

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155167	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/21/2016
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00209046 and Complaint IN00209400.</p> <p>Complaint IN00209046-Substantiated. No deficiencies related to the allegations were cited.</p> <p>Complaint IN00209400 -- Substantiated. Federal/State deficiencies related to the allegations are cited at F223, F225, F226 and F309</p> <p>Survey dates: September 19, 20 and 21, 2016</p> <p>Facility number: 000084 Provider number: 155167 AIM number: 100284600</p> <p>Census bed type: SNF/NF: 119 Total: 119</p> <p>Census payor type: Medicare: 23 Medicaid: 58 Other: 38 Total: 119</p> <p>Sample: 4</p>	F 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F 0223 SS=D Bldg. 00	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on September 28, 2016</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 1 of 3 residents reviewed for abuse and the use of side rails was not involuntarily secluded in that the resident had bilateral top and bottom side rails utilized by a staff member to prevent him from exiting the bed without an assessment being conducted prior to their use or without authorization by the physician or resident and/or family. (Resident #B)</p> <p>Findings include:</p>	F 0223	PLEASE NOTE THAT THE SURVEYOR ERRONEOUSLY IDENTIFIED SOME OF THE COMMENTARY IN THE SURVEY CITINGS AS THOSE OF THE "EXECUTIVE DIRECTOR". IN THE INTEREST OF ACCURACY, THE COMMENTS THAT WERE	10/19/2016

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	<p>In a written statement provided by a family member of Resident #B, it was alleged on 8-19-16, the family member observed "all 4 rails were up," on the bed of Resident #B.</p> <p>During an interview with the Director of Nursing on 9-20-16 at 11:20 a.m., she relayed she had spoken with the spouse of Resident #B on/around the evening of 8-19-16. "She said, one evening she came in [to see Resident #B] and all four rails were up on his bed. She asked the aide why and the aide told her she knew he was a fall risk, so that was why she had put them up. When we spoke to the aide, she was upset and crying. She said until the nurse told her, she didn't know we have to have a doctor's order for all the rails to be up." She indicated the staff person involved was CNA #1. "She [CNA #1] was suspended in regards to the 4 rails being up. We ended up having to let the CNA go, because she had an out of state license and her 120 days were nearly up. She had taken her [Indiana] test and had not passed it. So she was not terminated related to the restraint issue, but specific to the licensure dates issue. In talking with the aide, I don't think for one minute that she was trying to harm him, she just thought it would keep him from falling...I think it was just a poor judgement issue with her. I think she</p>		<p>ATTRIBUTED TO THE "EXECUTIVE DIRECTOR" WERE, IN FACT, MADE BY THE ADMINISTRATOR.</p> <p>F 223</p> <p>REGARDING RESIDENT #8: There are no additional measures to be instituted regarding Resident #8, as Resident #8 has been discharged to home.</p> <p>The use of four side rails on a Resident's bed has never occurred before in this facility. This is, obviously, an isolated event. A 100% audit has been conducted and no other issues were noted. The Maintenance staff</p>	

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	<p>was trying to be cautious and just didn't understand."</p> <p>The Director of Nursing provided a copy of a written "follow-up" of concerns, dated 8-23-16 and signed by the Director of Nursing. It indicated the spouse of Resident #B was unable to specify the name of the CNA involved in an incident on 8-18-16, but upon review of the work schedule, it was decided the person was CNA #1. It specified the Director of Nursing interviewed CNA #1 on 8-23-16. The document clarified, "She said that she had, in fact, put all four rails up on [name of Resident #B]'s bed. [Name of CNA #1] said, 'I was just trying to do my best to keep him from falling. I know that he is a fall risk. Everybody says he tries to get up by himself. I just didn't want him to fall'...'[Name of CNA #1] was asked why she thought that the use of the four 1/2 length rails was a good idea for [name of Resident #B], as no one else in the facility utilizes four 1/2 length rails. [Name of CNA #1] repeated, 'I just thought that I was doing the right thing to keep him from falling.'..."</p> <p>In an interview on 9-21-16 at 4:12 p.m., with the Executive Director, she asserted, "I had a chance to look at the security tapes for 8-18-16 about [name of Resident #B]. It looked like the last time,</p>		<p>will remove the bilateral lower rails from the beds equipped with the same. Thus, this particular event cannot be repeated in the future. The Maintenance Director is responsible. The Administrator will monitor.</p> <p>The Quality Assurance Nurse will audit one time per month times six months to ensure facility policy regarding the use of side rails is in compliance. Additionally, additional inservice education will be made available to nursing personnel regarding the use of side rails. The Quality Assurance Nurse is responsible. The Director of Nursing will monitor.</p>	

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	<p>before the wife came in, that the nurse came out of [name of Resident #B]'s room was 6:43 p.m. In talking with her [the nurse on duty], she said the side rails were not up at that time. The last time the CNA exited the room, before the wife came in, was 6:55 p.m. The wife arrived at 8:42 p.m. So from what I can tell, that would mean the side rails would have been up for less than two hours.</p> <p>The aide, [name of CNA #1], was hired on 4-25-16 and was suspended, effective on 8-19-16, and terminated on 8-26-16. I could not find any other disciplinary issues in her file. She signed our form about involuntary seclusion during her orientation. To the best of my knowledge, we did not do any staff education on side rail use or involuntary seclusion after this...The aide had a CNA license from another state, but hadn't passed the test for Indiana yet and she was right at the 120 day mark. So we couldn't let her work as an aide anymore."</p> <p>The clinical record of Resident #B was reviewed on 9-19-16 at 2:20 p.m. His diagnoses included, but were not limited to, malignant brain tumor, hemiplegia which affected his left side, left axillary embolism (blood clot), diabetes and polyneuropathy. His admission</p>		<p>Quality Assurance Nurse will bring results of monthly audits for side rail compliance to the facility's monthly Quality Assurance Committee Meetings for no less than six months. At the end of the six month period, the Committee may opt to dispense with the monthly review of this topic if 100 % compliance is achieved.</p> <p>The facility would also like for the record to show that C.N.A. #1 actions, unarguably, was a demonstration of poor judgement. When interviewed by the Director of Nursing post suspension, C.N.A. #1 tearfully explained that she was concerned that Resident #8 would sustain a fall, acknowledging that</p>	

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	<p>Minimum Data Set assessment, dated 8-11-16, indicated he was moderately cognitively impaired, required extensive assistance with bed mobility and transfers of two or more persons, required extensive assistance of one person with locomotion, did not ambulate, used a wheelchair for mobility and had one fall without injury after admission to the facility. Fall risk assessments on 8-6-16 and 8-21-16 documented he was a fall risk. The admission physician orders, dated 8-4-16, indicated an order for bilateral one-half side rails to promote mobility, typically specified for the upper portion of the bed. The clinical record failed to have any physician orders specific to the use of physical restraints for Resident #B. The clinical record failed to have any type of assessment for the use of physical restraints or authorization for the use of physical restraints from the resident or family.</p> <p>On 9-19-16 at 11:21 a.m., the Executive Director provided a copy of policy entitled, "Resident Rights." This policy was dated 11-10-93, and was identified to be the current policy utilized by the facility. This policy specified, "...Restraints. The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not</p>		<p>she was aware that this Resident was a fall risk However, there is absolutely no evidence that C.N.A. #1's errant use of the side rails was a demonstration of any "willful" intent to act in a manner that would be akin to "abuse" or "involuntary seclusion". The Resident resided in a private room. It was his normal routine to remain in his room during the evening. Therefore this scenario does not represent "a separation of a resident from other residents or from his/her room". The Resident did not object when C.N.A. #1 utilized the lower two rails: thus, he was not confined against his will. The Resident's wife had authorized the use of the two upper bilateral</p>	

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	<p>required to treat the resident's medical symptoms. Abuse. The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, neglect and involuntary seclusion."</p> <p>On 9-21-16 at 4:30 p.m., the Executive Director provided a copy of a policy entitled, "Restraint Use." This policy was undated, but indicated to be the current policy utilized by the facility. This policy stated, "Purpose: To assure resident safety when restrictive devices are required. Note: Under no circumstances is it ever acceptable for a physical restraint to be utilized for a Resident as a punitive measure OR for staff convenience..."</p> <p>On 9-21-16 at 4:30 p.m., the Executive Director provided a copy of a policy entitled, "Abuse Prohibition/Know Your Role." The Executive Director clarified this copy was from CNA #1's employee record and had been signed by CNA #1 on 4-27-16, as a part of her orientation process. This document indicated, "The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion...Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment</p>		<p>half-length side rails for the Resident, but not the two lower rails. When the wife arrived the evening in question, she reported her observations to the R.N. on duty, which immediately went to the Room of Resident #8 and lowered the two bilateral half-length side rails at the foot of the bed. Resident #8 was not injured, nor did he present with any signs/symptoms of emotional distress as a result of the four rails being in place for 1 hour and 47 minutes. Review of video surveillance identified the time in question that all four rails remained in the up position. This R.N. also proceeded to verbally counsel C.N.A. #1 regarding the use of the</p>	

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F 0225 SS=D Bldg. 00	<p>with resulting physical harm, pain or mental anguish...Involuntary seclusion - A separation of a resident from other residents or from her/his room or confinement against the resident's will, or the will of the legal representative..."</p> <p>This Federal tag relates to Complaint IN00209400.</p> <p>3.1-27(a)(4)</p> <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>four side rails. The facility also acted promptly, as C.N.A. #1 was suspended: the date of this incident was the last date that she worked in the facility.</p>	

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	<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> <p>Based on interview and record review, the facility failed to ensure the timely and thorough investigation of an abuse allegation involving the use of all four side rails of a bed to prevent a resident from exiting his bed for one of three residents reviewed for abuse and side rail usage in a sample of four, as well as the lack of reporting of the incident to the Indiana State Department of Health. (Resident #B)</p> <p>Findings include:</p> <p>In a written statement provided by a family member of Resident #B, it was alleged on 8-19-16 [sic], the family member observed "all 4 rails were up," on the bed of Resident #B.</p> <p>During an interview with the Director of</p>	F 0225	<p>PLEASE NOTE THAT THE SURVEYOR ERRONEOUSLY IDENTIFIED SOME OF THE COMMENTARY IN THE SURVEY CITINGS AS THOSE OF THE "EXECUTIVE DIRECTOR". IN THE INTEREST OF ACCURACY, THE COMMENTS THAT WERE ATTRIBUTED TO THE "EXECUTIVE DIRECTOR" WERE, IN FACT, MADE BY THE ADMINISTRATOR.</p> <p>The surveyor's rationale for her decision to cite</p>	10/19/2016

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	<p>Nursing (DON) on 9-20-16 at 11:20 a.m., she relayed she had spoken with the spouse of Resident #B on/around the evening of 8-19-16 regarding the spouse finding all four side rails up on the resident's bed the evening prior. She indicated CNA #1 was suspended on 8-19-16 regarding this issue, pending investigation of the incident. She did not return to work and was terminated on 8-26-16 in regards to an issue with her licensure not being updated in a timely manner.</p> <p>The DON provided a copy of a written "follow-up" of concerns, dated 8-23-16 and signed by the DON. It indicated the spouse of Resident #B was unable to specify the name of the CNA involved in an incident on 8-18-16, but upon review of the work schedule, it was decided the person was CNA #1. It specified the DON interviewed CNA #1 on 8-23-16. The document clarified, "She said that she had, in fact, put all four rails up on [name of Resident #B]'s bed. [Name of CNA #1] said, 'I was just trying to do my best to keep him from falling. I know that he is a fall risk. Everybody says he tries to get up by himself. I just didn't want him to fall'...[Name of CNA #1] was asked why she thought that the use of the four 1/2 length rails was a good idea for [name of Resident #B], as no one</p>		<p>the facility for F 225 is as follows:</p> <p><i>"Based upon interview and record review, the facility failed to ensure the timely and thorough investigation of an abuse allegation involving the use of all four side rails of a bed to prevent a resident from exiting his bed for one of three residents reviewed for abuse and side rail usage in a sample of four, as well as the lack of reporting of the Incident to the Indiana State Department of Health (Resident #8)".</i></p> <p>The evidence clearly proves that the facility did, in fact, conduct a timely and thorough investigation of the use of four side rails on the use</p>	

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	<p>else in the facility utilizes four 1/2 length rails. [Name of CNA #1] repeated, 'I just thought that I was doing the right thing to keep him from falling.'..."</p> <p>In an interview with the Executive Director on 9-21-16 at 2:10 p.m., she indicated, "The situation with the side rails...We did not look at it as a seclusion issue. Just as a side rail issue. No, I did not report it to ISDH."</p> <p>In an interview on 9-21-16 at 4:12 p.m., with the Executive Director, she reported, "The aide, [name of CNA #1], was hired on 4-25-16 and was suspended, effective on 8-19-16, and terminated on 8-26-16. I could not find any other disciplinary issues in her file. She signed our form about involuntary seclusion during her orientation. To the best of my knowledge, we did not do any staff education on side rail use or involuntary seclusion after this...The aide had a CNA license from another state, but hadn't passed the test for Indiana yet and she was right at the 120 day mark. So we couldn't let her work as an aide anymore."</p> <p>The clinical record of Resident #B was reviewed on 9-19-16 at 2:20 p.m. His diagnoses included, but were not limited to, malignant brain tumor, hemiplegia</p>		<p>of four side rails on the bed of Resident #8, as soon as the Director of Nursing was advised of the same. The employee was suspended pending the investigation. The employee's employment was severed with the facility.</p> <p>The facility concedes that the matter was not reported to ISDH. The facility did not perceive that this isolated event constituted a "reportable unusual occurrence" due to the following facts: it was an isolated event; there was no malice of forethought by C.N.A.#1—no willful intent to cause harm or distress to the Resident; the Resident did not object to the use of the</p>	

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	<p>which affected his left side, left axillary embolism (blood clot), diabetes and polyneuropathy. His admission Minimum Data Set assessment, dated 8-11-16, indicated he was moderately cognitively impaired, required extensive assistance with bed mobility and transfers of two or more persons, required extensive assistance of one person with locomotion, did not ambulate, used a wheelchair for mobility and had one fall without injury after admission to the facility. Fall risk assessments on 8-6-16 and 8-21-16 documented he was a fall risk. The admission physician orders, dated 8-4-16, indicated an order for bilateral one-half side rails to promote mobility, typically specified for the upper portion of the bed. The clinical record failed to have any physician orders specific to the use of physical restraints for Resident #B. The clinical record failed to have any type of assessment for the use of physical restraints or authorization for the use of physical restraints from the resident or family.</p> <p>On 9-19-16 at 11:21 a.m., the Executive Director provided a copy of policy entitled, "Resident Rights." This policy was dated 11-10-93, and was identified to be the current policy utilized by the facility. This policy specified, "...Restraints. The resident has the right</p>		<p>side rails; the Resident was not injured nor did he display any changes in behavior, mood, or affect; the lower rails were immediately lowered when the wife advised the R.N. of the situation.</p> <p>Going forward, the facility staff is now keenly aware of the need to report to ISDH any allegations involving a side rail that is utilized without the appropriate documentation in place.</p> <p>Administrative Nursing staff, including the Director of Nursing will be given an additional inservice regarding the requirements for the reporting of unusual occurrences as they may</p>	

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	<p>to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms. Abuse. The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, neglect and involuntary seclusion."</p> <p>On 9-21-16 at 4:30 p.m., the Executive Director provided a copy of a policy entitled, "Restraint Use." This policy was undated, but indicated to be the current policy utilized by the facility. This policy stated, "Purpose: To assure resident safety when restrictive devices are required. Note: Under no circumstances is it ever acceptable for a physical restraint to be utilized for a Resident as a punitive measure OR for staff convenience..."</p> <p>On 9-21-16 at 4:30 p.m., the Executive Director provided a copy of a policy entitled, "Abuse Prohibition/Know Your Role." The Executive Director clarified this copy was from CNA #1's employee record and had been signed by CNA #1 on 4-27-16, as a part of her orientation process. This document indicated, "The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and</p>		<p>need to participate in the investigate process. The Administrator will provide the inservice training.</p> <p>Additionally, the Executive Director will be advised when it is necessary to suspend a Nursing employee due to a care concern. This will be completed by Director of Nursing and/or Administrator. This systemic change will help minimize the facility's failure to report any future incidents that require the same.</p> <p>Subsequent to this citing, the facility as reviewed and revised the following polices: Siderail Use and Restraint Use. Also, an addendum has been attached to the</p>	

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	<p>involuntary seclusion...Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish...Involuntary seclusion - A separation of a resident from other residents or from her/his room or confinement against the resident's will, or the will of the legal representative..."</p> <p>On 9-19-16 at 11:21 a.m., the Executive Director provided a copy of a policy entitled, "Abuse Policy." This policy was updated on 8-30-16 and was indicated to be the current policy utilized by the facility. It indicated, "Purpose: To establish guidelines for assuring the residents are free of all abusive acts and to establish guidelines for investigating, resolving and reporting abuse...Abusive acts covered by this policy include: Corporal punishment, involuntary seclusion...Definitions: Abuse - The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish...Involuntary Seclusion - Means separation of the resident from other residents or from his/her room against the resident's will or the will of the resident's legal representative...Standards: All organization staff will be trained during initial orientation...regarding prevention</p>		<p>Reportable Occurrence Guidelines, subsequent to this event which was included in the in-service education.</p> <p>Going forward, the Quality Assurance Committee will review the facility's Reportable Unusual Occurrences during the monthly Quality Assurance Meetings for no less than six months. At the end of the six month period, the Committee may opt to discontinue the monthly reviews of this topic, if 100% compliance is achieved.</p>	

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	of abuse, neglect, punishment and seclusion and their responsibilities to report suspected abuse as well as conduct their particular service to residents in a manner which assures protection from intentional or unintentional abuse...any staff member who has knowledge of the abuse of a resident, has a reasonable cause to believe that a resident is being or has been abused...must report this to ISDH...immediately...Immediately means as soon as possible, but ought not exceed 24 hours after discovery of the incident...The Director of Health Center Operations and Director of Nursing shall be responsible for initiating proper interventions to assure the resident is protected from any further abusive acts while the incident is being investigated...In the event an investigation of a report of suspected abuse of a resident indicates, based on credible evidence, that an employee is a perpetrator of the abuse, the employee shall be immediately barred from any further contact with the residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action of the employee...All reports of suspected or known abuse shall be reported immediately or within 24 hours via telephone to the Indiana State Department of Health..."			

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F 0226 SS=D Bldg. 00	<p>On 9-21-16 at 4:30 p.m., the Executive Director provided a copy of CNA #1's "Nurse Aide I Registry" from another state. This document specified, as of 5-3-16, CNA had completed the testing on 1-10-15, and her certification would expire on 1-31-17.</p> <p>This Federal tag relates to Complaint IN00209400.</p> <p>3.1-28(a) 3.1-28(c) 3.1-28(d) 3.1-28(e)</p> <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. Based on interview and record review, the facility failed to ensure abuse prohibition polices were implemented regarding an allegation of abuse, specific to failure to report an allegation of abuse, to the Indiana State Department of Health, in which a staff member engaged the use of four side rails of a bed to</p>	F 0226	PLEASE NOTE THAT THE SURVEYOR ERRONEOUSLY IDENTIFIED SOME OF THE COMMENTARY IN THE SURVEY CITINGS AS THOSE OF THE	10/19/2016

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	<p>prevent a resident from exiting his bed for one of three residents reviewed for abuse and side rail usage in a sample of four. (Resident #B)</p> <p>Findings include:</p> <p>In a written statement provided by a family member of Resident #B, it was alleged on 8-19-16 [sic], the family member observed "all 4 rails were up," on the bed of Resident #B.</p> <p>During an interview with the Director of Nursing (DON) on 9-20-16 at 11:20 a.m., she relayed she had spoken with the spouse of Resident #B on/around the evening of 8-19-16 regarding the spouse finding all four side rails up on the resident's bed the evening prior. She indicated CNA #1 was suspended on 8-19-16 regarding this issue, pending investigation of the incident. She did not return to work and was terminated on 8-26-16 in regards to an issue with her licensure not being updated in a timely manner.</p> <p>The DON provided a copy of a written "follow-up" of concerns, dated 8-23-16 and signed by the DON. It indicated the spouse of Resident #B was unable to specify the name of the CNA involved in an incident on 8-18-16, but upon review</p>		<p>"EXECUTIVE DIRECTOR".</p> <p>IN THE INTEREST OF ACCURACY, THE COMMENTS THAT WERE ATTRIBUTED TO THE "EXECUTIVE DIRECTOR" WERE, IN FACT, MADE BY THE ADMINISTRATOR.</p> <p>F 226</p> <p>The use of four side rails on a Resident's bed has never occurred before in this facility. This is, obviously, an isolated event. The Maintenance problem will remove the bilateral lower rails from the beds equipped with the same. Thus, this particular event cannot be repeated in the future. The Maintenance Director is responsible. The Administrator will monitor.</p>	

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	<p>of the work schedule, it was decided the person was CNA #1. It specified the DON interviewed CNA #1 on 8-23-16. The document clarified, "She said that she had, in fact, put all four rails up on [name of Resident #B]'s bed. [Name of CNA #1] said, 'I was just trying to do my best to keep him from falling. I know that he is a fall risk. Everybody says he tries to get up by himself. I just didn't want him to fall'...[Name of CNA #1] was asked why she thought that the use of the four 1/2 length rails was a good idea for [name of Resident #B], as no one else in the facility utilizes four 1/2 length rails. [Name of CNA #1] repeated, 'I just thought that I was doing the right thing to keep him from falling.'..."</p> <p>In an interview with the Executive Director on 9-21-16 at 2:10 p.m., she indicated, "The situation with the side rails...We did not look at it as a seclusion issue. Just as a side rail issue. No, I did not report it to ISDH."</p> <p>In an interview on 9-21-16 at 4:12 p.m., with the Executive Director, she reported, "The aide, [name of CNA #1], was hired on 4-25-16 and was suspended, effective on 8-19-16, and terminated on 8-26-16. I could not find any other disciplinary issues in her file. She signed our form about involuntary seclusion during her</p>		<p>The facility will continue to review the use of side rails as part of the orientation for all newly hired nursing personnel. Additionally, additional inservice education will be made available to nursing personnel regarding the use of side rails. The Quality Assurance Nurse is responsible. The Director of Nursing will monitor.</p> <p>Going forward, side rail use will be reviewed during the facility's monthly Quality Assurance Committee Meetings for no less than six months. At the end of the six month period, the Committee may opt to dispense with the monthly review of this</p>	

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	<p>orientation. To the best of my knowledge, we did not do any staff education on side rail use or involuntary seclusion after this...The aide had a CNA license from another state, but hadn't passed the test for Indiana yet and she was right at the 120 day mark. So we couldn't let her work as an aide anymore."</p> <p>The clinical record of Resident #B was reviewed on 9-19-16 at 2:20 p.m. His diagnoses included, but were not limited to, malignant brain tumor, hemiplegia which affected his left side, left axillary embolism (blood clot), diabetes and polyneuropathy. His admission Minimum Data Set assessment, dated 8-11-16, indicated he was moderately cognitively impaired, required extensive assistance with bed mobility and transfers of two or more persons, required extensive assistance of one person with locomotion, did not ambulate, used a wheelchair for mobility and had one fall without injury after admission to the facility. Fall risk assessments on 8-6-16 and 8-21-16 documented he was a fall risk. The admission physician orders, dated 8-4-16, indicated an order for bilateral one-half side rails to promote mobility, typically specified for the upper portion of the bed. The clinical record failed to have any physician orders</p>		<p>topic if 100 % compliance is achieved.</p> <p>The facility would also like for the record to show that C.N.A. #1 actions, unarguably, was a demonstration of poor judgement. When interviewed by the Director of Nursing post suspension, C.N.A. #1 tearfully explained that she was concerned that Resident #8 would sustain a fall, acknowledging that she was aware that this Resident was a fall risk However, there is absolutely no evidence that C.N.A. #1's errant use of the side rails was a demonstration of any "willful" intent to act in a manner that would be akin to "abuse" or "involuntary seclusion". The Resident resided in a</p>	

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	<p>specific to the use of physical restraints for Resident #B. The clinical record failed to have any type of assessment for the use of physical restraints or authorization for the use of physical restraints from the resident or family.</p> <p>On 9-21-16 at 4:30 p.m., the Executive Director provided a copy of a policy entitled, "Abuse Prohibition/Know Your Role." The Executive Director clarified this copy was from CNA #1's employee record and had been signed by CNA #1 on 4-27-16, as a part of her orientation process. This document indicated, "The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion...Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish...Involuntary seclusion - A separation of a resident from other residents or from her/his room or confinement against the resident's will, or the will of the legal representative..."</p> <p>On 9-19-16 at 11:21 a.m., the Executive Director provided a copy of policy entitled, "Resident Rights." This policy was dated 11-10-93, and was identified to be the current policy utilized by the facility. This policy specified,</p>		<p>private room. It was his normal routine to remain in his room during the evening. Therefore this scenario does not represent "a separation of a resident from other residents or from his/her room". The Resident did not object when C.N.A. #1 utilized the lower two rails: thus, he was not confined against his will. The Resident's wife had authorized the use of the two upper bilateral half-length side rails for the Resident, but not the two lower rails. When the wife arrived the evening in question, she reported her observations to the R.N. on duty, which immediately went to the Room of Resident #8 and lowered the two bilateral half-length side rails at the foot of the bed.</p>	

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	<p>"...Restraints. The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms. Abuse. The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, neglect and involuntary seclusion."</p> <p>On 9-21-16 at 4:30 p.m., the Executive Director provided a copy of a policy entitled, "Restraint Use." This policy was undated, but indicated to be the current policy utilized by the facility. This policy stated, "Purpose: To assure resident safety when restrictive devices are required. Note: Under no circumstances is it ever acceptable for a physical restraint to be utilized for a Resident as a punitive measure OR for staff convenience..."</p> <p>On 9-19-16 at 11:21 a.m., the Executive Director provided a copy of a policy entitled, "Abuse Policy." This policy was updated on 8-30-16 and was indicated to be the current policy utilized by the facility. It indicated, "Purpose: To establish guidelines for assuring the residents are free of all abusive acts and to establish guidelines for investigating, resolving and reporting abuse...Abusive</p>		<p>Resident #8 was not injured, nor did he present with any signs/symptoms of emotional distress as a result of the four rails being in place for 1 hour and 47 minutes. Review of video surveillance identified the time in question that all four rails remained in the up position. This R.N. also proceeded to verbally counsel C.N.A. #1 regarding the use of the four side rails. The facility also acted promptly, as C.N.A. #1 was suspended: the date of this incident was the last date that she worked in the facility.</p> <p>The evidence clearly proves that the facility did, in fact, conduct a timely and thorough</p>	

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	acts covered by this policy include: Corporal punishment, involuntary seclusion...Definitions: Abuse - The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish...Involuntary Seclusion - Means separation of the resident from other residents or from his/her room against the resident's will or the will of the resident's legal representative...Standards: All organization staff will be trained during initial orientation...regarding prevention of abuse, neglect, punishment and seclusion and their responsibilities to report suspected abuse as well as conduct their particular service to residents in a manner which assures protection from intentional or unintentional abuse...any staff member who has knowledge of the abuse of a resident, has a reasonable cause to believe that a resident is being or has been abused...must report this to ISDH...immediately...Immediately means as soon as possible, but ought not exceed 24 hours after discovery of the incident...The Director of Health Center Operations and Director of Nursing shall be responsible for initiating proper interventions to assure the resident is protected from any further abusive acts while the incident is being investigated...In the event an		investigation of the use of four side rails on the use of four side rails on the bed of Resident #8, as soon as the Director of Nursing was advised of the same. The employee was suspended pending the investigation. The employee's employment was severed with the facility. The facility concedes that the matter was not reported to ISDH. The facility did not perceive that this isolated event constituted a "reportable unusual occurrence" due to the following facts: it was an isolated event; there was no malice of forethought by C.N.A.#1—no willful intent to cause harm or distress to the Resident; the Resident did not	

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	<p>investigation of a report of suspected abuse of a resident indicates, based on credible evidence, that an employee is a perpetrator of the abuse, the employee shall be immediately barred from any further contact with the residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action of the employee...All reports of suspected or known abuse shall be reported immediately or within 24 hours via telephone to the Indiana State Department of Health..."</p> <p>This Federal tag relates to Complaint IN00209400.</p> <p>3.1-28(a)</p>		<p>object to the use of the side rails; the Resident was not injured nor did he display any changes in behavior, mood, or affect; the lower rails were immediately lowered when the wife advised the R.N. of the situation.</p> <p>Going forward, the facility staff is now keenly aware of the need to report to ISDH any allegations involving a side rail that is utilized without the appropriate documentation in place.</p> <p>Director of Nursing will be given additional information regarding the requirements for the reporting of unusual occurrences.</p>	

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			<p>Additionally, the Executive Director will be advised when it is necessary to suspend a Nursing employee due to a care concern.</p> <p>Going forward, the Quality Assurance Committee will review the facility's Reportable Unusual Occurrences during the monthly Quality Assurance Meetings for no less than six months. At the end of the six month period, the Committee may opt to discontinue the monthly reviews of this topic, if 100% compliance is achieved.</p> <p>Additional inservice education will be provided to the staff</p>	

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			<p>regarding Abuse Prohibition. The Quality Assurance Nurse is responsible. The Director of Nursing will monitor.\</p> <p>The Executive Director is now being advised of the need to suspend an employee due to a Resident care concern. This systemic change is hoped to minimize the risk of the facility's failure to report any incident in the future that requires the same.</p> <p>Facility policies for Siderail Use and Restraint Use have been reviewed and revised subsequent to this citing. Also, an Addendum has been added to the Reportable Unusual Occurrence Guidelines.</p>	

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NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
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			It has always been the practice of this facility to review Residents' Rights and Abuse Prohibition, along with the use of siderails, during the orientation process for all newly hired nursing employees. This practice shall continue. The Quality Assurance Nurse shall be responsible for the presentation of the aforementioned materials and shall secure the signature of the orientee upon completion of the presentation of the aforementioned topics. The Director of Nursing shall monitor by reviewing the orientation packets of all new nursing employees hired as of the stated completion date for this plan of correction. The Director of Nursing shall present	

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F 0309 SS=E Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to ensure staff responded to call lights activated by residents for various care needs in a timely manner for 2 of 3 residents reviewed for staffing. (Residents #C and #E)</p> <p>Findings include:</p> <p>1. In an interview with a family member</p>	F 0309	<p>the findings of said reviews during the monthly Quality Assurance Meetings for the next six month period. At the end of the six month period, the Committee may opt to discontinue the monthly review of this subject.</p> <p>PLEASE NOTE THAT THE SURVEYOR ERRONEOUSLY IDENTIFIED SOME OF THE COMMENTARY IN THE SURVEY CITINGS AS THOSE OF THE "EXECUTIVE DIRECTOR". IN THE INTEREST OF ACCURACY, THE</p>	10/19/2016

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	<p>of Resident #C on 9-19-16 at 3:10 p.m., the family member shared, "[Resident #C] understood how to use the call light. But he couldn ' t always get to it because I found it laying on the floor several times."</p> <p>Review of Resident #C's clinical record on 9-19-16 at 1:43 p.m., demonstrated his diagnoses included, but were not limited to, diabetes, unspecified heart failure with a pacemaker, malignancy of the prostate and dementia. His most recent Minimum Data Set assessment, dated 8-3-16, indicated he was severely cognitively impaired, required limited assistance of one person with bed mobility, transfers, ambulation and toileting needs, was continent of bowel and bladder and had the ability to understand others and to be understood.</p> <p>2. In an interview with Resident #E on 9-20-16 at 10:44 a.m., she shared, "[I] don ' t feel they have enough staff here. From listening to the girls [staff], it sounds like they have trouble getting aides to stay or to come into work. Takes around 30-45 minutes to answer my call light. This is better than it was a year or so ago. I have had several times where I have wet the bed or had an incontinent stool while waiting on them to answer my call light."</p>		<p>COMMENTS THAT WERE ATTRIBUTED TO THE "EXECUTIVE DIRECTOR" WERE, IN FACT, MADE BY THE ADMINISTRATOR.</p> <p>F 309</p> <p>Due to the anonymity of Residents C and E, the facility can neither interview the two residents in question nor investigate their comments that were allegedly made to the surveyor.</p> <p>Random interviews of alert and oriented Residents were conducted by the Social Service Department subsequent to citing. No concerns identified.</p>	

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	<p>Review of Resident #E's clinical record on 9-21-16 at 11:02 a.m., indicated her diagnoses included, but were not limited to atrial fibrillation, chronic pain and COPD (chronic obstructive pulmonary disease). Her most recent Minimum Data Set assessment, dated 7-14-16, indicated she is cognitively intact, is dependent of two or more persons for bed mobility and transfers, is dependent of one person for toileting needs and is always incontinent of stool, as well as has a urinary catheter with occasional urinary incontinence.</p> <p>On 9-21-16 at 4:30 p.m., the Executive Director provided a copy of a policy entitled, "Call Light." This policy was dated 6-13-14, and was indicated to be the current policy utilized by the facility. This policy indicated, "The goal is for the call lights to be answered within an eight (8) minute guideline timeframe. All residents shall have the nurse call light system available at all times and will be within easy accessibility to the resident at the bedside and in the resident's bathroom..."</p> <p>This Federal tag relates to Complaint IN00209400.</p> <p>3.1-37(a)</p>		<p>Therefore, the facility staff will be provided with additional education regarding call light response time. The Quality Assurance Nurse is responsible and the Director of Nursing will monitor.</p> <p>Additionally, the Quality Assurance Nurse will review call light response times one time weekly and will include all three shifts. The Quality Assurance Nurse will investigate should inappropriate response times be noted. The Director of Nursing will monitor.</p> <p>Additionally, the Quality Assurance Nurse will review call light response times at least once weekly and will</p>	

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			<p>investigate should inappropriate response times be noted. The Director of Nursing and Administrator will monitor.</p> <p>Going forward, the Quality Assurance Nurse will advise the Quality Assurance Committee of the results of the review of call light response times during the monthly Quality Assurance Meetings. This practice shall continue for no less than six months. At the end of the six month period, the Committee may opt to discontinue the review of this topic if 100% compliance is achieved.</p>	

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

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