

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 12/05/2012
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NAME OF PROVIDER OR SUPPLIER KEEPSAKE VILLAGE OF COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2564 FOXPOINTE DR COLUMBUS, IN 47201
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R0000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey Dates: December 3, 4, and 5, 2012</p> <p>Facility number: 010680 Provider number: 010680 AIM number: N/A</p> <p>Survey Team: Diana Sidell, RN</p> <p>Census bed type: Residential: 34 Total: 34</p> <p>Census Payor type: Other: 34 Total: 34</p> <p>Residential sample: 7</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p>	R0000	Submission and implementation of this plan of correction shall not constitute an admission by Keepsake Village of Columbus to any allegations or conclusions within the survey report. Rather, this plan of correction is submitted for compliance with State and Federal Rules.	

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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R0052	<p>410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to ensure a resident remained free of abuse in that one incident of staff to resident verbal abuse occurred in the facility. This affected 1 of 2 residents reviewed for abuse in a sample of 7. (Resident #10 and CNA #1)</p> <p>Findings include:</p> <p>Resident #10's record was reviewed on 12/5/12 at 1:35 p.m. The record indicated Resident #10 was admitted with diagnoses that included, but were not limited to, diabetes mellitus, anxiety disorder, and bi-polar disorder with psychosis.</p> <p>A fax report dated 11/29/12, and provided by the Director of Nursing (DoN) on 12/5/12 at 12:50 p.m., indicated "Resident reports that CNA was rude/mean to him. Investigation pending. Brief description of incident: Resident [#10] reported to [C.N.A. #2] that [C.N.A. #1] was rude and verbally abusive to him. He reported</p>	R0052	<p>1.) What corrective action will be accomplished for those residents found to be affected?</p> <p>C.N.A. was suspended pending investigation and subsequently terminated from her position, following the investigation results. Resident #10 was referred for psychological services to rule out any emotional trauma related to incident. All Staff Inservice completed on Abuse Prevention and Reporting on 12-11-12.</p> <p>2.) How did the facility identify other residents having the potential to be affected?</p> <p>Facility conducted interviews with other interviewable residents to identify if they had any problems. Facility will continue interviewing residents on a monthly basis through the QA process about staff treatment of residents (see Attachment A). All-Staff Inservice completed on Abuse Prevention and Reporting on 12-11-12.</p> <p>3.) What measures will be put in place to ensure practice does not</p>	12/30/2012			

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	<p>that he asked her for assistance to help him get out of wet clothes due to an incontinent episode, and was told rudely that he could 'do it himself.' Type of injury/injuries: None. Immediate Action Taken: 1.) Employee [CNA #1] was suspended pending investigation. 2.) [LPN #3] notified Director of Nursing and Executive Director of the incident...Preventive measures taken: 1.) Resident will be seen by psychiatrist [from a mental health facility] to determine if there is any emotional trauma due to the incident. 2.) [LPN #3 and CNA # 2] interviewed and statements taken about the incident. 3.) Resident [#10] interviewed about the incident. 4.) Other residents who are interviewable will be interviewed to assess if there are any other problems or concerns involving this employee. 5.) Employee [CNA #1] will be interviewed as well to get her side of the story. 6.) Investigation to be completed by December 2, 2012 and results and continued preventative measures will be sent to ISDH during 5 day follow-up. 7.) Mandatory Inservice for Abuse Prevention and Reporting was completed on 9/28/12 for all staff. A refresher inservice will be scheduled for December 11, 2012."</p> <p>The investigation included, but was not limited to, "[CNA #1] entered [Resident</p>		<p>recur?</p> <p>Monthly interviews with interviewable residents to QA staff treatment toward residents. Executive Director and Director of Nursing will continue daily rounds to check on all residents. Executive Director and Director of Nursing will continue to inservice on Abuse Prevention and Reporting at least twice yearly and upon new employee orientation. Facility will continue practice of checking references, criminal background histories on all new employees.</p> <p>4.) How will facility monitor corrective actions to ensure that practice will not recur?</p> <p>Executive Director and Director of Nursing will monitor via monthly QA interviews with residents that addresses staff treatment of residents (See Attachment A). Executive Director and Director of Nursing will also do daily rounds checking on all residents. Any negative responses to QA questions will be reported to Executive Director immediately for investigation. Director of Nursing will also QA to ensure all new employees receive inservice upon hire and all existing employees will receive inservice on Abuse Prevention and Reporting at least twice yearly.</p> <p>5.) Systemic changes will be</p>				

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	<p>#10's) room, after being summoned by his call light at 11:30 p.m. Per resident interview, [Resident #10] called for assistant on his call light, as he had had an incontinent episode and needed help getting cleaned up. He said [CNA #1] entered his room and he asked her to help him. She stated to [Resident #10], 'Do it yourself,' and went to his closet to get him some clothes. [Resident #10] got upset and began yelling at [CNA #1] to get out of his room. [CNA #1] then called [CNA #2] to come down to the room on her walkie. Per [Resident #10's] interview, [CNA #2] came in and asked what was going on. He said, 'I told her I needed help and that [CNA #1] was being mean to me.' Per interview with [CNA #2], she stated [CNA #1] was giving [Resident #10] "attitude" and stated, 'Whatever,' when [Resident #10] told [CNA #2] that [CNA #1] was being mean to him. [CNA #1] left the room and [CNA #2] assisted [Resident #10] to get dressed and brought him up to the nurse's station to report the incident to the charge nurse. While [CNA #2] was reporting the incident, [CNA #1] walked in and [Resident #10] apologized to her for yelling at her and said he just wanted to forget the incident. He extended his hand out to [CNA #1] for a handshake; however, [CNA #1] ignored it and walked out of the nursing station and into the laundry room. She then went to</p>		completed by 12/30/12.	

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	<p>clock out, as it was the end of her shift. Per interview with [LPN #3], she stated that [CNA #1] was very rude to [Resident #10] and refused to shake his hand."</p> <p>The last paragraph of the investigation indicated: "It is the opinion of this investigator that the allegation of verbal abuse against [CNA #1] toward [Resident #10] is substantiated. [CNA #1], who was suspended during investigation, will be terminated from her position here at Keepsake Village of Columbus to prevent further occurrence. An all-staff inservice will be held on December 11, 2012 to update all employees on our abuse prevention and reporting procedures. [Resident #10] will be referred to [Mental health facility] for mental health screening to assess if there is any emotional trauma or distress."</p> <p>During an interview on 12/5/12 at 11:00 a.m., the DoN indicated CNA #1 was terminated for verbal abuse.</p> <p>During an interview on 12/5/12 at 2:15 p.m., Resident #10 indicated he felt "bad and angry" and thought [CNA #1] was cruel to him that night.</p> <p>A policy and procedure for "Abuse, Neglect and Exploitation Reporting and Investigation", with a last review date of</p>						

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	5/12/12, was provided by the DoN on 12/5/12 at 2:47 p.m. The policy indicated, but was not limited to, "Policy: This facility is committed to maintaining a safe environment for each resident, visitor, and employee. Instances or allegations of abuse, neglect or exploitation should be treated seriously and must be reported to the Executive Director or the supervisor on duty for investigation and appropriate follow-up...."			

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R0144	<p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the dumpster area remained free of debris for 1 of 3 survey days and 1 of 1 observations.</p> <p>Findings include:</p> <p>During an observation on 12/4/12 at 3:30 p.m., with the Dietary Manager, the dumpster area was observed. The dumpster was enclosed with a high wooden fence. On the ground under the front of the dumpster was a plastic plate and two plastic spoons. On the ground in back of the dumpster were four styrofoam cups and an empty soda bottle. Dried leaves were scattered around and under the dumpster intermingled with the plastic and styrofoam items. The Dietary Manager indicated the dumpster is emptied on Mondays and Thursdays each week.</p> <p>During an interview on 12/5/12 at 3:05 p.m., the Executive Director and the Dietary Manager indicated the Maintenance Director maintains the dumpster area and said the persons</p>	R0144	<p>1. What corrective action will be accomplished for these residents found to have been affected? Dumpster area was cleaned. 2. How will facility identify others residents affected? Facility will identify other residents affected by checking dumpster area daily and ensure it is free from debris on a daily basis. 3. What measures will be put into place to ensure practice does not reoccur? A daily log will be initiated by maintenance director to ensure daily checks and clean up of any debris around dumpster area. Maintenance director will address any issues with dumpster area via QA process/meeting on monthly basis. 4. How will corrective actions be monitored to ensure practice will not reoccur? Corrective action will be monitored by maintenance Director daily via log. (see attachment B) and through monthly QA meeting. 5. Systemic change will be completed by 12/30/12.</p>	12/30/2012

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	<p>contracted to empty the dumpster don't pick up anything that falls out while it is being emptied.</p> <p>A policy and procedure for "Maintaining Refuse Areas and Enclosures", with a last review date of 5/12/12, was provided by the Director of Nursing (DoN) on 12/5/12 at 2:47 p.m. The policy included, but was not limited to, "A storage area and enclosure for refuse, recyclables, or returnables, shall be maintained free of unnecessary items...and clean...."</p>			

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R0271	<p>410 IAC 16.2-5-5.1(d) Food and Nutritional Services - Deficiency (d) All modified diets shall be prescribed by the attending physician.</p> <p>Based on record review and interview, the facility failed to ensure 1 resident had a current diet order. This affected 1 of 7 residents reviewed for physician's orders in a sample of 7. (Resident #26)</p> <p>Findings include:</p> <p>Resident #26's record was reviewed on 12/3/12 at 1:20 p.m. The record indicated Resident #26 was admitted with diagnoses that included, but not limited to, dementia, high blood pressure, anxiety, edema, arthritis, and constipation.</p> <p>Physician's recapitulation orders, dated 11/1/12 through 11/30/12, failed to indicate a diet order.</p> <p>Physician's recapitulation orders, dated 12/1/12 through 12/31/12, failed to indicate a diet order.</p> <p>During an interview on 12/5/12 at 3:05 p.m., the Director of Nursing (DoN) provided a dietary card that indicated this resident was receiving a mechanical soft diet. She further indicated the dietary department had their own book with the residents' diets in it, and this was the diet</p>	R0271	<p>1.) What corrective actions will be accomplished for the residents found to be affected? Resident #26 record was updated to reflect diet order change per attending physician. M.D. will sign updated re-write to reflect the change.2.) How will facility identify other residents having the potential to be affected?All other residents' charts will be audited to ensure diet orders are updated via monthly re-writes and pharmacy was notified of the problem and that diet order was omitted. 3.) What measures will be put in place to ensure practice does not recur?Re-writes will be checked and double checked for accuracy by Director of Nursing and Assistant Director of Nursing to ensure all residents have correct and updated diet orders every month. This will be done monthly.4.) What corrective actions will be monitored to ensure the practic will not recur? Diet orders will be reviewed by Director of Nursing and Assistant Director of Nursing every month and will be addressed in the monthly QA meeting for any problems with the process.5.) Systemic changes will be completed by 12/30/12.</p>	12/30/2012

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	<p>the physician had ordered on 9/7/12. She indicated the pharmacy didn't carry it over with the monthly rewrites, and that it would have been written on a physician's telephone order.</p> <p>A "Dietary Services Policy," with a last review date of 5/12/12, was provided by the DoN on 12/5/12 at 2:58 p.m. The policy indicated, but was not limited to, "Purpose: To define the facility's responsibilities for the provision of resident meal service and adequate nutrition...6. Each resident shall have a diet order written by the attending physician upon admission and updated as the resident's condition may require, and no less than annually...."</p>			