

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155325	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/05/2016
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NAME OF PROVIDER OR SUPPLIER MEADOW VIEW HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00192729.</p> <p>Complaint IN00192729 - Substantiated. Federal/State deficiencies related to the allegations are cited at F225 and F226.</p> <p>Survey dates: February 4 and 5, 2016</p> <p>Facility number: 000218 Provider number: 155325 AIM number: 100274800</p> <p>Census bed type: SNF/NF: 77 Total: 77</p> <p>Census payor type: Medicare: 9 Medicaid: 58 Other: 10 Total: 77</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 34849 on February 11, 2016.</p>	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0225 SS=D Bldg. 00	<p>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</p>			

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	<p>(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 observation, interview and record review, the facility administration failed to thoroughly investigate abuse allegations, reported by nursing staff, for 2 of 3 residents reviewed for abuse (Resident #B and Resident #D). This deficient practice had the potential to affect 77 of 77 residents residing in the facility.</p> <p>Findings include:</p> <p>1. The clinical record for Resident #B was reviewed on 2/4/16 at 11:00 a.m. Diagnoses included, but were not limited to, dementia with mood disturbance and insomnia. The MDS (Minimum Data Set) assessment, dated 1/27/16, indicated Resident #B was an extensive, one person physical assist with toileting and the Brief Interview of Mental Status (BIMS) score for Resident #B was 07, which indicated a severe cognitive deficit.</p> <p>On 2/4/16 at 11:45 a.m., Resident #B's left posterior (outer) forearm was observed with a healing skin tear, approximately 0.8 cm (centimeters) by 0.6 cm in size. Resident #B's left forearm</p>	F 0225	<p>1. One of the residents identified has been discharged to home. The 2nd resident still resides in the facility. The skin tear has healed and the bruises will continue to be monitored. Both allegations have been thoroughly investigated per policy by the ED. Social service followed up with the resident with no s/s of distress. Staff #6 had appropriate discipline rendered.</p> <p>2. All residents have the potential to be affected. Residents and/or responsible parties will be interviewed by SS and/or designee using QIS questions to inquire about concerns of care and staff to ensure no further actions are needed. Staff will be educated on Abuse/Neglect Policy and Procedures as well as the ISDH guidelines to reportable incidents by the CEC and/or designee by 3.6.16. ED will be in serviced by DO by 3.6.16 regarding investigation of abuse allegations.</p> <p>3. Staff will be educated on Abuse/Neglect Policy & Procedure as well as the ISDH Guidelines to reportable incidents by the CEC and/or designee by 3.6.16. ED will be in serviced by DO by 3.6.16 regarding investigation of abuse allegations. ED will ensure all allegations of abuse, neglect, or</p>	03/06/2016

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	<p>was also observed with purple and brown bruises from the wrist up to 2 inches above the posterior elbow.</p> <p>The Observation Report, dated 1/28/16 at 2:08 a.m., included, but was not limited to, the following: "...Description...Weekly skin assessment...Skin Assessment...Indicate any areas of skin integrity alteration the resident currently has...Check all that apply...Skin tears...Marks...Bruises...Discoloration/Rashes...[box with check mark] None of the above...."</p> <p>The Event Report, dated 1/29/2016 at 2:00 a.m., included, but was not limited to, the following: "Description...Skin Tear...Wound/Area present on admission...No...Site/Location of Wound/Area...Left anterior forearm...Please list the preventative measures that have been put in place...Staff education on keeping fingernails trimmed and filed to an appropriate length...."</p> <p>The physician order, dated 1/29/16 at 4:30 a.m., indicated to cleanse skin tear to left forearm with normal saline (solution used to clean wounds) and apply tegaderm (wound covering) every 3 days until healed.</p>		<p>misappropriation of property will be reported and thoroughly investigated immediately per the abuse policy and procedure, including but not limited to suspension of employee; immediate reporting to ISDH, Notification to family and physician, investigation of the allegation. The DO/Designee will review all investigations of allegations of abuse to ensure the allegation was investigated thoroughly and per policy.</p> <p>4. Abuse prohibition and investigation CQI tool will be used by the ED/Designee weekly X4 weeks, monthly X 6 months and quarterly thereafter. Results of CQI audits will be reviewed by CQI committee monthly and action plans will be developed as needed if 100% threshold is not achieved.</p>	

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	<p>The IDT (Interdisciplinary Team) note, dated 1/29/16 at 10:46 a.m., included, but was not limited to, the following: "IDT met and reviewed for skin tear to left forearm. Resident assisted to bathroom this am [sic] and became combative with care. CNA [Certified Nursing Assistant] states skin tear possibly from his own nail. CNA reported skin tear to nurse and immediately trimmed and filed his own nails. [physician name] and [family name] updated. Order for transparent dressing every three days until healed...."</p> <p>The Observation Report, dated 2/4/16 at 12:38 a.m., included, but was not limited to, the following: "...Description...weekly summary...Skin Assessment...Residents skin is...Check all that apply...[box with check mark] Skin tears (description/site) - arm...."</p> <p>During an interview on 2/4/16 at 10:10 a.m., the Executive Director indicated during the 1/29/16 incident, Staff #6's fingernail caught the resident [Resident #B] during care and Staff #6 cut his/her fingernails right after that. The Executive Director also indicated the incident was not reported because they knew what happened.</p> <p>During a confidential telephone interview</p>			

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	<p>(regarding the 1/29/16 incident) on 2/4/16 at 12:45 p.m., Staff #1 indicated Staff #6 admitted to grabbing Resident #B's arm, causing a skin tear. Staff #1 indicated Staff #6 told Staff #2 to go to Resident #B's room. Resident #6 raised Resident #B's arm where Staff #2 observed a skin tear. Staff #1 indicated the Director of Nursing (DON) came in and talked to Staff #6 and walked him/her out. Staff #1 indicated the DON asked him/her to write a statement. Staff #1 indicated he/she did and that was the last he/she heard of it.</p> <p>During a confidential telephone interview (regarding the 1/29/16 incident) on 2/4/16 at 1:15 p.m., Staff #2 indicated Staff #6 came out of Resident #B's room to get him/her. Staff #2 indicated Resident #B was sitting on the side of the bed with a skin tear to his left forearm. Staff #2 indicated Staff #6 said Resident #B's roommate was loud and woke up Resident #B. Staff # 2 indicated Staff #6 said Resident #B became agitated, started swinging at him/her and he/she grabbed Resident #B causing a skin tear. Staff #2 indicated he/she spoke with Staff #4, who indicated he/she heard what sounded like Staff #6 pushing Resident #B on to the toilet. Staff #2 indicated Staff #6 was sent home on 1/29/16 around 3:30 a.m. Staff #2 indicated Staff #6 was back</p>			

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	<p>working the next night.</p> <p>During a confidential telephone interview (regarding the 1/29/16 incident) on 2/4/16 at 2:15 p.m., Staff #3 indicated he/she was working together with Staff #6. Staff #3 indicated they were providing care to Resident #B's roommate. Staff #3 indicated Resident #B got up out of bed and was tugging on his pants as if he had to go to the bathroom. Staff #3 indicated he/she asked Staff #6 to take Resident #B to the bathroom. Staff #3 indicated Staff #6 raised his/her voice and told Resident #B to sit down. Staff #3 indicated he/she could tell Staff #6 was somewhat agitated. Staff #3 indicated he/she did not see anything, but it sounded like Staff #6 "sat him down on the toilet". Staff #3 indicated the DON sent Staff #6 home around 3:30 a.m.</p> <p>During a confidential interview on 2/4/16 at 3:20 p.m., Staff #4 indicated Staff #6 is young, frustrated and has an anger problem.</p> <p>During a confidential interview (regarding the 1/29/16 incident) on 2/4/16 at 10:29 p.m., Staff #6 indicated he/she took Resident #B the the bathroom and sat him/her on the toilet. Staff #6 indicated he/she stepped out of</p>			

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	<p>the bathroom to retrieve a brief, and upon re-entering the bathroom, Resident #B was attempting to stand up. Staff #6 indicated he/she told Resident #B to wait a second. Staff #6 indicated Resident #B tried to lash out at him/her and tried to hit him/her. Staff #6 indicated he/she gently grabbed Resident #B's arms and placed his/her hands on his/her lap. Staff #6 indicated he/she discovered the skin tear later and it must have been caused by his/her fingernail. Staff #6 indicated the DON took his/her statement and told Staff #6 he/she was suspended the rest of the night. Staff #6 indicated the DON and Executive Director did their investigation and said, "they felt comfortable with what I told them".</p> <p>During a confidential interview (regarding the 1/29/16 incident) on 2/4/16 at 11:06 p.m., Staff #5 indicated Staff #6 was stern and aggressive with care. Staff #5 indicated Staff #6 rolls residents over fast when changing and transfers fast. Staff #5 indicated Staff #6 has a sternness in his/her voice and is aggressive as far as doing care.</p> <p>The following written statements (regarding the 1/29/16 incident) were provided by the DON on 2/5/16 at 12:01 a.m. These statements included, but were not limited to, the following:</p>			

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	<p>"[staff names] was [sic] doing bed check when we entered the room to [resident name] [plus sign] [and] [Resident #B], [sic] As I was tending to [resident name] [sic] [Resident #B] got out of bed - [sic] [Staff #6] took him to rest room where [Resident #B] became combative with [Staff #6] - [sic] [Staff #6] trying [sic] to control [Resident #B] resulted in [Resident #B] getting a skin tear on his left arm - [sic] I did not visually see what was happening but I was close to the bathroom door to note the tone of [Staff #6] voice was agitated [sic] after he noticed the skin tear [sic] he reported to [nurses name] [sic] Then she [plus sign] [and] I done [sic] a skin assessment [plus sign] [and] she tended to [sic] wound on his left arm...."</p> <p>"I was at nurse [sic] station, [Staff #6] came into hall and asked me to come to Res [residents] room. I came into room; Res [resident] noted to be sitting on side of bed with skin tear to (L) [left] anterior forearm. I asked [Staff #6] what had happened, [Staff #6] states that Res [resident] in bed B had been talking very loudly and woke res [resident] in bed A up. Res [Resident] in bed A then became angry and tried to swing and hit [Staff #6], [sic] [Staff #6] said he the grabbed Res [Resident] arm to stop the swing;</p>			

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	<p>[sic] he then noticed skin tear and came to get me. I then asked [staff name], who was also in Res [resident] room what happened. She told me that she was [triangle]ing [changing] [resident name] and emptying bed b's cath [catheter] bag and heard [Staff #6] become loud [plus sign] [and] angry [c with line over it] [with] Res [Resident #B]. Then heard him shove Res [Resident] down onto toilet, then heard Res [Resident] become agitated and [Staff #6] grabbed a hold of him. She doesn't know exactly when the skin tear happened...."</p> <p>"I was standing at the desk on North hall talking to [staff name] and [staff name]. [Staff #6] came to desk and told [staff name] she needed to come down the hallway "now". [staff name] went [c with line over it] [with] [Staff #6]. She came back to the desk and asked me to look at a skin tear. [Resident #B] had a skin tear on his LFA [left forearm]. [staff name] dressed the wound and came back out to the desk to do a skin event. [Staff #6] stated that the resident tried to fight him and he got angry and grabbed the resident's [Resident #B] arms causing the skin tear. [staff name] and I discussed the situation and [staff name] said she would talk to [staff name] who was also in the room. [staff name] stated that she witnessed the abuse. She stated to me</p>			

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	<p>that [Staff #6] pushed the resident down on the toilet forcefully and grabbed the resident's arms. She was writing her statement when I call [sic] and texted [Executive Director's name] and texted [DON's name] DON...."</p> <p>"[staff name] and I were In [sic] [resident name] and [Resident #B] room [sic] [Resident name] would not Be [sic] quite [sic] so we could take care of him [sic] he woke [Resident #B] up [sic] I Took [sic] him To [sic] The [sic] Bathroom [sic] ran to get a Brief [sic] ran Back [sic] in The [sic] Bathroom [sic] he was standing Back [sic] up [sic] Tried To [sic] get him to sit Back [sic] down on The [sic] Toliet [sic] he could not hear me or would not Listen [sic] To [sic] me so I repeated myself again and again [sic] he Lashed [sic] out swinging at me [sic] Tried to grab his arms not To [sic] hit me or The [sic] wall [sic] when he became sitted [sic] he was fine and so was I [sic] he [sic] Let [sic] me get him changed [sic] walked him Back [sic] To [sic] The [sic] The [sic] Bed [sic] set [sic] him down [sic] Put his feet in The [sic] Bed [sic] and was ready to move on To [sic] The [sic] next task and I saw red on The [sic] curtain and knew That [sic] was not right and started to check The [sic] resident [sic] saw [sic] his arm [sic] called for the nurse...."</p>			

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	<p>During an interview on 2/5/16 at 10:30 a.m., the Executive Director indicated no residents were interviewed during the investigation into the allegation of abuse incident from 1/29/16 with Resident #B.</p> <p>2. The clinical record for Resident #D was reviewed on 2/4/16 at 3:00 p.m. Diagnosis included, but was not limited to, hemachromatosis. The MDS (Minimum Data Set) assessment, dated 12/11/15, indicated Resident #D required supervision with ambulation and Resident #D's cognition was intact as evidenced by a BIMS (Brief Interview of Mental Status) score of 15.</p> <p>Resident #D was discharged home from the facility on 1/27/16.</p> <p>During a confidential interview (regarding the incident) on 2/4/16 at 3:20 p.m., Staff #4 indicated Staff #6 was sitting on a linen cart working on the Kiosk [system for tracking resident activities of daily living] and Resident #D walked up from behind and pulled on the linen cart Staff #6 was sitting on. Staff #4 indicated he/she heard Staff #6 say, "I have told you not to mess [c with line over it] [with] me" and then Staff #4 heard what sounded like a smack. Staff #4 indicated Resident #D came to the</p>			

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	<p>nurses station and told her, "He is an ass, he hit me. I was just messing with him, but look at this, he hit me and I have a red mark." Staff #4 indicated Resident #D had red marks, which resembled hand prints, on the left inner arm. Staff #4 indicated no one wrote a statement because the Executive Director indicated Staff #6 was defending him/herself. Staff #4 indicated Staff #6 had written a statement and he/she had some paperwork regarding the incident, but the Executive Director took it. Staff #4 indicated Staff #6 was young, frustrated, and had an anger problem. Staff #4 could not give a specific date of the incident.</p> <p>During an interview with Resident #D's sister, on 2/4/16 at 3:45 p.m., she indicated, while at lunch one day with Resident #D, he/she indicated he/she was "kinda fooling around" with Staff #6 and the staff member "swatted" at him. Resident #D's sister also indicated she waited for someone at the facility to notify her regarding the matter, but nothing was ever said. Resident D's sister could not give a specific date of the incident.</p> <p>During an interview (regarding the incident) on 2/4/16 at 6:20 p.m., Resident #D indicated he/she was fooling around and Staff #6 was sitting on the cart, and</p>			

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	<p>he/she pulled on the cart. Resident #D indicated it was probably an accident and "I shouldn't have been screwing around". Resident #D indicated he/she had red marks on his/her arm, but they went away. Resident #D indicated he/she got upset because it stung. Resident #D could not recall the date of the incident.</p> <p>During a confidential interview (regarding the incident) on 2/4/16 at 10:29 p.m., Staff #6 indicated he/she had been sitting on the linen cart while using the kiosk. He/she indicated Resident #D likes to play around and had moved the barrel Staff #6 was sitting on. Staff #6 indicated, "I was trying to grab onto something and I think I bumped [Resident #D]. He/she told the nurse I hit him/her, but I was told he/she was kidding." Staff #6 indicated the Executive Director and DON both talked to Resident #D and their stories "mirrored" so they figured nothing bad happened. Staff #6 could not give a specific date of the incident</p> <p>During a confidential interview (regarding the incident) on 2/4/16 at 10:48 p.m., Staff #7 indicated Staff #6 was sitting on the linen cart and Resident #D pulled the cart. Staff #7 indicated Resident #D had some pinkness to his/her arm. Staff #7 indicated the</p>			

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	<p>Executive Director was notified, came in, and talked to Resident #D. Staff #7 indicated Staff #6 was sent home around 3:00 a.m., but was able to come back to work the next day. Staff #7 indicated the Executive Director told him/her that a written statement did not need to be provided regarding the incident.</p> <p>During a confidential interview on 2/4/16 at 11:55 p.m., Staff #8 indicated he/she generally does not have to work North hall, but was moved there one night because they had to send Staff #6 home. Staff #8 indicated he/she does not generally work with Staff #6, but has seen Staff #6 get "aggravated" a little bit.</p> <p>During an interview on 2/5/16 at 12:02 a.m., the Executive Director indicated there was not an investigation done because he talked to Resident #D who indicated it was an accident. The Executive Director also indicated family may not have been notified since Resident #D was his own POA (Power of Attorney).</p> <p>The clinical record for Resident #D lacked any documentation regarding the incident. The Administrative staff could not provide any documents to indicate an investigation was completed regarding the incident involving Resident #D.</p>			

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	<p>On 2/5/16 at 12:13 a.m., the DON provided a copy of the document titled, "ABUSE PROHIBITION, REPORTING, AND INVESTIGATION", dated March 2015, and indicated as current. This document included, but was not limited to, the following: "...It is the policy of American Senior Communities to protect residents from abuse...POLICY/PROCEDURE: 1. American Senior Communities will not permit residents to be subjected to abuse by anyone, including employees...6. The Executive Director is designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed. In the absence of the Executive Director, this responsibility will be delegated to the Director of Nursing Services...RESIDENT ABUSE - Staff member...Policy: It is the policy of American Senior Communities to assure appropriate interventions are in place and followed to assure safety of the resident (s) is maintained if abuse is identified or suspected...Procedure: If resident abuse is identified or suspected, the following guidelines will be followed...1. The resident (s) involved in the incident will be protected...2. Any individual who witnesses abuse or has suspicion of, shall</p>			

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	<p>immediately notify charge nurse of unit...3. Any staff member implicated in the alleged abuse will be removed from the facility at once and will remain suspended until an investigation is completed...4. The Executive Director and/or Director of Nursing will be notified of the report and the initiation of the investigation...8. An incident report will be initiated, following the guidelines for "Unusual Occurrence Reporting", along with a narrative description...9. Residents will be questioned (if alert and competent) about the nature of the incident and their statement will be put in writing...10. An investigation will be done to assure other residents have not been affected by the incident or inappropriate behavior, and the results documented...11. The investigation will include:...Facts and observations by involved employees...Facts and observations by witnessing employees...Facts and observations by witnessing non-employees...Facts and observations from others who might have pertinent information...Facts and observations by the supervisor or individual whom the initial report was made...12. Follow up assessments will be completed/documented during every shift until the resident (s) is stable, and the resident (s) safety is maintained...."</p>			

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F 0226 SS=D Bldg. 00	<p>This Federal tag relates to Complaint IN00192729.</p> <p>3.1-28(d)</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 observation, interview and record review, the facility failed to implement written policies and procedures regarding abuse as evidenced by the failure to report two abuse allegations to the Indiana State Department of Health for 2 of 3 residents (Resident #B and Resident #D) reviewed for abuse.</p> <p>Findings include:</p> <p>1. The clinical record for Resident #B</p>	F 0226	<p>1. One of the residents identified has been discharged to home. The 2nd resident still resides in the facility. The skin tear has healed and the bruises will continue to be monitored. Both allegations have been thoroughly investigated per policy by the ED. Social service followed up with the resident with no s/s of distress. Staff #6 had appropriate discipline rendered. Reportables have been sent to ISDH per policy.</p> <p>2. All residents have the potential to be affected. Residents and/or responsible parties will be</p>	03/06/2016	

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	<p>was reviewed on 2/4/16 at 11:00 a.m. Diagnoses included, but were not limited to, dementia with mood disturbance and insomnia. The MDS (Minimum Data Set) assessment, dated 1/27/16, indicated Resident #B was an extensive, one person physical assist with toileting and the Brief Interview of Mental Status (BIMS) score for Resident #B was 7, which indicated a severe cognitive deficit.</p> <p>On 2/4/16 at 11:45 a.m., Resident #B's left posterior (outer) forearm was observed with a healing skin tear, approximately 0.8 cm (centimeters) by 0.6 cm in size. Resident #B's left forearm was also observed with purple and brown bruises from the wrist up to 2 inches above the posterior elbow.</p> <p>The IDT (Interdisciplinary Team) note, dated 1/29/16 at 10:46 a.m., included, but was not limited to, the following: "IDT met and reviewed for skin tear to left forearm. Resident assisted to bathroom this am [sic] and became combative with care. CNA [Certified Nursing Assistant] states skin tear possibly from his own nail. CNA reported skin tear to nurse and immediately trimmed and filed his own nails. [physician name] and [family name] updated. Order for transparent dressing every three days until healed...."</p>		<p>interviewed by SS and/or designee using QIS questions to inquire about concerns of care and staff to ensure no further actions are needed. Staff will be educated on Abuse/Neglect Policy and Procedures as well as the ISDH guidelines to reportable incidents by the CEC and/or designee by 3.6.16. ED will be in serviced by DO by 3.6.16 regarding investigation and reporting of abuse allegations.</p> <p>3. Staff will be educated on Abuse/Neglect Policy & Procedure as well as the ISDH Guidelines to reportable incidents by the CEC and/or designee by 3.6.16. ED will be in serviced by DO by 3.6.16 regarding investigation and reporting of abuse allegations. ED will ensure all allegations of abuse, neglect, or misappropriation of property will be reported and thoroughly investigated immediately per the abuse policy and procedure, including but not limited to suspension of employee; immediate reporting to ISDH, Notification to family and physician, investigation of the allegation. The DO/Designee will review all investigations of allegations of abuse to ensure the allegation was investigated thoroughly and per policy.</p> <p>—4. Abuse prohibition and investigation CQI tool will be used by the ED/Designee weekly X 4 weeks, monthly X 6 months and</p>	

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	<p>During an interview on 2/4/16 at 10:10 a.m., the Executive Director indicated Staff #6's fingernail caught the resident [Resident #B] during care and Staff #6 cut his/her fingernails right after that. The Executive Director also indicated it was not reported to the Indiana State Department of Health because they knew what happened.</p> <p>During a confidential telephone interview (regarding the 1/29/16 incident) on 2/4/16 at 12:45 p.m., Staff #1 indicated Staff #6 admitted to grabbing Resident #B's arm, causing a skin tear. Staff #1 indicated Staff #6 told Staff #2 to go to Resident #B's room. Resident #6 raised Resident #B's arm where Staff #2 observed a skin tear. Staff #1 indicated the Director of Nursing (DON) came in and talked to Staff #6 and walked him/her out. Staff #1 indicated the DON asked him/her to write a statement. Staff #1 indicated he/she did and that was the last he/she heard of it.</p> <p>During a confidential telephone interview (regarding the 1/29/16 incident) on 2/4/16 at 1:15 p.m., Staff #2 indicated Staff #6 came out of Resident #B's room to get him/her. Staff #2 indicated Resident #B was sitting on the side of the bed with a skin tear to his left forearm.</p>		<p>quarterly thereafter. Results of CQI audits will be reviewed by CQI committee monthly and action plans will be developed as needed if 100% threshold is not achieved.</p>	

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	<p>Staff #2 indicated Staff #6 said Resident #B's roommate was loud and woke up Resident #B. Staff #2 indicated Staff #6 said Resident #B became agitated, started swinging at him/her and he/she grabbed Resident #B causing a skin tear. Staff #2 indicated he/she spoke with Staff #4, who indicated he/she heard what sounded like Staff #6 pushing Resident #B on to the toilet. Staff #2 indicated Staff #6 was sent home on 1/29/16 around 3:30 a.m. Staff #2 indicated Staff #6 was back working the next night.</p> <p>During a confidential telephone interview (regarding the 1/29/16 incident) on 2/4/16 at 2:15 p.m., Staff #3 indicated he/she was working together with Staff #6. Staff #3 indicated they were providing care to Resident #B's roommate. Staff #3 indicated Resident #B got up out of bed and was tugging on his pants as if he had to go to the bathroom. Staff #3 indicated he/she asked Staff #6 to take Resident #B to the bathroom. Staff #3 indicated Staff #6 raised his/her voice and told Resident #B to sit down. Staff #3 indicated he/she could tell Staff #6 was somewhat agitated. Staff #3 indicated he/she did not see anything, but it sounded like Staff #6 "sat him down on the toilet". Staff #3 indicated the DON sent Staff #6 home around 3:30 a.m.</p>			

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	<p>During a confidential interview (regarding the 1/29/16 incident) on 2/4/16 at 10:29 p.m., Staff #6 indicated he/she took Resident #B the the bathroom and sat him/her on the toilet. Staff #6 indicated he/she stepped out of the bathroom to retrieve a brief, and, upon re-entering the bathroom, Resident #B was attempting to stand up. Staff #6 indicated he/she told Resident #B to wait a second. Staff #6 indicated Resident #B tried to lash out at him and was trying to hit him. Staff #6 indicated he/she gently grabbed Resident #B's arms and placed his/her hands on his/her lap. Staff #6 indicated he/she discovered the skin tear later and it must have been caused by his/her fingernail. Staff #6 indicated the DON took his/her statement and told Staff #6 he/she was suspended the rest of the night. Staff #6 indicated the DON and Executive Director did their investigation and said "they felt comfortable" with what I told them.</p> <p>The clinical record nor the reportables (incidents reported by the facility) reviewed did not contain any documentation to indicate the Indiana State Department of Health had been notified regarding the incident that occurred on 1/29/16 involving Resident #B.</p>			

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	<p>2. The clinical record for Resident #D was reviewed on 2/4/16 at 3:00 p.m. Diagnosis included hemachromatosis. The MDS (Minimum Data Set) assessment, dated 12/11/15, indicated Resident #D was supervision with ambulation and Resident #D's cognition was intact as evidenced by a BIMS (Brief Interview of Mental Status) score of 15.</p> <p>Resident #D was discharged home from the facility on 1/27/16.</p> <p>During a confidential interview on 2/4/16 at 3:20 p.m., Staff #4 indicated Staff #6 was sitting on a linen cart working on the Kiosk [system for tracking resident activities of daily living] and Resident #D walked up from behind and pulled on the linen cart Staff #6 was sitting on. Staff #4 indicated he/she heard Staff #6 say, "I have told you not to mess [c with line over it] [with] me" and then Staff #4 heard what sounded like a smack. Staff #4 indicated Resident #D came to the nurses station and told her, "He is an ass, he hit me. I was just messing with him, but look at this, he hit me and I have a red mark." Staff #4 indicated Resident #D had red marks, which resembled hand prints, to Resident #D left inner arm. Staff #4 indicated no one wrote a statement because the Executive Director</p>			

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	<p>indicated Staff #6 was defending him/herself. Staff #4 indicated Staff #6 had written a statement and he/she had some paperwork regarding the incident, but the Administrator took it. Staff #4 indicated Staff #6 was young, frustrated, and had an anger problem. Staff #4 could not give a specific date of the incident.</p> <p>During an interview with Resident #D's sister, on 2/4/16 at 3:45 p.m., she indicated while at lunch one day with Resident #D, the resident indicated he/she was "kinda fooling around" with Staff #6 and the staff member "swatted" at him. Resident #D's sister also indicated she waited for someone at the facility to notify her regarding the matter, but nothing was ever said. Resident D's sister could not give a specific date of the incident.</p> <p>During an interview (regarding the incident) on 2/4/16 at 6:20 p.m., Resident #D indicated he was fooling around and Staff #6 was sitting on the cart, and he pulled on the cart. Resident #D indicated it was probably an accident and I shouldn't have been screwing around. Resident #D indicated he had red marks on his arm, but they went away. Resident #D indicated he got upset because it stung. Resident #D could not recall the date of the incident.</p>			

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	<p>During a confidential interview (regarding the incident) on 2/4/16 at 10:29 p.m., Staff #6 indicated he had been sitting on the linen cart while using the kiosk. He/she indicated Resident #D likes to play around and had moved the barrel Staff #6 was sitting on. Staff #6 indicated, "I was trying to grab onto something and I think I bumped him. He told the nurse I hit him, but I was told he was kidding." Staff #6 indicated the Executive Director and DON both talked to Resident #D and their stories mirrored so they figured nothing bad happened. Staff #6 could not give a specific date of the incident</p> <p>During a confidential interview (regarding the incident) on 2/4/16 at 10:48 p.m., Staff #7 indicated Staff #6 was sitting on the linen cart and Resident #D pulled the cart. Staff #7 indicated Resident #D had some pinkness to his arm. Staff #7 indicated the Administrator was notified, came in, and talked to Resident #D. Staff #7 indicated Staff #6 was sent home around 3:00 a.m., but was able to come back to work the next day. Staff #7 indicated the Executive Director told him/her that a written statement did not need to be provided regarding the incident.</p>			

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	<p>During an interview on 2/5/16 at 12:02 a.m., the Executive Director indicated there was not an investigation done because he talked to Resident #D and the resident indicated it was an accident. The Executive Director also indicated family may not have been notified since Resident #D was his own POA (Power of Attorney).</p> <p>The clinical record for Resident #D lacked any documentation regarding the incident.</p> <p>The clinical record nor the reportables (incidents reported by the facility) reviewed did not contain any documentation to indicate the Indiana State Department of Health had been notified regarding the incident that occurred with Resident #D.</p> <p>On 2/5/16 at 12:13 a.m., the DON provided a copy of the document titled, "ABUSE PROHIBITION, REPORTING, AND INVESTIGATION", dated March 2015, and indicated as current. It included, but was not limited to, the following: "...6. The Executive Director is designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed. In the absence of the</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Executive Director, this responsibility will be delegated to the Director of Nursing Services. 7. The Executive Director/designees will report all unusual occurrences, which include allegations of abuse, immediately, to the Long Term Care Division of the Indiana State Department of Health. Upon completion of the investigation, which must occur within 5 working days of the reporting of an occurrence, a report of the investigation must be forwarded to the Long Term Care Division of the Indiana State Department of Health. Copies of the completed investigation must also be sent to the Adult Protective Services, Ombudsman, and Director of Operations. 8. A comprehensive record of the abuse investigation is to be kept by the facility Executive Director and/or Director of Nursing Services...10...Staff members showing any trend toward impatience or frustration...should be evaluated...."</p> <p>The Federal tag related to Complaint IN00192729.</p> <p>3.1-28(a) 3.1-28(c)</p>			

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

PRINTED: 02/24/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155325	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/05/2016
NAME OF PROVIDER OR SUPPLIER MEADOW VIEW HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167		
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