...Conclusion of Investigation/Final action taken: Nurse terminated 12/27/13 due to tone of voice used when speaking with residents...."</p> <p>On 2/14/14 at 10:46 a.m., the Corporate Nurse Consultant indicated the activity aide thought it was panic in her nurse's tone and not abuse, and that's why the physical abuse was not reported. She indicated the "Statements they got from the first investigation covered the physical abuse, the nurse was terminated, the resident died, it was in the hands of police and they didn't have anything else to go back and look at."</p> <p>Resident #A's closed record was reviewed on 2/11/14 at 4:20 p.m. Physician's orders, dated 12/1/13 through 12/31/13, indicated Resident #A was admitted with diagnoses that included, but were not limited to, high blood pressure, chronic liver disease, cirrhosis of the</p>			

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	<p>liver, enlarged spleen, anemia, protein deficiency, kyphosis (curved spine), hypothyroidism, high blood fats, and gastroesophageal reflux disease.</p> <p>A quarterly Minimum Data Set Assessment, dated 12/18/13, indicated Resident #A was independent, decisions consistent/reasonable in cognitive skills for daily decision making, hearing was adequate, wore no hearing aids, had no behaviors, required supervision and set up for bed mobility, transfers, walking in corridor, dressing, eating, toilet use, and personal hygiene, had no impairment in range of motion, used a walker for mobility, was always incontinent of bowel and bladder, and experienced pain almost constantly in the last 5 days of the assessment, at the intensity of 8 (on a zero to ten scale, with zero being no pain, and 10 as the worst pain).</p> <p>Nurse's notes, dated 12/20/13 at 12:00 p.m., and signed by LPN #1, indicated: "Went to resident room &amp; resident asked writer to walk her to the bathroom, walking [with] unsteady gait. Color pale [with] resp. (respirations) easy. Talking to staff abd (abdomen) soft and</p>			

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	<p>distended [with] [decreased bowel sounds] X 4 q (quads). Had sm (small) form[ed] BM (bowel movement). Refused food took carton of milk."</p> <p>Nurse's notes, dated 12/20/13 at 12:20 p.m., and signed by LPN #1, indicated: "Called a code [no] pulse [no] resp[irations]. 2 staff doing CPR in bed on board...[Physician] called [with] order to send to [local hospital] ER for TX &amp; evaluation...."</p> <p>Nurse's notes, dated 12/20/13 at 12:50 p.m., and signed by LPN #1, indicated: "911 stretcher [with] 02 on P (pulse) 48 R (respirations) 10 - 02 sat 68% [with] 02 on. Resp[irations] Cheynes Stoke. (sic) to [local hospital] ER for TX &amp; Eval. Color cyanotic [with] resp labored."</p> <p>Nurse's notes, dated 12/20/13 at 1:50 p.m., and signed by LPN #1, indicated: "Called from [local hospital] ER. Deceased. [Name of resident's contact] called."</p> <p>Once the facility was aware of Resident #A 's death and police investigation, they failed to investigate and report to the Indiana State Department of Health.</p>			

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	<p>On 2/13/14, at 11:56 a.m., the County Coroner indicated Resident #A had a fractured vertebrae, at the T-8 level (thoracic level - where ribs attach), which was "consistent with a blunt force trauma to the back."</p> <p>During a confidential interview, in a confidential time and date, a resident indicated he has heard "loud yelling and cursing" that occurs "not every day but quite often, when there is no upper staff here."</p> <p>A policy and procedure for "Abuse Prohibition, reporting and investigation", dated 11/2012, was provided by the Director of Nurses on 2/11/14 at 2:04 p.m. The policy indicated, but was not limited to, "It is the policy of this facility that reports of abuse will be communicated to, and thoroughly investigated by, the correct authority.</p> <p>1. This facility will not permit residents to be subjected to abuse by anyone, including employees, other residents, consultants, volunteers, staff or personnel of other agencies serving the resident, family members, legal guardians, sponsors, friends or other individuals. 2. This facility will ensure that all alleged violations, including mistreatment, neglect or</p>				

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	<p>abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility. Violations of the aforementioned will be reported to other officials in accordance with state law through established procedures (including to the state survey and certification agency) as outlined in paragraph #3. This facility will report all unusual occurrences, which includes abuse, within 24 hours of discovery, to the Long Term Care Division of the Indiana State Department of Health...Upon completion of the investigation, which must occur within 5 days of the reporting of an incident, a report of the investigation must be forwarded to the Long Term Care Division of the Indiana State Department of Health...Residents will be protected from abuse through the provisions of this policy, the procedure for investigation of abuse, orientation training and ongoing inservice education...."</p> <p>An Immediate Jeopardy was identified on 2/14/14. The Immediate Jeopardy began on 12/20/13 when a nurse was not immediately reported for verbal and physical abuse and continued to</p>				

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	<p>work, residents were not protected while the nurse was working, and there was no thorough investigation of the occurrence of physical and verbal abuse. The Administrator, Director of Nursing, Corporate Nurse Consultant, and Regional Director of Operations were notified of the Immediate Jeopardy, related to verbal and physical abuse, at 10:53 a.m. on 2/14/14. The Immediate Jeopardy was removed on 2/17/14, when through observations, interviews and record reviews, it was determined the facility had implemented the plan of action to remove the Immediate Jeopardy and that steps taken removed the immediacy of the problem. LPN #1 had been terminated, the Administrator began inservicing staff on the abuse policy,. Even though the facility's corrective actions removed the Immediate Jeopardy, the facility remained out of compliance at a reduced scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>This Federal tag relates to Complaint IN00142655.</p> <p>3.1-28(c)</p>				

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F000226 SS=L	<p>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.</p> <p>Based on record review and interview, the facility failed to implement their policies and procedures regarding reporting, in that there was no thorough investigation of the allegation of physical abuse, no reporting of the allegation of physical and verbal abuse to the Administrator by the activity aide, the residents did not have a safe environment while the LPN continued to work the rest of her shift, and an additional day. The allegations of abuse were not reported immediately to the ISDH and other agencies. This affected all 45 residents.</p>	F000226	F226 Requires the facility to implement their policies and procedures regarding reporting. The involved resident is expired and the involved staff member is no longer employed, thus, no further corrective action can be taken relative to the specific resident/incident. As all residents could be affected the following actions shall be taken: As means to ensure all verbal/physical abuse is reported immediately, all interviewable residents will be identified and interviewed in regards to staff interaction with emphasis on resident abuse and each resident again educated as to immediately report should any concern (i.e. abuse) be identified. All allegations made by a resident	02/18/2014

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	<p>This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy was identified on 2/14/14, and began on 12/20/13. The Administrator, Director of Nursing, Corporate Nurse Consultant, and Regional Director of Operations were notified of the Immediate Jeopardy, related to verbal and physical abuse, at 10:53 a.m. on 2/14/14. The Immediate Jeopardy was removed on 2/17/14, but the facility remained out of compliance at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy because not all staff had been re-inserviced on the abuse policy.</p> <p>Findings include:</p> <p>During an interview on 2/13/14, at 8:37 p.m., a family member indicated she was at the facility the day an incident happened. The family member it was on 12/20/13 at "12:10 p.m. or so" she thought [Resident #A] died that day, but she died at the hospital. She said LPN #1 "wasn't screaming, but her tone was bad" and LPN #1 was "behind Resident #A with both of her arms</p>		<p>(whether the resident is considered interviewable or non-interviewable) will be investigated using the same policy. An investigation will be initiated in follow up to any allegation of abuse made by any resident.</p> <p>Additionally, All residents are monitored by staff to ensure that any potential non-verbal indicators of abuse are immediately reported should a concern be identified. (e.g., changes in behavior, withdrawal when being touched or/and care being provided, sudden change in participation in activities or social events, etc.). The facility will also conduct weekly skin assessments monitoring for any bruising and/or injury of unknown origin. If a concern is identified, the administrator will immediately initiate a thorough investigation as per policy and the same be documented. All residents (interviewable and non-interviewable) have the means to report allegations of abuse immediately. All residents and legal representatives are appraised of the ability to notify the nurse on duty, department supervisor or administrator directly of any concerns. Additionally, the facility conducts quarterly interviews with all residents and/or legal representatives that address abuse prohibition, including provision of verbal</p>				

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	<p>up underneath Resident #A's arms, jerking her to the right saying let go [resident's name], let go." The family member indicated "the activity [aide] came in and started talking while they were listening [to LPN #1], and the activity [aide] started listening. [LPN #1] was saying 'let go [Resident #A], let go'. [LPN #1] left the room and came back 10 minutes later. The activity [aide] listened and the family member thought she heard what she was hearing". The family member indicated she didn't report it because she "was so upset and wanted to get to [a scheduled engagement] and was hoping nothing sinister happened to LPN #1 harming Resident #A." The family member indicated she thought she would go to the DoN and talk to her, and the DoN asked if there was something she wanted to tell them, she said yes and the DoN got the Administrator. The family member indicated she told them "to talk to the activity aide, so they did, and fired [LPN #1] on the spot." She said "it was very, very alarming, guess I should have told the police."</p> <p>During an interview, on 2/14/14 at 12:10 p.m., Activity Aide #3 indicated she went in to see</p>		<p>education/reminder as to how to report abuse immediately and means in place in which to do so (e.g., report to staff in charge, administrative staff, use of hotline, etc.). If any allegations are made through these interviews, the facility will follow their policy and procedure and immediately suspend the employee who the allegation was made against as well as report the allegation to the Indiana State Department of Health. All staff again will be educated prior to their next tour of duty as to the Abuse Prohibition Policy and Procedure, and mandate to immediately report to the administrator should there be an allegation of abuse of any type per the policy. Upon any report of an allegation of abuse, the administrator will immediately follow the Abuse Prohibition Policy and Procedure by suspending the involved employee and reporting per policy. The administrator will also inform the Regional Director of the allegation and the Regional Director will also ensure the Abuse Prohibition Policy and Procedure is followed. In an effort to ensure ongoing compliance and quality assurance, the full written record of any investigation shall be reviewed during at least weekly visits by the assigned nurse consultant to ensure the Abuse Prohibition Policy and Procedure was accurately</p>	

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	<p>[Resident #D] on 12/20/13, and her [family member] was there. The [family member] turned to [Resident #D] and said something, then [LPN #1] was speaking loudly; "[Resident #A] open your eyes, speak to me [Resident #A]." [Name of family member] said "would you listen to her, how she is talking to her, she should be fired" , then [LPN #1] yelled " I need help, call 911 " and staff started running. Activity Aide #3 said she was going to leave so she wouldn't be in the way, and left. She also indicated the voices she heard "started a moment after that, it was quiet when I entered the room." She said "I said to the [family member], there is an emergency situation going on."</p> <p>During an interview, on 2/14/14, at 5:20 p.m., CNA #6 indicated she "was present during the whole thing" then declined to say anything further about the events that day.</p> <p>During an interview, on 2/15/14 at 3:18 p.m., CNA #4 indicated she had left the floor at 11:45 a.m. to 12:15 p.m. and " when I got back, [LPN #1] called me to the bathroom. [LPN #1] had [Resident #A] on the toilet; [Resident #A] was unresponsive, they [Former DoN</p>		<p>followed. Should any concern be identified relative to the facility policy regarding Abuse Prohibition, the same shall be immediately addressed, including disciplinary action and/or re-education, as warranted. All allegations, investigations, reporting and resolution shall again be reported and reviewed during each quarterly Quality Assurance meeting. The facility requests that this citation be submitted for Independent Informal Dispute Resolution Review. A complete packet of IDR Rationale and corresponding supporting documentation was delivered to ISDH on Friday, March 7th, due to the volume of materials submitted. A brief overview is provided below: F226 states, "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). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative</p>				

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	<p>and LPN #1] put her on the walker and transferred her to her bed. Then [LPN#1] had the other CNA [CNA #6] get all the staff in the room and the DoN started chest compressions. The respiratory therapy was called because she [Resident #A] was vomiting a small trickle out of the corner of her mouth." CNA #4 then indicated she rode to the hospital with [Resident #A] after the ambulance got there.</p> <p>A facility "Incident Report Form" was provided by the Administrator on 2/13/14 at 2:40 p.m. The incident report form indicated the initial report date was 12/23/13, with a follow up report on 12/27/13. The report indicated an incident occurred between Resident #A and LPN #1, and indicated: "Brief description of incident: Family member voiced an allegation of a nurse yelling at resident and prying her hands off of her walker. This was the first report to administration regarding this allegation. Type of injury/injuries: none. Immediate Action Taken: Nurse suspended immediately and investigation initiated. Preventive measures taken: Investigation indicated residents felt that the nurse in question was abrupt with them on more than one occasion.</p>		<p>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."Woodland Hills Care Center affirms the facility had in place and continues to follow policies that 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). The facility ensures that all alleged violations are thoroughly investigated, and prevents further potential abuse while the investigation is in progress. The facility disagrees with the aforementioned statement, as there was a thorough investigation when there was an allegation lodged by the family member; the activity aide did not fail to report the allegation, as she did not believe she had witnessed abuse nor had the family member reported abuse, following her explanation of the emergency procedures in place. The facility disagrees that it failed to have a safe environment while [LPN #1] continued to work the rest of</p>				

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	<p>Nurse has been terminated effective 12/27/13. Residents will be addressed at next resident council meeting regarding immediate reporting of any staff member who speaks to them inappropriately/abusively. Staff will again be inserviced on abuse prohibition and immediate reporting of any concerns voiced by residents. Newly hired staff will continue to receive abuse prohibition inservice training upon hire and periodically thereafter. Allegations of abuse will continue to be investigated when reported, as per facility policy."</p> <p>Attached to the "Incident Report Form" was the facility investigation which included, but was not limited to, an "Abuse Investigation Worksheet". The worksheet indicated: "Date of incident: 12/20/13. Time: 1:00 p.m. Resident involved: [Resident #A] Other party involved: Resident [#D], staff: [LPN #1], Family: [Family member]...Description of Allegation: Yelling @ Resident - prying her hands off of walker. Tone of voice inappropriate. Allegation reported by: [family member], Date: 12/23/13 Time: 4:00 p.m. Immediate action taken to protect resident: When mgmt (management) was notified by</p>		<p>her shift and an additional day, as the facility didremove [LPN #1] from resident care and subsequently suspended her after having received the allegation on 12/23/13; and the facility did report the allegation of abuse immediately to ISDH and other agencies when the allegation was lodged by the family member on 12/23/13.The facility respectfully disagrees with the statement "the facility failed to implement their policies and procedures regarding reporting, in that there was no thorough investigation of the allegation of physical abuse, no reporting of the allegation of physical and verbal abuse to the Administrator by the activity aide, the residents did not have a safe environment while the LPN continued to work the rest of her shift, and an additional day. The allegationsof abuse were not reported immediately to the ISDH and other agencies." and requests the citation be deleted as a finding.</p>		

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	<p>family immediately suspended nurse involved - reported to State and started investigation...Plan of action to prevent further recurrence: Talk [with] staff on when and how to report abuse. Staff member did not feel like family was voicing a concern of abuse...Conclusion of Investigation/Final action taken: Nurse terminated 12/27/13 due to tone of voice used when speaking with residents...."</p> <p>On 2/14/14 at 10:46 a.m., the Corporate Nurse Consultant indicated the activity aide thought it was panic in her nurse's tone and not abuse, and that's why the physical abuse was not reported. She indicated the "Statements they got from the first investigation covered the physical abuse, the nurse was terminated, the resident died, it was in the hands of police and they didn't have anything else to go back and look at."</p> <p>During an interview, on 2/14/14 at 10:46 a.m., the Administrator indicated January 3, 2014, after the police arrived at the facility regarding this incident, was the first they knew of any physical abuse; of any jerking, the family member just said LPN #1 was loud and prying</p>			

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	<p>[Resident #A's] hands off the walker, was never told anything about the physical abuse, just said she was removing her fingers from the walker. She indicated they did not know what happened, there wasn't any physical abuse, the family member didn't say anything about [LPN #1] being rough with [Resident #A], just that it was "her tone of voice." The Administrator indicated [LPN #1] worked the rest of her shift on 12/20/13, and on 12/23/13, was clocked out at 5:17 p.m. The Administrator also indicated they did not "feel the need to investigate the physical [abuse allegation] any further, they had already looked at the abuse protocol with the investigation of the verbal abuse, and they did not report the physical abuse to the ISDH."</p> <p>On 2/17/14 at 11:02 a.m., the Administrator provided a time card for LPN #1. The time card was dated 12/20/13, and indicated LPN #1 worked from 5:55 a.m. to 6:25 p.m. A time card, dated 12/23/13, indicated LPN #1 worked from 5:55 a.m. to 5:17 p.m.</p> <p>On 2/13/14, at 11:56 a.m., the County Coroner indicated Resident #A had a fractured vertebrae, at the</p>			
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	<p>T-8 level (thoracic level - where ribs attach), which was "consistent with a blunt force trauma to the back."</p> <p>A policy and procedure for "Abuse Prohibition, reporting and investigation", dated 11/2012, was provided by the Director of Nurses on 2/11/14 at 2:04 p.m. The policy indicated, but was not limited to, "It is the policy of this facility that reports of abuse will be communicated to, and thoroughly investigated by, the correct authority.</p> <p>1. This facility will not permit residents to be subjected to abuse by anyone, including employees, other residents, consultants, volunteers, staff or personnel of other agencies serving the resident, family members, legal guardians, sponsors, friends or other individuals. 2. This facility will ensure that all alleged violations, including mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility. Violations of the aforementioned will be reported to other officials in accordance with state law through established procedures (including to the state survey and certification agency) as</p>			

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	<p>outlined in paragraph #3. This facility will report all unusual occurrences, which includes abuse, within 24 hours of discovery, to the Long Term Care Division of the Indiana State Department of Health...Upon completion of the investigation, which must occur within 5 days of the reporting of an incident, a report of the investigation must be forwarded to the Long Term Care Division of the Indiana State Department of Health...Residents will be protected form abuse through the provisions of this policy, the procedure for investigation of abuse, orientation training and ongoing inservice education...."</p> <p>An Immediate Jeopardy was identified on 2/14/14. The Immediate Jeopardy began on 12/20/13 when a nurse was not immediately reported for verbal and physical abuse and continued to work, residents were not protected while the nurse was working, and there was no thorough investigation of the occurrence of physical and verbal abuse. The Administrator, Director of Nursing, Corporate Nurse Consultant, and Regional Director of Operations were notified of the Immediate Jeopardy, related to verbal and physical abuse, at 10:53</p>			

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	<p>a.m. on 2/14/14. The Immediate Jeopardy was removed on 2/17/14, when through observations, interviews and record reviews, it was determined the facility had implemented the plan of action to remove the Immediate Jeopardy and that steps taken removed the immediacy of the problem. LPN #1 had been terminated, the Administrator began inservicing staff on the abuse policy, . Even though the facility's corrective actions removed the Immediate Jeopardy, the facility remained out of compliance at a reduced scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>This Federal tag relates to Complaint IN00142655.</p> <p>3.1-28(c)</p>				

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F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to maintain complete and accurate clinical records in that a transfer sheet was not completed, and nurses handwriting was not legible. This affected 1 of 12 residents reviewed for complete and accurate records in a sample of 12. (Resident #A)</p> <p>Findings include:</p>	F000514	F514 Requires the facility to maintain complete and accurate clinical records. 1. Resident #A's clinical chart was reviewed for concerns as stated in the 2567. No corrective measures can be taken in regard to the closed chart; however the examples will be used to educate staff regarding compliance. 2. All residents have the potential to be affected. Per review of transfer forms completed in the prior 30 days, no negative outcome(s) were identified regarding accuracy, completeness and legible handwriting errors of	02/18/2014	

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	<p>Resident #A's closed record was reviewed on 2/11/14 at 4:20 p.m. Physician's orders, dated 12/1/13 through 12/31/13, indicated Resident #A was admitted with diagnoses that included, but were not limited to, high blood pressure, chronic liver disease, cirrhosis of the liver, enlarged spleen, anemia, protein deficiency, kyphosis (curved spine), hypothyroidism, high blood fats, and gastroesophageal reflux disease.</p> <p>A transfer sheet, dated 12/20/13, indicated the following information was not completed; if the hospital was contacted, vital signs, resistant organism, communicable disease, flu vaccine, tetanus, and chief complaint/problem.</p> <p>Nurse's notes, dated 12/20/13 at 12:20 p.m., indicated: "Called a code [no] pulse [no] resp[irations]. 2 staff (RN #3 and LPN #1) doing CPR in bed on board[this part was illegible]...[Physician] called [with] order to send to [local hospital] ER for TX &amp; evaluation...[this part illegible]."</p> <p>During an interview, on 2/17/14 at 1:45 p.m., the Administrator indicated the forms were supposed</p>		<p>transfer forms for applicable residents. No corrective measures can be taken in regard to completion of prior transfer forms, however, findings (i.e., identification of areas in need of improvement) will be used to educate staff regarding ongoing compliance with accuracy, completeness and legible handwriting on transfer forms as well as all other facility documentation. The following actions shall be taken. 3. The Nursing Department Charting Policy and Procedure was reviewed with no changes made to the policy. As a means to ensure ongoing compliance, the nursing staff was inserviced on the policy, with emphasis on correct completion of the transfer sheet and ensuring handwriting is legible. 4. As a means of quality assurance, the DON or her designee will utilize a monitoring tool to audit at least ten residents' nursing entries to ensure that the handwriting is legible. If the writing is not legible, the nurse making the entry will be asked to rewrite the entry to ensure it is legible. The DON or her designee will also ensure that all transfer sheets are completed for residents being transferred. The DON or designee will utilize the nursing monitoring tool daily on scheduled days of work times four weeks, then weekly times four weeks, then every 2 weeks times two</p>				

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	<p>to be completed fully. The Director of Nurses indicated at that time that handwriting should be legible, and "would make them write an addendum and then make them print."</p> <p>A policy and procedure for "Nursing Department Charting Policy and Procedure", with a revised dated of 3/2011, indicated, but was not limited to, "Purpose: To accurately document in an organized manner all pertinent information related to the resident in the nurse's notes and other designated sections of the clinical record...The following guidelines should assist the nurse in appropriate documentation for charting. Be complete, concise and factual...Entries must be legible, written or printed in ink and in order of time occurrence...."</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>		<p>months then quarterly thereafter until 100% compliance is obtained and maintained. The audits and any corrective actions taken will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly, if warranted.</p>		