STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00199249. Complaint IN00199249 - Substantiated. Federal/State deficiencies related to the allegation are cited at F157 and F514. Unrelated deficiencies are cited. Survey date: May 19 and 20, 2016 Facility number: 000563 Provider number: 155766 AIM number: 100267610 Census bed type: SNF/NF: 46 Total: 46 Census payor type: Medicare: 1 Medicaid: 32 Other: 13 Total: 46 Sample: 3 This deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

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

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	Quality review completed by 34233 on May 25, 2016.			
F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on on interview and record review, the facility failed to notify the physician	F 0157	All MARs from 6/1/2016 are being reviewed for any unavailable/not given medications with	07/07/2016

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	and family of a medication that was withheld due to unavailability for 1 of 3 residents reviewed for medication administration. (Resident #D) Findings include: The clinical record for Resident #D was reviewed on 5/20/16 at 9 :40 a.m. Diagnosis included, but was not limited to, osteoporosis with history of fracture. The physician progress note, dated 8/21/15 and untimed, indicated to add Prolia for osteoporosis. The physician order, dated 8/21/15 and untimed, included, but was not limited to, the following: "...add Prolia [medication used for osteoporosis] 60 mg [milligrams] sc [subcutaneous] Q [every] 6 mo [months] - dx [diagnosis] - OP [osteoporosis] [c with line over it] [with] - recent L [left] femur fx [fracture] - long term steroid use...." The February 2016 MAR (Medication Administration Record) included the following: "Prolia Sol [solution] 60 mg/ml [milliliters]...08/21/15...Inject 60 mg...every 6 months (Due: 02/26/16) for Osteoporosis...." The MAR was not initialed by staff as given.		appropriate actions being taken for any noted issues An administrative staff member will review MAR's for any unavailable/not given meds Staff in-service on 6/7/2016 notifying MD/NP and documenting notification when a medication is unavailable If non-covered form is received this has to be forwarded to Administrative nurse to be addressed The attached QA sheet will be used as the monitoring tool It will be completed 3x's weekly x 4 weeks then 2x's weekly x 4 weeks, then weekly x 4 weeks then biweekly x 3 months. Based on results from QA it will be determined at that time, by the QA committee, if QA should continue, can be decreased further or stopped.	

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	The nurses note, dated 2/29/16 and untimed, included, but was not limited to, the following: "...Prolia due on 2-26 not covered by insurance. Non coverage form available...DON [Director of Nursing's name] made aware...." The clinical record lacked documentation of physician and family notification related to the Prolia not being administered. During an interview on 5/19/16 at 10:40 a.m., LPN (Licensed Practical Nurse) #1 indicated there were no notes indicating whether the Prolia was or was not given. During an interview on 5/20/16 at 2:10 p.m., Resident #D's POA (Power of Attorney) indicated she was never told the Prolia was discontinued. The POA also indicated the nurse practitioner was not aware of any issues related to getting the Prolia until she told her. The policy and procedure for "Notification of Change" was provided by the Administrator on 5/20/16 at 4:02 p.m. It included, but was not limited to, the following: "...It is the intent of this facility to attempt to obtain all medications as ordered. If a medication is not available for whatever reason ie: insurance non-coverage...the facility will			

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	advise physician or nurse practitioner and family of the delay in medication...Documentation will occur with each notification...." This Federal tag relates to Complaint IN00199249 3.1-5(a)(3)			
F 0225 SS=D Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further			

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	potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to report an allegation of abuse to the Indiana State Department of Health and other agencies for 1 of 3 residents reviewed for abuse. (Resident #B) Findings include: The clinical record for Resident #B was reviewed on 5/19/16 at 11:00 a.m. Diagnoses included, but were not limited to, depression and osteoarthritis. The quarterly MDS (Minimum Data Set) assessment, dated 4/23/16, indicated Resident #B's cognition was intact. The nurses note, dated 4/29/16 at 9 a.m., included, but was not limited to, the following: "was [sic] told by resident that a CNA [Certified Nursing Assistant] was mistreating her. was [sic] overly rough and hurt her...States "I do not want her back in my room." reported [sic] to	F 0225	All allegations even those that the residents deny voicing will be reported with in 24 hours. This will be monitored by DON or DON designee and this process will be an on going process. It will not have an end date.	06/06/2016

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	[Director of Nurse's name] and [Social Services Directors name]...." The nurses note, dated 4/29/16 and untimed, included the following: "LPN [Licensed Practical Nurse] came to me that this res [resident] had stated that someone was rough with her. I went into resident's room to find out the specifics of the situation. I asked her "do you feel like you was [sic] abused or hurt intentionally" and she replied, "no, I would go before a court of law [the number 3 backward with a horizontal line through it] [and] say no" [sic] I asked her for a description of the person she felt like might have been rough with her [the number 3 backward with a horizontal line through it] [and] she said [sic] "I can't remember" [sic] She did say [sic] "she isn't black" [sic] This resident did say, "I'm just hard to handle/transfer" [sic] [the number 3 backward with a horizontal line through it] [and] I'm transferred a lot because of the "pee" pill I take. I did express the importance of if you ever feel abused or mistreated in any way to please let nurse or myself known [sic]...Daughter expressed [0 with a line through it] [no] concerns with [residents first name] comment of one statement saying [sic] "someone was a little rough with me" [sic] especially since her story changed when I went in...."			

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The nurses note, dated 4/29 16 at 5 p.m., included, but was not limited to, the following: "Cont [continues] to c/o [complain of] about being mistreated by the CNA..."Black with kinky hair."...."

The nurses note, dated 4/30/16 at 4 a.m., included, but was not limited to, the following: "...Res [resident] has voiced [0 with a line through it] [no] c/s [complaints] to this nurse about CNA abusig [sic] her, but this nurse worked on another unit...."

The nurses note, dated 4/30/16 at 9 a.m., included the following: "Cont [continues] to voice concerns about the "CNA that was rough". [sic] "I don't think she likes me", [sic] "She does not talk to me". "She hurts me and I tell her but she acts like she doesn't care". "When there are 2 in the room they have their own conversation and don't include me [sic] they [sic] act like I'm not there." States was "told by the other nurse," [sic] [Director of Nursing's name] "that she will not be allowed back in my room." [sic] "I'm glad but I'm worried she will do this to some one else...."

The nurses note, dated 4/30/16 at 12 p.m., included the following: "[Director of Nursing's name] here and interviewed

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	resident. Social Services also here. Was told by DON [Director of Nursing] that family was notified...." The nurses note, dated 5/1/16 at 2:45 p.m., included, but was not limited to, the following: "...[0 with line through it] [no] further c/o [complaints of] abuse stated to this nurse on this shift...." The nurses note, dated 5/2/16 at 2:00 p.m., included, but was not limited to, the following: "...[0 with line through it] [no] further c/o [complaints of] abuse...." During an interview on 5/20/16 at 10:00 a.m., the Administrator indicated he was unaware of an abuse allegation until Monday, 5/2/16. The Administrator also indicated he was told it was taken care of and there was no abuse. During an interview on 5/20/16 at 11:45 a.m., LPN #1 indicated Resident #B told her a CNA (Certified Nursing Assistant) with bushy hair and dark skin was mean and rough with her and would not speak to her. LPN #1 indicated Resident #B told her, "I kept telling her she was hurting me, but she kept going." LPN #1 indicated the DON was notified of the incident. During an interview on 5/20/16 at 11:45			

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	a.m., Resident #B indicated a CNA was rough with her when taking her to the bathroom. Resident #B stated, "She was incredibly rough. I would tell her, ouch, you are hurting me and she said, well I have to get you up. Then I was scared to say anything." Resident #B indicated she reported the incident with the 3rd shift CNA to the oncoming day shift CNA. During an interview on 5/20/16 at 2:07 p.m., the Director of Nursing indicated the incident was not reported because, after interviewing the resident, she felt there was no abuse. The DON also indicated the CNA in question does not provide care for Resident #B anymore since Resident #B indicated the CNA was not a "happy camper". On 5/20/16 at 10:45 a.m., Medical Records provided a current copy of the document titled, "RESIDENT ABUSE POLICY". It included, but was not limited to, the following: "...PROCEDURES...Investigation...If a situation meeting one (or more) of the definitions of abuse...or is reported to staff by a resident...the following steps must be taken: 1. All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are to be reported immediately			

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	to the Administrator and/or Director of Nursing either in person or over the phone...2. Each allegation will be investigated with results documented on an Incident Investigation Report by the Administrator, Director of Nursing or designee...3. If the incident is determined as a "reportable unusual occurrence" the Administrator, Director of Nursing or designee will contact the ISDH (Indiana State Department of Health) within 24 hours of the allegation...The list of other agencies...Adult Protective Services...Local Ombudsman...Health Professional Bureau...Office of the Attorney General...." 3.1-28(b)(2)			
F 0226 SS=D Bldg. 00	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 implement written policies and procedures regarding abuse as evidenced by failure to report an abuse allegation to the Indiana State Department of Health and other agencies for 1 of 3 residents (Resident #B) reviewed for abuse.	F 0226	All allegations even those that the residents deny voicing will be reported with in 24 hours. At that time interviews will completed by the SSD or administrative staff on the other residents also After the initial interviews then additional interviews will be completed 1 x weekly x 6 months At the point when there are no findings	06/06/2016

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	Findings include: The clinical record for Resident #B was reviewed on 5/19/16 at 11:00 a.m. Diagnoses included, but were not limited to, depression and osteoarthritis. The quarterly MDS (Minimum Data Set) assessment, dated 4/23/16, indicated Resident #B was alert and oriented to person, place and time. The nurses note, dated 4/29/16 at 9 a.m., indicated Resident #B told LPN #1 a CNA (Certified Nursing Assistant) was overly rough and hurt her. The nurses note also indicated Resident #B stated, "I do not want her back in my room." The nurses note, dated 4/29/16 and untimed, included the following: "LPN [Licensed Practical Nurse] came to me that this res [resident] had stated that someone was rough with her. I went into resident's room to find out the specifics of the situation. I asked her "do you feel like you was [sic] abused or hurt intentionally" and she replied, "no, I would go before a court of law [the number 3 backward with a horizontal line through it] [and] say no" [sic] I asked her for a description of the person she felt like might have been rough with her [the number 3 backward with a horizontal line		noted then no more interviews will be conducted Immediately upon notification employee will be notified and asked to give their statement and may be suspended until investigation is complete with no findings	

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	through it] [and] she said [sic] "I can't remember"...Daughter expressed [0 with a line through it] [no] concerns with [residents first name] comment of one statement saying [sic] "someone was a little rough with me" [sic] especially since her story changed when I went in... [Director of Nursing's [DON] signature]...." The nurses note, dated 4/29 16 at 5 p.m., indicated Resident #B continued to complain about being mistreated by a CNA. The nurses note also indicated the CNA was "Black with kinky hair." The nurses note, dated 4/30/16 at 4 a.m., indicated Resident #B had no complaints of abuse. The nurses note, dated 4/30/16 at 9 a.m., included the following: "Cont [continues] to voice concerns about the "CNA that was rough". [sic] "I don't think she likes me", [sic] "She does not talk to me". "She hurts me and I tell her but she acts like she doesn't care". "When there are 2 in the room they have their own conversation and don't include me [sic] they [sic] act like I'm not there." States was "told by the other nurse," [sic] [Director of Nursing's name] "that she will not be allowed back in my room." [sic] "I'm glad but I'm worried she will do			

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	this to some one else...." The nurses note, dated 4/30/16 at 12 p.m., indicated the Director of Nursing and Social Services Director were in the building. The nurses note also indicated the DON notified the family of the abuse allegation. The nurses note, dated 5/1/16 at 2:45 p.m., indicated Resident #B had no further complaints of abuse. The nurses note, dated 5/2/16 at 2:00 p.m., indicated Resident #B had no complaints of abuse. On 5/20/16 at 10:00 a.m., during an interview, the Administrator indicated he was unaware of an abuse allegation until Monday, 5/2/16. The Administrator also indicated he was told it was taken care of and there was no abuse. On 5/20/16 at 11:45 a.m., during an interview with LPN #1, he/she indicated Resident #B told him/her a CNA with bushy hair and dark skin was mean and rough with her and would not speak to her. LPN #1 indicated Resident #B told the CNA she was hurting her, but the CNA did not stop. LPN #1 indicated the DON was notified of the incident.			

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	On 5/20/16 at 11:45 a.m., Resident #B indicated a CNA was rough with her when taking her to the bathroom. Resident #B stated, "She was incredibly rough. I would tell her, ouch, you are hurting me and she said, well I have to get you up. Then I was scared to say anything." Resident #B indicated she reported the incident with the 3rd shift CNA to the oncoming day shift CNA. On 5/20/16 at 2:07 p.m., during an interview, the Director of Nursing indicated the incident was not reported because, after interviewing the resident, she felt there was no abuse. The DON also indicated the CNA in question does not provide care for Resident #B anymore since Resident #B indicated the CNA was not a "happy camper". On 5/20/16 at 10:45 a.m., Medical Records provided a current copy of the document titled, "RESIDENT ABUSE POLICY". It included, but was not limited to, the following: "It is the policy of this facility that each resident has the right not to be subject to abuse by anyone, including staff members...5. Employees who have been accused of mistreatment, neglect or resident abuse will be suspended until the Administrator has reviewed the results of the investigation. 6. The Administrator will			

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	155766	A. BUILDING 00 B. WING	05/20/2016

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	keep the resident and his/her representative informed of the progress of the investigation. 7. The results of the investigation will be recorded on the resident abuse investigation report form. 8. Within 24 hours of the completion of the investigation, the Administrator will report, by phone and in writing the results of the investigation and corrective action taken...a. Resident and his/her representative...b. Indiana State Department of Health...c. Adult Protective Services...d. State Licensing Agency...e. Resident Physician...." 3.1.28(a)			
F 0514 SS=D Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to obtain a physicians order to discontinue a medication for 1 of	F 0514	All MARs from 6/1/2016 are being reviewed for any unavailable, not given and/or	07/07/2016

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	3 residents reviewed for physician orders. (Resident #D) Findings include: The clinical record for Resident #D was reviewed on 5/20/16 at 9 :40 a.m. Diagnosis included, but was not limited to, osteoporosis with history of fracture. The physician progress note, dated 8/21/15 and untimed, indicated to add Prolia for osteoporosis. The physician order, dated 8/21/15 and untimed, included, but was not limited to, the following: "...add Prolia [medication used for osteoporosis] 60 mg [milligrams] sc [subcutaneous] Q [every] 6 mo [months] - dx [diagnosis] - OP [osteoporosis] [c with line over it] [with] - recent L [left] femur fx [fracture] - long term steroid use...." The February 2016 MAR (Medication Administration Record) included the following: "Prolia Sol [solution] 60 mg/ml [milliliters]...08/21/15...Inject 60 mg...every 6 months (Due: 02/26/16) for Osteoporosis...." The MAR was not initialed by staff as given. The March 2016 and April 2016 MAR indicated the Prolia was discontinued on		discontinued medications with appropriate actions being taken for any noted issues An administrative staff member will review MAR's for any unavailable, not given and/or discontinued medications Staff in-service on 6/7/2016 notifying MD/NP and documenting notification when a medication is unavailable If non-covered form is received this has to be forwarded to Administrative nurse to be addressed The attached QA sheet will be used as the monitoring tool It will be completed 3x's weekly x 4 weeks then 2x's weekly x 4 weeks, then weekly x 4 weeks then biweekly x 3 months. Based on results from QA it will be determined at that time, by the QA committee, if QA should continue, can be decreased further or stopped.	

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	2/26/16. The physician progress note, dated 2/26/16 and untimed, lacked documentation related to the discontinuation of the Prolia. The nurses note, dated 2/26/16 at 6:30 p.m., indicated Resident #D was seen by the nurse practitioner and lacked documentation related to the discontinuation of Prolia. The nurses note, dated 2/29/16 and untimed, included, but was not limited to, the following: "...Prolia due on 2-26 not covered by insurance. Non coverage form available...DON [Director of Nursing's name] made aware...." The physician progress note, dated 3/2/16 and untimed, included, but was not limited to, the following: "...Pt [patient] seen...Prolia...OP [osteoporosis] [c with line over it] [with] hx [history] fx [fracture]...? [ask] if PA [prior authorization] was actually done...NEED PA - typically this is covered [c with line over it] [with] hx [history] fx [fracture]...." The physician progress note, dated 4/27/16 and untimed, included, but was not limited to, the following: "...Pt			

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	[patient] seen...4) OP [osteoporosis] ...? Prolia - was due 2/2016...." The physician order, dated 4/27/16 and untimed, included, but was not limited to, the following: "...Prolia [up arrow] 60 mg [milligrams] Q [every] 6 mo [months] SQ [subcutaneous] - dx [diagnosis] OP [osteoporosis] [c with line over it] [with] hx [history] fx [fracture]...was due in Feb [February] 2016 (I do not see this on med sheet)...." During an interview on 5/20/16 at 10:40 a.m., LPN (Licensed Practical Nurse) #1 indicated there was not an order from the physician to discontinue the Prolia. During an interview on 5/20/16 at 2:10 p.m., Resident #D's POA (Power of Attorney) indicated the nurse practitioner never discontinued the order for Prolia. During an interview on 5/20/16 at 3:00 p.m., the DON (Director of Nursing) indicated the nurse practitioner wrote on the prior authorization form from pharmacy to discontinue the Prolia. The DON indicated she could not locate the prior authorization form with the discontinuation order from the nurse practitioner. The DON also indicated she was unaware the discontinuation of the Prolia needed to be transcribed on a			

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	physicians order. This Federal tag relates to Complaint IN00199249 3.1-50(a)(1)(2)			