STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155700	A. BUILDING 00 B. WING	08/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00178261, Complaint IN00179054 and Complaint IN00179999. Complaint IN00178261 - Substantiated. No deficiencies related to the allegation are cited. Complaint IN00179054 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00179999 - Substantiated. Federal/State findings related to the allegation are cited at F224, F225, F226 and F309. Survey dates: August 17-19, 2015 Facility number: 002982 Provider number: 155700 AIM number: 200382090 Census bed type: SNF: 9 SNF/NF: 63 Total: 72 Census payor source: Medicare: 12 Medicaid: 23 Other: 37 Total: 72	F 0000	Please accept this Plan of Correction to be our credible allegation of compliance. Submission of this Plan of Correction does not constitute admission of the allegations contained in the CMS 2567 for the survey which ended August 19th, 2015	

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

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	Sample: 4 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.			
F 0224 SS=D Bldg. 00	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN 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 record review and interviews, the facility failed to prevent mistreatment by the Health Facility Administrator who obtained a non-medical magnet in an attempt to deactivate a resident's pacemaker. (Resident "C") Finding includes: During the survey Entrance Conference, on 08/17/15 at 9:30 a.m., the DNS (Director Nursing Services) indicated the Administrator was not available and remained on suspension related to an incident the facility was investigating. The incident occurred on 07/24/15, and was related to the Administrator's family member, a resident who was receiving	F 0224	F224 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident "C" has since expired and the Health Facility Administrator was suspended during facility investigation and is no longer employed by this facility F224 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have potential to be affected by the same deficient practice and the Health Facility Administrator is no longer employed by this facility. Staff will be interviewed to ensure that no other allegations of abuse have been unreported. F224 What measures will be put	09/18/2015

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	end of life care in the facility from Hospice. The DNS indicated the resident expired on 07/25/15. The record of Resident "C" was reviewed on 08/17/15 at 2:00 p.m. Resident "C" was admitted to the facility, on 10/15/14, with diagnoses including, but not limited to, Lewy body dementia, hypertension, seizures, tremors, depression, FTT (Failure To Thrive), prostate CA, TIAs (Trans Ischimal Attacks: "mini strokes"), pacemaker and CHF (Congestive Heart Failure). The resident was admitted to Hospice services on 04/16/15. The "NURSES' PROGRESS NOTES," indicated the resident had been unresponsive since 07/23/15 at 6:50 p.m. and pupils non reactive since 07/24/15 at 7:00 a.m. An entry noted: "07/24/15 12:00 p.m. Writer was approached by family friend of resident, [Name]. She stated they have decided to turn off the pacemaker and needed a magnet to do it. Writer explained to her that I needed to speak c [with] hospice. I explained to the hospice nurse [Name], [Administrator's name], the [family member], was present and [Name] the friend that this was not something we do and that if hospices [sic] states it is in there scope of practice our staff cannot		into place or what systemic changes will be made to ensure that the deficient practice does not recur? The policy and procedure document titled, "Abuse Prevention Protocol" will be reviewed and revised, if necessary, by the Administrative Leadership Team. Staff will then receive in-service education regarding the contents of the "Abuse Prevention Protocol" document. This policy and procedure will be reviewed annually by the Administrative Leadership Team Upon hire, new staff will be provided with education pertaining to "Abuse Prevention Protocol" policy and procedure and all staff will receive training annually F224 How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what QA programs will be put into place? Staff Development Coordinator or designee will report quarterly to QA regarding ratio of new staff having received education on current "Abuse Prevention Protocol" policy and procedure F224 By what date will the systemic changes be completed? September 18th, 2015	

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	assist s [without] contact c facilities [sic] Medical Director approval. Hospice continued to request the magnet which we did not have available. [Name] RN nurse manager approached the resident's room to speak c hospice nurse [Name] and resident's [family member] [Name] who stated they had turned off the pacemaker." The resident continued to be monitored and comfort measures provided by the facility staff throughout 07/24/15, until the resident expired, with family at bedside, on 07/25/15 at 8:20 a.m. The record contained a faxed copy of a Hospice physician's typed order, on a prescription pad with a signature, which indicated: "[Resident's name] 07/24/15 May turn off pacemaker. [Hospice Physician handwritten signature]." Three attempts, on 8/18/15, to reach the physician by the phone number, as provided on the prescription, were unsuccessful. RN #8 was interviewed on 08/17/15 at 1:50 p.m. RN #8 indicated the Administrator requested the Maintenance man be summoned to get her a magnet. When staff would not comply, the Administrator was discovered to have			

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	gone down the facility stairway to the maintenance area and obtained a magnet, returned to the family member's room and indicated to nursing staff "it is done." The Staff Education RN was interviewed on 08/18/15 at 9:25 a.m. and indicated the magnet used by the Administrator was small and not the type used in programing a pacemaker. The nurse further indicated she assured the staff the magnet did not turn off the pacemaker and provided staff with further pacemaker information. The primary care Hospice RN for Resident "C" was interviewed, via phone, on 08/18/15 at 10:00 a.m. The Hospice RN indicated the Administrator obtained a magnet and the Hospice RN applied it to Resident "C's" chest. The Hospice RN indicated it was not an appropriate magnet and she did not relay to the Administrator it would have no effect on the outcome for resident "C." On 08/18/15 at 10:15 a.m., the Staff Education nurse provided a copy of the information, titled, "Pacemakers and Implantable Cardioverter-Defibrillators: 05/02/2014" which indicated: "...Magnet Inhibition: Features of magnet inhibition are as follows: In most devices, placing a magnet over a permanent			

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	pacemaker temporarily 'reprograms' the pace into asynchronous mode; it does not turn the pacemaker off." On 08/17/15 at 3:00 p.m., the DNS provided a copy of the facility's current Policy & Procedure, titled, "ABUSE," which indicated: "PREVENTION PROTOCOL: June 4, 2015," which indicated: "STANDARD: Each resident has the right to be free from physical, verbal, sexual abuse, neglect, corporal punishment, ...Residents must not be subjected to abuse by anyone, including, but not limited to, facility, staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. POLICY: The facility will do all that is within its control to prevent occurrences of abuse to the residents, by implantation of procedures that include seven components of screening, training, prevention, identification, investigation, protection and reporting/response. DEFINITIONS: 'Abuse' means the willful infliction of injury, unreasonable confinement,			

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	intimidation, or punishment with resulting physical harm, pain or mental anguish... This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish...." 3.1-28(a)			
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			

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	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 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 record review and interview, the facility failed to report an incident involving the mistreatment by the Health Facility Administrator who obtained a non-medical magnet in an attempt to deactivate a resident's pacemaker. This deficiency effected 1 of 4 residents reviewed for abuse and neglect. (Resident "C") Finding includes:	F 0225	F225 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident "C" has since expired and the Health Facility Administrator was suspended during investigation and is no longer employed by this facility F225 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have potential to be	09/18/2015

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	The survey Entrance Conference was initiated on 08/17/15 at 9:30 a.m. The DNS (Director Nursing Services) indicated the Administrator was not available and remained on suspension related to an incident the facility was investigating. The incident occurred on 07/24/15, and was related to the Administrator's family member, a resident who was receiving end of life care in the facility from Hospice. The DNS indicated the resident expired on 07/25/15. The incident involved the Administrator obtaining a magnet, with no proven ability to deactivate a pacemaker, and giving it to the Hospice nurse in an attempt to deactivate the resident's pacemaker. The record of Resident "C" was reviewed on 08/17/15 at 2:00 p.m. Resident "C" was admitted to the facility, on 10/15/14, with diagnoses including, but not limited to, Lewy body dementia, hypertension, seizures, tremors, depression, FTT (Failure To Thrive), prostate CA, TIAs (Trans Ischimal Attacks: "mini strokes"), pacemaker and CHF (Congestive Heart Failure). The resident was admitted to Hospice services on 04/16/15. The Staff Education RN was interviewed,		affected by the same deficient practice and the Health Facility Administrator is no longer employed by this facility. Staff will be interviewed to ensure no other allegations of abuse have been unreported. F225 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The policy and procedure document titled, "Resident Abuse Reporting and Investigation" will be reviewed and revised, if necessary, by the Administration Leadership Team. Staff will then receive in-service education regarding the contents of the "Resident Abuse Reporting and Investigation" document. This policy and procedure will be reviewed annually by the Administrative Leadership Team Upon hire, new staff will be provided with education pertaining to "Resident Abuse Reporting and Investigation" policy and procedure and all staff will receive training annually. F225 How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what QA programs will be put into place? Staff Development Coordinator or designee will report quarterly to QA regarding ratio of new staff having received education on current "Resident Abuse Reporting and Investigation" policy and procedure. Addendum 9-22-15	

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	on 08/18/15 at 9:25 a.m., and indicated the magnet used by the Administrator was small and not the type used in programing a pacemaker. The nurse further indicated she assured the staff the magnet did not turn off the pacemaker and provided staff with further pacemaker information. The primary care Hospice RN for Resident "C" was interviewed, via phone, on 08/18/15 at 10:00 a.m. The Hospice RN indicated the Administrator obtained a magnet and the Hospice RN applied it to Resident "C's" chest. The Hospice RN indicated it was not an appropriate magnet and she did not relay to the Administrator it would have no effect on the outcome for resident "C." On 08/18/15 at 10:15 a.m., the Staff Education nurse provided a copy of the information, titled, "Pacemakers and Implantable Cardioverter-Defibrillators: 05/02/2014" which indicated: "...Magnet Inhibition: Features of magnet inhibition are as follows: In most devices, placing a magnet over a permanent pacemaker temporarily 'reprograms' the pace into asynchronous mode; it does not turn the pacemaker off." The ADNS (Assistant Director Nursing Services) was interviewed on 08/18/15 at		Daily rounds will be made by management for six months at which time staff interviews will be conducted. All allegations will be investigated and reported per Indiana State Department of Health guidelines. Staff will be inserviced quarterly for twelve months on abuse. F225 By what date will the systemic changes be completed? September 18th, 2015	

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	2:00 p.m. The ADNS indicated the incident was immediately reported to the Catherine Kasper Administrative Board since it involved the Administrator; however, because the pacemaker was not deactivated the incident was not reported. The ADNS further indicated the reporting system was not accessible as the Administrator had it password protected. On 08/17/15 at 3:00 p.m., the DNS provided a copy of the facility's current Policy & Procedure, titled, "RESIDENT ABUSE REPORTING AND INVESTIGATION: 03/21/14," which indicated: "STANDARD: To insure that reportable occurrences are recorded and monitored to facilitate compliance with state and federal laws. POLICY: All unusual occurrences reported to the Indiana State Department of Health ("ISDH") will be recorded and tracked or monitored to insure residents are receiving appropriate care and services. PROCEDURES: Facilities are required by law to report unusual occurrences within 24 hours of occurrence to the Long Term Care Division of the Indiana			

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	State Department of Health... (1) ABUSE - ...Abuse is willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, anguish, or deprivation by an individual of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well being...." 3.1-28(e)			
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 record reviews and interviews, the facility failed to implement the facility's Abuse & Neglect Policy & Procedure in regards to reporting an incident where the Administrator obtained a magnet with no proven ability to deactivate a resident's pacemaker. The magnet the Administrator obtained was used by Hospice and was not approved	F 0226	F226 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident "C" has since expired and the Health Facility Administrator was suspended during investigation and is no longer employed by this facility. F226 How other residents having the potential to be affected by the same deficient practice will be	09/18/2015

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	for medical usage. (Resident "C") Finding includes: The survey Entrance Conference was initiated on 08/17/15 at 9:30 a.m. The DNS (Director Nursing Services) indicated the Administrator was not available and remained on suspension related to an incident the facility was investigating. The incident occurred on 07/24/15, and was related to the Administrator's family member, a resident who was receiving end of life care in the facility from Hospice. The DNS indicated the resident expired on 07/25/15. The DNS was out of the country when the incident occurred. The incident involved the Administrator obtaining a magnet, with no proven ability to deactivate a pacemaker, and giving it to the Hospice nurse in an attempt to deactivate the resident's pacemaker. The record of Resident "C" was reviewed on 08/17/15 at 2:00 p.m. Resident "C" was admitted to the facility on 10/15/14 with diagnoses including, but not limited to, Lewy body dementia, hypertension, seizures, tremors, depression, FTT (Failure To Thrive), prostate CA, TIAs (Trans Ischimal Attacks: "mini strokes"),		identified and what corrective action will be taken? All residents have potential to be affected by the same deficient practice and the Health Facility Administrator is no longer employed by this facility. Staff will be interviewed to ensure no other allegations of abuse have been unreported. F226 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The policy and procedure document titled, "Resident Abuse Reporting and Investigation" will be reviewed and revised, if necessary, by the Administrative Leadership Team. Staff will then receive in-service education regarding the contents of the "Resident Abuse Reporting and Investigation" document. This policy and procedure will be reviewed annually by the Administrative Leadership Team. Upon hire, new staff will be provided with education pertaining to "Resident Abuse Reporting and Investigation" policy and procedure and all staff will receive training annually. F226 How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what QA programs will be put into place? Staff Development or designee will report quarterly to QA regarding ratio of new staff having received education on current "Resident Abuse	

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	pacemaker and CHF (Congestive Heart Failure). The resident was admitted to Hospice services on 04/16/15. The Staff Education RN was interviewed on 08/18/15 at 9:25 a.m. and indicated the magnet used by the Administrator was small and not the type used in programing a pacemaker. The nurse further indicated she assured the staff the magnet did not turn off the pacemaker and provided staff with further pacemaker information. The primary care Hospice RN for Resident "C" was interviewed, via phone, on 08/18/15 at 10:00 a.m. The Hospice RN indicated the Administrator obtained a magnet and the Hospice RN applied it to Resident "C's" chest. The Hospice RN indicated it was not an appropriate magnet and she did not relay to the Administrator it would have no effect on the outcome for resident "C." On 08/18/15 at 10:15 a.m., the Staff Education nurse provided a copy of the information, titled, "Pacemakers and Implantable Cardioverter-Defibrillators: 05/02/2014" which indicated: "...Magnet Inhibition: Features of magnet inhibition are as follows: In most devices, placing a magnet over a permanent pacemaker temporarily "reprograms" the		Reporting and Investigation" policy and procedure. Addendum 9-22-15: Daily rounds will be made by management for six months at which time staff interviews will be conducted. All allegations will be investigated and reported per Indiana State Department of Health guidelines. Staff will be inserviced quarterly for twelve months on abuse. F226 By what date will the systemic changes be completed? September 18th, 2015	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

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	pace into asynchronous mode; it does not turn the pacemaker off." The ADNS (Assistant Director Nursing Services) was interviewed on 08/18/15 at 2:00 p.m. The ADNS indicated the incident was immediately reported to the Catherine Kasper Administrative Board since it involved the Administrator; however, because the pacemaker was not deactivated the incident was not reported. The ADNS further indicated the reporting system was not accessible as the Administrator had it password protected. On 08/17/15 at 3:00 p.m., the DNS provided a copy of the facility's current Policy & Procedure, titled, "RESIDENT ABUSE REPORTING AND INVESTIGATION: 03/21/14", which indicated: "STANDARD: To insure that reportable occurrences are recorded and monitored to facilitate compliance with state and federal laws. POLICY: All unusual occurrences reported to the Indiana State Department of Health ("ISDH") will be recorded and tracked or monitored to insure residents are receiving appropriate care and services.			

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	PROCEDURES: Facilities are required by law to report unusual occurrences within 24 hours of occurrence to the Long Term Care Division of the Indiana State Department of Health... (1) ABUSE - ...Abuse is willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, anguish, or deprivation by an individual of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well being...." 3.1-28(a)			
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interviews, the facility failed to ensure the facility	F 0309	F309 What corrective action will be accomplished for those	09/18/2015

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	prevented the mistreatment of a resident and failed to ensure Hospice followed the expectations of the facility when the Health Facility Administrator provided Hospice with a non-medical magnet in an attempt to deactivate a resident's pacemaker. (Resident "C") Finding includes: The survey Entrance Conference was initiated on 08/17/15 at 9:30 a.m. The DNS (Director Nursing Services) indicated the Administrator was not available and remained on suspension related to an incident the facility was investigating. The incident occurred on 07/24/15, and was related to the Administrator's family member, a resident who was receiving end of life care in the facility from Hospice. The DNS indicated the resident expired on 07/25/15. The record of Resident "C" was reviewed on 08/17/15 at 2:00 p.m. Resident "C" was admitted to the facility on 10/15/14 with diagnoses including, but not limited to, Lewy body dementia, hypertension, seizures, tremors, depression, FTT (Failure To Thrive), prostate CA, TIAs (Trans Ischimal Attacks: "mini strokes"), pacemaker and CHF (Congestive Heart Failure). The resident was admitted to		residents found to have been affected by the deficient practice? Resident "C" has since expired and the Health Facility Administrator was suspended during investigation and is no longer employed by this facility. The hospice company that provided care to resident "C" have no other residents contracted at this time. F309 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the same deficient practice and the Health Facility Administrator is no longer employed by this facility. Staff will be interviewed to ensure no other allegations of abuse have been unreported. F309 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The policy and procedure document titled, "Abuse Prevention Protocol" will be reviewed and revised, if necessary, by the Administrative Leadership Team. Staff will then receive in-service education regarding the contents of the "Abuse Prevention Protocol" document. This policy and procedure will be reviewed annually by the Administrative Leadership Team. Upon hire, new staff will be provided with education pertaining to "Abuse	

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	Hospice services on 04/16/15. The "NURSES' PROGRESS NOTES," indicated the resident had been unresponsive since 07/23/15 at 6:50 p.m. and pupils non reactive since 07/24/15 at 7:00 a.m. An entry noted: "07/24/15 12:00 p.m. Writer was approached by family friend of resident, [Name]. She stated they have decided to turn off the pacemaker and needed a magnet to do it. Writer explained to her that I needed to speak c [with] hospice. I explained to the hospice nurse [Name], [Administrator's name], the [family member], was present and [Name] the friend that this was not something we do and that if hospices [sic] states it is in there scope of practice our staff cannot assist s [without] contact c facilities [sic] Medical Director approval. Hospice continued to request the magnet which we did not have available. [Name] RN nurse manager approached the resident's room to speak c hospice nurse [Name] and resident's[family member] [Name] who stated they had turned off the pacemaker." The resident continued to be monitored and comfort measures provided by the facility staff throughout 07/24/15, until the resident expired, with family at		Prevention Protocol" policy and procedure and all staff will receive training annually. A certified mailing will be sent to all current hospice contracts which will contain the facility policy and procedure for "Abuse Prevention Protocol" and "Resident Abuse Reporting and Investigation". Addendum 9-22-15: Administrator or designee will contact the Hospice provider when issues/circumstances go against the facility mission/belief practices. F309 How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what QA programs will be put into place? Staff Development Coordinator or designee will report quarterly to QA regarding ratio of new staff having received education on current "Abuse Prevention Protocol" policy and procedure. Addendum 9-22-15: Current and future Hospice service contracts will contain verbage that the facility policy and procedures will be in effect for all on site Hospice services provided to our residents. F309 By what date will the systemic changes be completed? September 18th, 2015	

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	bedside, on 07/25/15 at 8:20 a.m. The record contained a faxed copy of the Hospice physician's typed order, on a prescription pad, which indicated: "[Resident's name] 07/24/15 May turn off pacemaker. [Hospice Physician written signature]." Three attempts to reach the physician by the phone number, as provided on the prescription, were unsuccessful. RN #8 was interviewed on 08/17/15 at 1:50 p.m. RN #8 indicated the Administrator requested the Maintenance man be summoned to get her a magnet. When staff would not comply, the Administrator was discovered to have gone down the facility stairway to the maintenance area and obtained a magnet, returned to the family member's room and indicated to nursing staff "it was done." The Staff Education RN was interviewed on 08/18/15 at 9:25 a.m. and indicated the magnet used by the Administrator was small and not the type used in programing a pacemaker. The nurse further indicated she assured the staff the magnet did not turn off the pacemaker and provided staff with further pacemaker information.			

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	The primary care Hospice RN for Resident "C" was interviewed, via phone, on 08/18/15 at 10:00 a.m. The Hospice RN indicated the Administrator obtained a magnet and the Hospice RN applied it to Resident "C"'s chest. The Hospice RN indicated it was not an appropriate magnet and she did not relay to the Administrator it would have no effect on the outcome for resident "C". On 08/18/15 at 10:15 a.m., the Staff Education nurse provided a copy of the information, titled, "Pacemakers and Implantable Cardioverter-Defibrillators: 05/02/2014" which indicated: "...Magnet Inhibition: Features of magnet inhibition are as follows: In most devices, placing a magnet over a permanent pacemaker temporarily 'reprograms' the pace into asynchronous mode; it does not turn the pacemaker off." On 08/18/15 at 10:40 a.m., 2 members of the Administrative Board were interviewed, AB#1 and AB#2. AB#2 indicated until the incident, being unaware the Administrator had entered into contract with the agency providing Hospice care for the Administrator's family member. AB#1 indicated the actions of the Administrator did not align with the facility's Mission Statement and			

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	Vision Statement. A copy of the facility's Mission and Vision Statement, provided on 08/18/15 at 3:00 p.m., indicated: "CKLC [Catherine Kasper Life Center] Mission Statement: Inspired by the presence of God and God's care for all, our residents and co-workers form a community comprised of Catherine Kasper Home and Maria Center, in which all persons are equally listen to, cared for, appreciated, and respected. Sponsored by the Poor Handmaids of Jesus Christ and in the spirit of Blessed Catherine Kasper, this Continuing Care Retirement community is committed to the comfort, dignity, and well being of all residents as they continue on their journey through life. CKLC Vision Statement: Catherine Kasper Life Center, Inc. envisions a joy-filled community dedicated to creating a culture which respects spiritually, physically, emotionally, and intellectually the individualized needs and gifts of those that we serve while assuring that Christian values are live....10/2014." 3.1-37(a)			

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