STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	12999 N PENNSYLVANIA ST CARMEL, IN 46032

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00184693. Complaint IN00184693 - Substantiated. State deficiencies related to the allegations are cited at R0052 and R0090. Facility Number: 001159 Provider Number: 155618 AIM Number: 200145500 Residential Census: 85 Sample: 4 Supplemental Sample: 12 These State findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed by 21662 on November 30, 2015.	R 0000	The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or is planning to take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	
R 0052 Bldg. 00	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;			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	(5) neglect; and (6) involuntary seclusion. Based on record review and interview the facility failed to ensure residents were free from verbal/mental abuse for 3 of 4 sampled resident's (Residents "B", "C" and "E") and 12 of 12 supplemental sampled resident's. (Residents "F", "G", "H", "I", "J", "K", "L", "M", "N", "O", "P" and "Q") in regard to the mental and verbal abuse displayed by Licensed Nurse #12 and additional nursing staff members. This deficient practice had the potential to effect 81 of 81 resident's. Findings include: 1. The record for Resident "C" was reviewed on 11-18-15 at 11:00 a.m. Diagnoses included, but were not limited to, hypertension, glaucoma, macular degeneration and anxiety. These diagnoses remained current at the time of the record review During an interview on 11-20-15 at 9:45 a.m., indicated, "She made me bawl. I hate to say anything but I don't even want to see her come through the door. When she talks to me she makes me feel like a child and she talks down to me. I heard some other people who live here complained about her, but she made me feel like I was a problem."	R 0052	**R052** It is the practice of this facility to comply with R052, Residents Rights **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Licensed Nurse # 12 no longer works for the center. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken?** Residents who reside in this facility have the potential to be affected by this alleged finding. **What measures will be put into place of what systemic changes will be made to ensure that the deficient practice does not recur?** Staff will be re-educated on the guidelines stated in the Patient Protection Practice Guide which covers how to identify and prevent risk of abuse, neglect and	12/20/2015

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	2. The record for Resident "B" was reviewed on 11-18-15 at 12:00 p.m. Diagnoses included, but were not limited to, dementia, myocardial infarction, diabetes mellitus, hypertension and arterial sclerotic heart disease. These diagnoses remained current at the time of the record review. During an interview on 11-29-15 at 2:50 p.m., a concerned family member indicated "[name of Licensed Nurse #12]is very condescending and rude. She would talk to [family member] like she was a child as if she were an object and not a person. I didn't know I was suppose to sign a log book if I took [family member] out of the building. When I returned with [family member] and I was coming out of the elevator she [Licensed nurse #12] jumped on me and said 'you and I need to talk, you can't just take [family member] out of here.' She would try to manipulate the situation and she would lose sight that she was dealing with a person." 3. During an interview on 11-19-15 at 1:00 p.m., Resident "G" indicated, "There is a nurse here that works day shift. She's rude and unprofessional. She will talk down to me like I'm a child. She is very disrespectful. If I need something, like		misappropriation. Staff who fails to comply with expectations from the Patient Protection Practice Guide will be educated and or progressively disciplined as indicated. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?** Resident Services/designee will complete weekly audits for three months to ensure staff is following the guidelines set forth in the Patient Protection Practice Guide. The audits will include but not limited to staff interviews, review of any allegations of abuse and screening of potential hires. Results of the monitoring will be reviewed for patterns/trends monthly by Executive Director/designee. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Executive Director/designee until compliance is achieved. Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.	

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	right now I need an Aleve [a medication for pain], and some throat lozengers, but I'll wait until the evening shift nurse comes on duty rather than deal with her and listen to her lecture me. It's been like that since I've been here. The best thing for me is to avoid her." A review of the facility concern documentation, dated 10-14-15 indicated Resident "G"called office to report to me that she received her dinner late on 10-13-15 and stated that an aide brought her food and was very rude about having to bring her meal. The documentation further indicated the resident told the aide she didn't want the food but did want the ice cream. "Resident stated aide got very upset and asked the resident for a trash can and when the resident told the aide where it was the aide slammed the food in the trash and walked out." 4. During an interview on 11-19-15 at 1:30 p.m., Resident "F" indicated "I had a problem with 2 CNA's [certified nurses aides]. I know my condition and what works best for me, like transfers and after I use the bathroom. They kept insisting I do things their way over and over again. Even though the head nurse talked to me about it, those two kept taking care of me. They would tell me how educated they were in their job. It was always an			

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	issue." 5. During an interview on 11-20-15 at 10:30 a.m., Resident "I" indicated, "I had problems with her [in regard to Licensed Nurse #12] when I first came here. I had to stand my ground with her and she hasn't bothered with me since that time." 6. During an interview on 11-20-15 at 11:30 a.m., Resident "H" indicated, "We [in regard to the resident and spouse] had trouble with her [Licensed Nurse #12] when we first got here - if we had to get along with her we had to change our ways. That's what we had to do, and since then we haven't had problems with her, but we had to do things her way. One morning I decided to stay in bed and the next thing that happened she come into my room and started poking me and telling me I had to get up. I did what she said." 7. During an interview on 11-19-15 at 12:05 p.m., Licensed Nurse #10 indicated the following in regard to Licensed nurse #12. "I've had complaints from [Resident "I"]. She told me [name of Licensed nurse #12] was mean and rude and that [name of Licensed nurse #12] would say things to her like 'you have to do this or you have to do that.' [Name of Resident "E"]			

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	told me that [name of Licensed Nurse #12] was rude, aggressive and intimidating. [Name of Licensed nurse #12] had [name of Resident "J"] in tears. She told [name of resident] that the resident's daughter was incompetent and not reliable to order medications. [Name of Resident "G"] told me that [name of Licensed nurse #12] said I didn't have the right to refuse anything. When I approached [name of Licensed nurse #12] about what the resident said and her concerns that she didn't have the right to refuse anything, [name of Licensed nurse #12] told me that is just the way she is. I know I've given up talking to management about her." During an interview on 11-19-15 at 11:00 a.m., the Health Wellness Director indicated she had multiple complaints about [name of Licensed nurse #12] and that she had tried to work with her. "Some staff members gave me a list of residents who complained about her. I interviewed them. [Name of Resident "E"] is 'through' with her and angry with her. With [name of Licensed nurse #12] if she knows a resident has to take their medication and they don't want to she will tell them they have to take it." The Health Wellness Director further indicated "there's actually a "Warning Report" on the Human Resources desk			

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	right now." A review of the warning report on 11-19-15 at 11:45 a.m., indicated the following and was dated 10-28-15. "Previous warnings - 2 written - Several residents as well as staff have expressed concern about [name of Licensed nurse #12]. Residents feel she is quick to reprimand them and she doesn't help when they ask and is slow to get what they need. Some feel she is condescending to them and to their families. Some staff member have expressed concerns that [name of Licensed nurse #1] is rude to resident's and themselves." During an interview on 11-19-15 at 2:30 p.m., the Human Resources Director verified the Health Wellness Director "did write up the warning but it hadn't been given and she [in regard to Licensed nurse #12] was not suspended." A review of the employee file for Licensed nurse #12 contained two additional "employee warning notices." A warning notice, dated 02-26-15 indicated the the following: "On 02-23-15 I met with a resident to discuss some concerns presented. This resident states feeling 'picked on by [name of Licensed nurse #12], she goes through			

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	my mail and says I'm not going to get better, she's always picking me apart' and is apprehensive when this nurse come through the door." A subsequent notice, dated 10-08-15 indicated, "It was reported that [name of Licensed nurse #12] was rude to the Nurse Practitioner. She [in reference to the Nurse Practitioner] asked her to do vital signs and was told [by Licensed nurse #12] 'that's your job.' She [in reference to Licensed nurse #12] also stated the Nurse Practitioner was only interested in acute residents and not taking care of the residents who resided in Assisted Living. Multi other staff c/o [complaining of] similar nature that [name of Licensed nurse #12] was rude.'" During an interview on 11-20-15 at 10:00 a.m., Licensed nurse #13, indicated she provided a list of resident's to the Health Wellness Director, who had specific complaints about [name of Licensed nurse #12], and 'I even gave specifics about what had happened. I also wrote about what had happened in the 24 hour book, knowing anything written in there would be discussed in the morning meeting. There was one resident who had a headache, and she asked [name of Licensed nurse #12] for pain medication. This resident rarely asks for anything, but			

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	[name of Licensed nurse #12] told her that having a headache is not an indication for pain because having a headache is not considered pain. [Name of Resident "E"] witnessed [name of Licensed nurse #12] yelling at [name of Resident "K"]. She told me and I told the Health Wellness Director. Nothing seems to get done. I spoke to [name of Resident "C"] because she was upset and said [name of Licensed nurse #12] made her cry. When I talked with [name of Licensed nurse #12] about it all she said was that [name of Resident "C"] cries all the time. I've worked here a long time and I've known [name of Resident "C"] and she does cry but this situation was very different. After that happened and I reported it, and then nothing happened I gave up saying anything anymore. They just allow it to continue." During the Exit Conference on 11-20-15 at 12:15 p.m., the Executive Director provided the name of residents, as identified by Licensed Nurse #13, who had concerns related to the treatment they received from Licensed Nurse #12. The residents identified included Residents "C", "Q", "K", "L", "M", "J", "G", "E", "H", "N", "I", "O" and "P." When interviewed during the Exit Conference, if Licensed nurse #12 had			

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	been suspended when the notice dated 02-26-15 had been given and investigated, the Executive Director indicated he couldn't determine where the employee had been suspended. The Executive Director indicated that although there was a written notice dated 10-28-15, the notice was not given to the Licensed nurse. The Health Wellness Director indicated she started the investigation, but the Licensed nurse was allowed to continue to work with these residents. A review of the facility policy on 11-18-15 at 9:00 a.m., from the HCR Healthcare LLC, practice guideline, and dated 11-2011, indicated the following: "Summary - The patient Protection Practice Guide ("Guide") is an approach that uses the seven (7) key components of an abuse prevention program outlined in the federal regulations to identify and prevent risk of abuse, neglect and misappropriation. The "Guide" outlines the process for the reporting of a reasonable suspicion of a crime and a step-by-step process for system implementation and management." "Purpose - The purpose of the "Guide" is to outline the abuse prevention system			

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	using the seven (7) key components of: Screen, Train, Prevent, Identify, Investigate, Protect, Report/Respond." "The most critical step toward detecting and preventing abuse is acknowledging that no one should be subjected to violent, abusive, humiliating or neglectful behavior." "Centers must adopt and operationalize an abuse prevention system that includes...protection of patients, abuse, neglect, mistreatment...reporting and responding to the appropriate individuals or agencies." "Definitions - Abuse - means the willful infliction of ... intimidations ... or mental anguish." Mental abuse - includes, but is not limited to ... humiliation... ." "Procedures for Reporting - ... The administrator designates a staff member as an abuse preventing coordinator to manage and evaluate the abuse prevention process... . The administrator is responsible for the investigating, reporting and coordinating of the investigation process of any alleged or suspected abuse regardless of the source of the concern... . The abuse prevention coordinator should provide feedback to patients, family members and staff			

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	regarding any concerns or grievances that have been expressed." "Intervention, Analysis and Correction - ... Any allegation requires an investigation... , the facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. ... Once reported, the center conducts a timely, thorough and objective investigation of any allegations of abuse. ... Abuse against patients can be initiated by various people within the center. The center supports and protects patients, family members and staff from harm during an investigation of alleged abuse... . Patient protection actions include immediately removing the patient from contact with alleged abuser during the investigation. If the incident involves a center employee, the employee is suspended pending completion of the investigation." "Reporting - The center must follow the timeframes established in the regulation: that is, the center must ensure that any alleged violations are reported immediately to the administrator of the center and to other officials in accordance with state law through established procedures (including to the state survey and certification agency)."			

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	"Analysis and Response - The center evaluates processes and measures compliance against established indicators derived from policies and procedures and industry standards. ...audit tools, including the Abuse Prohibition Center Task Tool, identify the following as sources of information: ...patient interview, family interview, staff interview, occurrence review, clinical record review and Human resource review." This State findings relates to Complaint IN00184693.			
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents.			

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	If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on record review and interview the facility failed to report allegations of suspected abuse to the state agency when resident and staff reported situations where residents were exposed to the abusive actions of Licensed nurse #12. This deficient practice included 2 of 4 sampled 11 of 12 supplemental sampled residents. (Residents "C", "Q", "K", "L", "M", "J", "G", "E", "H", "N", "I", "O" and	R 0090	**R090** It is the practice of this facility to comply with R090, Administration and Management **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	12/20/2015

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	"P.") Findings include: During the Exit Conference on 11-20-15 at 12:15 p.m., the Executive Director provided the names of residents, as identified by Licensed Nurse #13, who had concerns related to the treatment they received from Licensed Nurse #12. The residents identified included Residents "C", "Q", "K", "L", "M", "J", "G", "E", "H", "N", "I", "O" and "P." During an interview on 11-19-15 at 11:00 a.m., the Health Wellness Director indicated she had multiple complaints about [name of Licensed nurse #12] and that she had tried to work with her. "Some staff members gave me a list of residents who complained about her. I interviewed them. [Name of Resident "E"] is 'through' with her and angry with her. With [name of Licensed nurse #12] if she knows a resident has to take their medication and they don't want to she will tell them they have to take it." The Health Wellness Director further indicated "there's actually a warning report on the Human Resources desk right now." A review of the warning report on 11-19-15 at 11:45 a.m.,originally dated		The allegation of suspected abuse regarding licensed nurse # 12 has been reported to ISDH. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken?** Residents who reside in this facility have the potential to be affected by this alleged finding. **What measures will be put into place of what systemic changes will be made to ensure that the deficient practice does not recur?** Staff will be re-educated on the guidelines stated in the Patient Protection Practice Guide which covers how to identify and prevent risk of abuse, neglect and misappropriation. The guide also covers reporting of suspected abuse. Staff who fails to comply with expectations from the Patient Protection Practice Guide will be educated and or progressively disciplined as indicated. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what**	

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	155618	A. BUILDING 00 B. WING	11/20/2015

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	10-28-15, indicated the following: "Previous warnings - 2 written - Several residents as well as staff have expressed concerns about [name of Licensed nurse #12]. Residents feel she is quick to reprimand them and she doesn't help when they ask and is slow to get what they need. Some feel she is condescending to them and to their families. Some staff member have expressed concerns that [name of Licensed nurse #1] is rude to resident's and themselves." During an interview on 11-20-15 at 9:45 a.m. Resident "C" indicated, "She made me bawl. I hate to say anything but I don't even want to see her come through the door. When she talks to me she makes me feel like a child and she talks down to me. I heard some other people who live here complained about her, but she made me feel like I was a problem." During an interview on 11-19-15 at 1:00 p.m., Resident "G" indicated, "There is a nurse here that works day shift. She's rude and unprofessional. She will talk down to me like I'm a child. She is very disrespectful. If I need something, like right now I need an Aleve [a medication for pain], and some throat lozengers, I'll wait until the evening shift nurse comes		**quality assurance program will be put in place?** Resident Services/designee will complete weekly audits for three months to ensure staff is following the guidelines set forth in the Patient Protection Practice Guide. The audits will include but not limited to staff interviews, review of any allegations of abuse and screening of potential hires. Results of the monitoring will be reviewed for patterns/trends monthly by Executive Director/designee. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Executive Director/designee until compliance is achieved. Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.	

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	on duty rather than deal with her and listen to her lecture me. It's been like that since I've been here. The best thing for me is to avoid her." A review of the facility concern documentation, dated 10-14-15 indicated Resident "G"called office to report to me that she received her dinner late on 10-13-15 and stated that an aide brought her food and was very rude about having to bring her meal. The documentation further indicated the resident told the aide she didn't want the food but did want the ice cream. "Resident stated aide got very upset and asked the resident for a trash can and when the resident told the aide where it was the aide slammed the food in the trash and walked out." During an interview on 11-20-15 at 10:30 a.m., Resident "I" indicated, "I had problems with her [in regard to Licensed Nurse #12 when I first come here. I had to stand my ground with her and she hasn't bothered with me since that time." During an interview on 11-20-15 at 11:30 a.m., Resident "H" indicated, "We [in regard to the resident and spouse] had trouble with her [Licensed Nurse #12] when we first got here - if we had to get along with her we had to change our ways. That's what we had to do, and			

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	since then we haven't had problems with her, but we had to do things her way. One morning I decided to stay in bed and the next thing that happened she come into my room and started poking me and telling me I had to get up. I did what she said." During an interview on 11-19-15 at 12:05 p.m., Licensed Nurse #10 indicated the following in regard to Licensed nurse #12. "I've had complaints from [Resident "I"]. She told me [name of Licensed nurse #12] was mean and rude and that [name of Licensed nurse #12] would say things to her like 'you have to do this or you have to do that.' [Name of Resident "E"] told me that [name of Licensed Nurse #12] was rude, aggressive and intimidating. [Name of Licensed nurse #12] had [name of Resident "J"] in tears. She told [name of resident] that the resident's daughter was incompetent and not reliable to order medications. [Name of Resident "G"] told me that [name of Licensed nurse #12] said I didn't have the right to refuse anything." During an interview on 11-19-15 during the daily exit conference at 3:15 p.m., the Administrator and Exit Director indicated the State Survey Agency had not been notified of the allegations of abuse by			

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	Licensed nurse #12. A review of the facility policy on 11-18-15 at 9:00 a.m., from the HCR Healthcare LLC, practice guideline, and dated 11-2011, indicated the following: "Summary - The patient Protection Practice Guide ("Guide") is an approach that uses the seven (7) key components of an abuse prevention program outlined in the federal regulations to identify and prevent risk of abuse, neglect and misappropriation. The "Guide" outlines the process for the reporting of a reasonable suspicion of a crime and a step-by-step process for system implementation and management." "Purpose - The purpose of the "Guide" is to outline the abuse prevention system using the seven (7) key components of: Screen, Train, Prevent, Identify, Investigate, Protect, Report/Respond." "The most critical step toward detecting and preventing abuse is acknowledging that no one should be subjected to violent, abusive, humiliating or neglectful behavior." "Centers must adopt and operationalize an abuse prevention system that includes...protection of patients, abuse,			

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	neglect, mistreatment...reporting and responding to the appropriate individuals or agencies." "Procedures for Reporting - ... The administrator designates a staff member as an abuse preventing coordinator to manage and evaluate the abuse prevention process... . The administrator is responsible for the investigating, reporting and coordinating of the investigation process of any alleged or suspected abuse regardless of the source of the concern... . The abuse prevention coordinator should provide feedback to patients, family members and staff regarding any concerns or grievances that have been expressed." "Reporting - The center must follow the timeframes established in the regulation: that is, the center must ensure that any alleged violations are reported immediately to the administrator of the center and to other officials in accordance with state law through established procedures (including to the state survey and certification agency)." This State findings relates to Complaint IN00184693.			