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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155357	A. BUILDING 00 B. WING	02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RAWLINS HOUSE HEALTH & LIVING COMMUNITY	300 J H WALKER DR PENDLETON, IN 46064

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00246929, IN00248080 and IN00250160. This visit resulted in a Partially Extended Survey-Substandard Quality of Care-Immediate Jeopardy. Complaint IN00250160 - Substantiated. Federal/State deficiencies related to the allegation are cited at F600, F609 F610 and F726. Complaint IN00246929 - Substantiated. Federal/State deficiencies related to the allegation are cited at F726. Complaint IN00248080 - Substantiated. Federal/State deficiencies related to the allegation are cited at F600, F609 F610 and F726. Unrelated deficiencies are cited. Survey dates: February 19, 20, 21, 22 and 23 2018. Facility number: 000248 Provider number: 155357 AIM number: 100291470 Census bed type: SNF/NF: 69 SNF: 17 Total: 86 Census payor type: Medicare: 20 Medicaid: 51 Other: 15 Total: 86	F 0000	The plan of correction is to serve as Rawlins House credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Rawlins House or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	These deficiencies reflects State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on February 28, 2018.			
F 0600 SS=K Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;			
	Based on interview and record review, the facility failed to prevent abuse by a staff member for 2 of 6 residents reviewed for abuse. This deficient practice resulted in Resident D being placed in a Broda chair as a restraint for approximately 4 hours and Resident J being tearful after medication administration with LPN 7. (Resident D and Resident J) This deficient practice had the potential to affect 56 residents who lived on the North Hall of 86 who resided in the facility. The immediate jeopardy began on 1/31/18 when LPN 7 placed Resident D in a Broda chair, tilted it back as LPN 7 slept at the nurses' station. This nurse also forcefully administered medication to a resident. The Administrator was notified of the immediate jeopardy on 2/21/18 at 1:20 p.m.	F 0600	**F 600** **We respectfully request a face to face IDR for this citation to present additional evidence for review.** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**	03/19/2018

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Findings include:

1. The clinical record for Resident D was reviewed on 2/19/18 at 5:38 p.m. Diagnoses included, but were not limited to, dementia with behaviors, Alzheimer's disease, chronic kidney disease, dysphagia, and anemia.

Resident D was admitted to the facility on 1/18/18. A 14-day Minimum Data Set (MDS) assessment, dated 1/30/18, indicated the resident was severely cognitively impaired. He required extensive assistance with 2 person assistance for bed mobility, transfers, walking, dressing and hygiene. The resident used a wheelchair as his mobility device.

A current health care plan, dated 1/22/18, indicated the resident exhibited wandering behaviors. Interventions included, but were not limited to, provide a magazine or book, walk the facility with the resident or join an activity.

On 1/24/18 at 1:00 a.m., the resident was observed to have been exit seeking on the North Hall.

Review of the staff schedule for 1/30/18, LPN 7 was assigned to the North Hall from 2:00 p.m. until 6:00 a.m. on 1/31/18.

Review of an Indiana State Department of Health reportable, dated 1/31/18 at 8:40 a.m., indicated Resident D was placed in a "geri chair in a reclined position. A staff member was concerned the resident would not be able to get up on his own." The incident was immediately reported to the Administrator. LPN 7 was suspended pending an investigation.

Resident D no longer resides in the facility.

LPN 7 employment has been terminated.

Resident J has received psychosocial follow up related to being tearful following medication administration from LPN 7.

CNA 10 employment has been terminated.

LPN 3 was in-serviced on abuse and reporting, but has since resigned and is no longer working in the facility.

CNA 2, CNA 9, CNA 8, and laundry Aide 16 were in-serviced on abuse and reporting.

II. The facility will identify other residents that may potentially be affected by the deficient practice.

Other residents residing at Rawlins House have the potential

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	Review of the facility investigation indicated the following: A statement, dated 2/1/18, by CNA 10, indicated she was told by LPN 7 to get a Broda chair (a reclining chair on wheels) from another hall. She asked the nurse if a resident needed an order and the nurse stated "It doesn't matter, he won't stay still." CNA 10 went to find a Broda chair on another hall and when she returned, LPN 7 had already retrieved one. CNA 10 indicated she did help move Resident D into the Broda chair because she did not want LPN 7 to transfer him herself. A statement provided by CNA 8, dated 2/1/18, indicated when she arrived, she noticed Resident D seated in a Broda chair. She indicated she picked up his gown and covered him up immediately. The statement indicated LPN 7 continued to say "You're going to want to keep him there." Another nurse directed CNA 8 to remove Resident D and move him into his wheelchair. A statement by CNA 9, dated 2/1/18, indicated she arrived at the facility at 6:00 a.m. She indicated Resident D had a gown on the floor beside him. He was seated in a Broda chair and it had been leaned back. She asked LPN 7 why Resident D was in the Broda chair and LPN 7 stated "He was too much last night." She indicated the other unit came to the North Hall unit looking for the Broda chair. A statement by LPN 4, indicated when he arrived to work, he saw Resident D "lying back in the broda" and asked LPN 7 what he was doing there. LPN 7 indicated "I couldn't do anything with him, so I put him there to keep him off the floor." LPN		to be affected by the alleged deficient practice. To identify concerns with abuse, restraint usage or medication administration, other residents with a BIMS of 8 or greater have been interviewed using an Abuse questionnaire. Families of non-interviewable residents have been interviewed using an Abuse questionnaire. Staff members who work at the facility have been interviewed by corporate staff regarding abuse. Any new allegations of abuse were reported to the Administrator and the ISDH immediately. A trend analysis was performed and no other staff members were identified to have ongoing concerns or an accumulation of abuse allegations. All residents at Rawlins House assessed on 2/21/18 to ensure the facility is restraint free. **III. The facility will put into place the following systemic changes to ensure that the**	

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	4 stated to LPN 7 that she could not really just put him there and LPN 7 stated "well I did." During review of the video surveillance of January 31, 2018 starting at 2:06 a.m., along with the Administrator, Director of Nursing and Corporate Nurse, Resided D was seen seated in his wheelchair at the nurses' station while LPN 7 was sleeping at the nurses station. At 2:08 a.m., CNA 10 brought a Broda chair to the North Hall and LPN 7 was waking up and stretching. At 2:32 a.m., Resident D was moved from his wheelchair into the Broda chair by CNA 10 and LPN 7. CNA 10 reclined the Broda chair completely back and placed a sheet over him. Resident D continued to be restless throughout the morning, continued to kick off his sheet and attempted to remove his gown. At 4:46 a.m., CNA 10 removed Resident D's brief while he was tilted back in the Broda chair. At 5:05 a.m., Resident D appeared to only have socks on his feet and no other clothing item covered him. Resident D remained at the nurses' station. At 5:55 a.m., CNA 10 and CNA 8 removed Resident D from the view of the video and he returned at 6:03 a.m. wearing a shirt and jeans. At 6:05 a.m., Resident D was transferred from the Broda Chair to his wheelchair. An employee communication form, dated 2/2/18, indicated LPN 7 was terminated for "Failure to ensure resident safety, sleeping on clock on unit." Confidential interviews for staff were completed. Exact times and dates withheld to maintain anonymity. Employee 1 indicated LPN 7 was the worst nurse ever by being mean and rude to the residents and the residents would refuse for LPN 7 to give them		**deficient practice does not recur.** Staff were educated on proper use of restraints and examples of inappropriate use of restraints resulting in abuse. Staff are being educated regarding appropriate behavioral interventions and fall interventions. All 3rd party vendors with direct patient care access that visit the property of Rawlins House will receive education related to identifying abuse with detailed examples of what constitutes abuse, including restraints, prior to third party services being provided to Rawlins House residents. Licensed nurses that work at Rawlins House will receive education immediately and prior to working any shifts related to proper administration of medication including the resident's right to refuse as well as documentation of medication	

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	their medication. Employee 1 indicated he/she wrote up several grievance forms, as did therapy. Employee 1 indicated that did not seem to work, so they just started calling the Administrator directly. Employee 2 indicated LPN 7 left Resident D naked and they had it on camera. He/She stated it was reported by a day shift nurse The Administrator and Director of Nursing (DON) were aware of the concerns with LPN 7. He/She thought the nurses' were passing along the information, but felt it stopped with the Administrator and Director of Nursing (DON). Employee 3 indicated LPN 7 did not treat residents in a "good way" by not giving the residents their pain medication and the residents would have to repeatedly ask her for it. He/She thought management was aware that LPN 7 was abusive. Employee 3 indicated staff often refused to work with LPN 7. Employee 4 indicated he/she often heard complaints of LPN 7 not giving residents their pain medication. Employee 5 indicated the complaints had been going on for some time and the complaints went up the chain, but staff thought nothing was being done. Employee 6 indicated he/she heard a lot of complaints about LPN 7 withholding pain medication. LPN 7 should have been gone a long time ago. He/She heard LPN 7 say "if they are going to laugh and joke with me, I am not giving them their pain medicine." Employee 7 indicated staff often filled out		administration at time of administration, according to professional nursing practice standards and CarDon policies. Licensed nurses that work at Rawlins House will complete a skills validation of medication pass. Newly hired licensed nurses will complete a medication pass skills validation prior to working on the floor and their skills and compliance with CarDon policies and professional standards will be monitored through observation to ensure competence. Human Resources director, Director of Nursing and Administrator educated regarding accurate documentation of reason for termination for employees. Administrator and staff educated on grievance process including follow up on grievances voiced by residents regarding medication administration or potential medication errors.	

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	grievance forms and to his/her knowledge, the Administrator had not spoken to any of them. Employee 8 indicated when staff mentioned anything to the Administrator, he told them to go to nursing. Employee 9 indicated when he/she arrived to work on 1/31/18, Resident D's genitals were visible and the chair was tipped back. On 2/19/18 at 8:27 a.m., the Administrator indicated for the last couple of months, things were not working well with LPN 7. He indicated she had a problem administering medications timely. During an interview on 2/20/18 at 9:46 a.m., the DON indicated early in 2017, LPN 7 was not getting the flow of day shift and she moved her to night shift. She did bring her in and talk to her, but felt she was not "teachable." On 2/20/18 at 10:27 a.m., LPN 9 indicated when he arrived to work, Resident D only had a T-shirt on and no brief and there was a sheet on the floor. He indicated Resident D was reclined in the chair. He instructed the aides to take him to his room, clean him up and put him in his wheelchair. During an interview on 2/21/18 at 9:48 a.m., the DON indicated LPN 7 told CNA 10 to go and get a Broda chair. CNA 10 did help transfer Resident D into the Broda chair. LPN 7 did not provide a written statement and although the DON had viewed the video surveillance, she was unable to provide the time Resident D was placed in the Broda chair. During a telephone interview on 2/22/18 at 11:49		Grievances voiced by a resident, family member or staff member will be immediately reported to the administrator who will delegate the appropriate steps and determine if the concern constitutes a reportable or a grievance. The grievance process directing staff to contact the administrator directly for each and every grievance/concern has been posted at each nurse's station, outside the social services office, and in the break room. All staff members that work at Rawlins House will receive education immediately and prior to working any shifts related to directly and immediately reporting allegations of abuse to the Administrator, after ensuring resident safety, with detailed examples of what constitutes abuse. Staff members will be educated to follow the above protocol, without fear of retaliation, even if the abuser is a superior or manager.	

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a.m., LPN 3 indicated she did remember the night when Resident D was in the Broda chair. She was told her image was seen on the video moving Resident D to the side so she could weigh another resident. She indicated she was unfamiliar with the resident and if he was usually in a Broda chair. She did not report the incident to the Administrator.

Review of LPN 7's employee record, indicated she signed an acknowledgement of policies on 12/7/16. The policies included, but were not limited to, abuse prevention, code of conduct, and reporting a reasonable suspicion of a crime against a resident.

LPN 7 also signed a general orientation checklist on 12/7/16, indicating she had received sufficient education and training for abuse, neglect and resident rights.

On 12/7/16, LPN 7 signed an affirmation statement indicating she agreed to abide by the code of conduct.

On 2/22/18 at 12:24 p.m., the Corporate Administrator indicated CNA 10 had been terminated that day for her contributions to the abusive conduct

During a telephone interview on 2/22/18 at 3:22 p.m., LPN 7 indicated it was the CNA who suggested to put Resident D in the Broda chair. She had complained to management before that Resident D needed one on one observation because he would often wander into other resident rooms. LPN 7 indicated she would often put her head down because she had a headache. LPN 7 indicated she would occasionally document that she had administered medication on her shift,

IV The facility will monitor the corrective action by implementing the following measures.

The Director of Nursing, or designee, will audit new restraints for appropriate usage daily for 30 days, then weekly for 90 days then monthly for 9 months.

The Director of Nursing, or designee, will audit medication pass with 5 nurses weekly for 30 days, then 5 nurses monthly for 90 days then one 1 nurse monthly for 9 months.

The Administrator or designee will interview a minimum of 5 residents with a BIMS of 8 or greater, 5 family members or representatives of residents who have cognitive impairment, and 5 staff members using an Abuse

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	but because she was busy, the day shift nurse would then give the medication. She gave no explanation as to why as the nurse in charge, she would allow Resident D to be placed in the Broda chair. 2. The clinical record for Resident J was reviewed on 2/20/18 at 9:26 a.m. Diagnoses included, but were not limited to, bacterial pneumonia, dysphagia, muscle weakness, hypertension and peripheral vascular disease. During an interview on 2/21/18 at 10:54 a.m., Resident J indicated she received two doses of her medications one night. She indicated she was unsure of the date, but stated the nurse brought her a second dose of crushed medications and told her to take it. The nurse was forceful and the resident was tearful and very scared. The medicine cup had her blood pressure medications in it. She told CNA 6 about the incident. An Admission Minimum Data Set (MDS) assessment, dated 1/19/18, indicated Resident J was cognitively intact. During an interview on 2/19/18 at 9:26 p.m., CNA 6 indicated she came to work at 10:00 p.m. on 1/30/2018 and worked until 6:00 a.m. on 1/31/18. During her shift, she saw LPN 7 coming out of Resident J's room. When she made her way back to Resident J's room, she was crying and said the nurse made her take her medications again. The resident said she told the nurse she had already taken them. The resident was afraid and did not want her to leave her. CNA 6 indicated she notified the charge nurse, LPN 5, that Resident J stated she had taken her medication twice. LPN 5 told her to report it.		questionnaire to ensure residents are free from abuse. This will be completed weekly for 9 weeks and monthly for 9 months for a total of 12 months of monitoring. Any allegations of abuse will be reported immediately and investigated. Results of the interviews and audits will be reported to the QA committee monthly and ongoing frequency will be adjusted as need if compliance is below 100%. **V. Date of Compliance 03/19/18.** Facility Administrator will be responsible for ensuring compliance by the date listed.	

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During a telephone interview on 2/20/18 at 11:41 a.m., LPN 5 indicated CNA 6 did tell her that Resident J supposedly took her medication twice. She did not go and assess the resident, but called the unit manger that evening at home.

On 2/21/18 at 11:13 a.m., Unit Manager 4, DON, Administrator and Corporate Nurse were interviewed. The Corporate Nurse indicated she was told during the day by the therapist that the next door roommate to Resident J was heard saying Resident J received two doses of her medication. They immediately assessed Resident J and spoke to CNA 6, who indicated she did not say anything to the next door roommate about Resident J.

On 2/21/18 at 12:31 p.m., the DON indicated she had spoken to LPN 5. LPN 5 went to the North Hall to get something and CNA 6 told her that LPN 7 gave Resident J two doses of medicine. She did not assess her and was unaware the resident was tearful. The DON indicated LPN 5 stated she did call Unit Manager 4 at home. She had interviewed Resident J and the resident denied saying she was scared or tearful, but did state the nurse "just stuck it in my mouth."

A current facility policy, dated October 2014 and revised August 2016, titled "Abuse Policy," provided by the DON on 2/20/18 at 8:50 a.m., indicated the following:
"It is the policy...to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion...."

...IV. IDENTIFYING & RECOGNIZING SIGNS AND SYMPTOMS OF ABUSE

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Policy Statement
Our facility will not condone any form of resident abuse or neglect. To aid in abuse prevention, all personnel are to report any signs and symptoms of abuse/neglect to their supervisor immediately who will report to the Administrator or authorized designee immediately.

...VII. REPORTING ABUSE TO:
A. Administrator

Policy Statement
It is the responsibility of our employees...to immediately report any incident or suspected incident of neglect or abuse...to the Administrator or Designee if the Administrator is unavailable.
..a. Abuse is defined as the willful infliction of injury; unreasonable confinement; intimidation; punishment with resulting physical harm; pain or mental anguish; or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.
...e. Involuntary seclusion is defined as separation of a resident from other residents or from his or her room...."

A current undated facility policy, titled "Use of Restraints," provided by the DON on 2/22/18 at 12:16 p.m., indicated the following:

"Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls.
...3. Examples of devices...geri-chairs...."

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	An undated, facility policy, titled "Licensed Nurse Med Pass Clinical Skills Validation," which was provided by the DON on 2/21/18 at 4:10 p.m., indicated the following: "...29. Medication was given within the 60 minutes before or after the time designated unless otherwise directed by the physician..." The Immediate Jeopardy (IJ) that began on 1/31/18 was removed on 2/22/18 when interviews with staff confirmed the facility had begun inservicing staff on abuse, restraints and the reporting process. The noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all employees had not been inserviced. This Federal tag relates to Complaint IN00250160. 3.1-27(a)(1)			
F 0609 SS=K Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the			

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	155357	A. BUILDING 00 B. WING	02/23/2018

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	administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 ensure that staff members who had knowledge of an incident of physical abuse and a resident who was tearful after medication administration on the evening shift, immediately reported those concerns to the facility Administrator for 2 of 6 residents reviewed for abuse (Resident D and Resident J). This deficient practice had the potential to affect 56 residents who lived on the North Hall of 86 who resided in the facility. The immediate jeopardy began on 1/31/18 when LPN 7 placed Resident D in a Broda chair, as a restraint and a resident was forcibly given medication and staff did not immediately report their observations to the Administrator. The Administrator was notified of the immediate jeopardy on 2/21/18 at 1:20 p.m. Findings include: 1. The clinical record for D was reviewed on 2/19/18 at 5:38 p.m. Diagnoses included, but were not limited to, dementia with behaviors,	F 0609	F 609 We respectfully request a face to face IDR for this citation to present additional evidence for review. **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Allegations for Resident D and Resident J have been reported to the ISDH. CNA 2, CNA 9, CNA 8, and laundry Aide 16 were	03/19/2018

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	Alzheimer's disease, chronic kidney disease, dysphagia, and anemia. Resident D was admitted to the facility on 1/18/18. A 14-day Minimum Data Set (MDS) assessment, dated 1/30/18, indicated Resident D was severely cognitively impaired. Resident D required extensive assistance with 2 person assistance for bed mobility, transfers, walking, dressing and hygiene. Resident D used a wheelchair as his mobility device. A current health care plan, dated 1/22/18, indicated Resident D exhibited wandering behaviors. Interventions included, but were not limited to, provide a magazine or book, walk the facility with the resident or join an activity. Review of the staff schedule for 1/30/18, LPN 7 was assigned to the North Hall from 2:00 p.m. until 6:00 a.m. on 1/31/18. During review of the video surveillance of January 31, 2018 starting at 2:06 a.m., along with the Administrator, Director of Nursing and Corporate Nurse, the following was noted: At 3:05 a.m., CNA 2 was seen walking around Resident D as the resident sat in a Broda chair (reclining chair on wheels). At 3:51 a.m., Laundry Aid 10 was seen in the video with her laundry carts near Resident D while he was seated in the Broda chair, leaned back. No other staff person was present. At 4:44 a.m., LPN 3 was seen bringing another resident in a Broda chair to be weighed. She moved Resident D out of the way, then pushed the other resident to be weighed and then left.		in-serviced on abuse and reporting. CNA 10 employment has been terminated. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Other residents with a BIMS of 8 or greater have been interviewed using an Abuse questionnaire. Families of non-interviewable residents have been interviewed using an Abuse questionnaire. Staff members who work at the facility have been interviewed by corporate staff regarding abuse. Any new allegations of abuse were reported to the Administrator and the ISDH immediately. **III. The facility will put into place the following systemic changes to ensure that the deficient practice does not**	

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	At 5:29 a.m., CNA 8 walked by Resident D, picked up his sheet that was on the floor and tossed it back over the resident. At 5:30 a.m., CNA 11 walked past Resident D to place her items at the nurses' station. Review of an Indiana State Department of Health reportable, dated 1/31/18 at 8:40 a.m., indicated Resident D was placed in a "geri chair in a reclined position. A staff member was concerned the resident would not be able to get up on his own." The report indicated the incident was immediately reported to the Administrator. LPN 7 was suspended pending an investigation. Although this incident started at 2:06 am, no one reported it to the Administrator until the LPN 4 arrived to work on day shift. Review of the facility investigation, a statement, dated 2/1/18, by CNA 10, indicated she was told by LPN 7 to get a Broda chair from another hall. She asked the nurse if a resident needed an order and the nurse stated "It doesn't matter, he won't stay still." CNA 10 went to find a Broda chair on another hall and when she returned, LPN 7 had already retrieved one. CNA 10 indicated she did help remove Resident D into the Broda chair because she did not want LPN 7 to transfer him herself. A statement provided by CNA 8, dated 2/1/18, indicated when she arrived, she noticed Resident D seated in a Broda chair. She indicated she picked up his gown and covered him up immediately. The statement indicated LPN 7 continued to say "You're going to want to keep him there." Another nurse directed CNA 8 to		**recur.** All staff members that work at Rawlins House received education immediately and prior to working any shifts related to directly and immediately reporting allegations of abuse to the Administrator, after ensuring resident safety, with detailed examples of what constitutes abuse. Staff members will be educated to follow the above protocol, without fear of retaliation, even if the abuser is a superior or manager. 3rd party vendors with direct patient care access that visit the property of Rawlins House will receive education related to directly and immediately reporting allegations of abuse to the Administrator with detailed examples of what constitutes abuse and how to report abuse prior to third party services being provided to Rawlins House residents.	

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	removed Resident D and move him into his wheelchair. A statement by CNA 9, dated 2/1/18, indicated she arrived at the facility at 6:00 a.m. She indicated Resident D had a gown on the floor beside him. He was seated in a Broda chair and it had been leaned back. She asked LPN 7 why Resident D was in the Broda chair and LPN 7 stated "He was too much last night." She indicated the other unit came to the North Hall unit looking for the Broda chair. A statement by LPN 4, indicated when he arrived to work, he saw Resident D "lying back in the broda" and asked LPN 7 what he was doing there. LPN 7 indicated "I couldn't do anything with him, so I put him there to keep him off the floor." LPN 4 stated to LPN 7 that she could not really just put him there and LPN 7 stated "well I did." An employee communication form, dated 2/2/18, indicated LPN 7 was terminated for "Failure to ensure resident safety, sleeping on clock on unit." On 2/20/18 at 10:27 a.m., LPN 9 indicated when he arrived to work, Resident D only had a T-shirt on and no brief. The sheet was on the floor. He indicated Resident D was reclined in the chair. He instructed the aides to take him to his room, clean him up and put him in his wheelchair. During an interview on 2/21/18 at 9:48 a.m., the DON indicated LPN 7 told CNA 10 to go and get a Broda chair. CNA 10 did help transfer Resident D into the Broda chair. LPN 7 did not provide a written statement and although the DON had viewed the video surveillance, she was unable to provide the time Resident D was placed in the Broda chair.		The Administrator and DON received Corporate Directed training on CarDon's abuse reporting policy. The Administrator has since resigned and is no longer employed at the facility. An interim administrator with considerable experience in long term care is filling the role of the Administrator until a new Administrator is hired. Any new Administrator will receive thorough training by CarDon corporate staff on CarDon's abuse reporting policy. Administrator and staff educated on grievance process including follow up on grievances voiced by residents regarding medication administration or potential medication errors. Grievances voiced by a resident, family member or staff member will be immediately reported to the administrator who will delegate the appropriate steps and determine if the concern constitutes a reportable or a grievance. The grievance process directing staff to contact the administrator directly for each and every	

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	During an interview on 2/22/18 at 12:58 p.m., CNA 8 indicated she questioned where the Broda came from when she saw Resident D. She did not report the incident to the Administrator. On the surveillance video, CNA 8 was seen on the video at 5:28 a.m. tossing a sheet over the resident as he sat in the Broda chair. During a telephone interview on 2/22/18 at 11:49 a.m., LPN 3 indicated she did remember the night when Resident D was in the Broda chair. She was told her image was seen on the video moving Resident D to the side so she could weigh another resident. She was unfamiliar with the resident and if he was usually in a Broda chair or not. She did not report the incident to the Administrator. During a telephone interview on 2/22/18 at 3:22 p.m., LPN 7 indicated it was the CNA who suggested to put Resident D in the Broda chair. She had complained to management before that Resident D needed one on one observation because he would often wander into other resident rooms. LPN 7 indicated she would often put her head down because she had a headache. She occasionally documented that she had administered medication on her shift, but because she was busy, the day shift nurse would then give the medication. She gave no explanation as to why as the nurse in charge, she would allow Resident D to be placed in the Broda chair. 2. The clinical record for Resident J was reviewed on 2/20/18 at 9:26 a.m. Diagnoses included, but were not limited to, bacterial pneumonia, dysphagia, muscle weakness, hypertension and peripheral vascular disease. During an interview on 2/21/18 at 10:54 a.m.,		grievance/concern has been posted at each nurse's station, outside the social services office, and in the break room. **IV The facility will monitor the corrective action by implementing the following measures.** The Regional Director of Operations and Corporate Clinical Specialist will oversee all allegations of abuse to ensure immediate reporting is occurring by using a timeline for each occurrence daily and ongoing with no current end date. A third party consulting firm, Lacy Beyl, will review all allegations of abuse to ensure immediate reporting is occurring by using a timeline for each occurrence monthly ongoing with no current end date. The Administrator or designee interview any resident (or representative) who has alleged abuse or been alleged to have	

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	Resident J indicated she received two doses of her medications one night. She indicated she was unsure of the date, but stated the nurse brought her a second dose of crushed medications and told her to take it. The nurse was forceful, she was tearful and very scared. The medicine cup had her blood pressure medications in it. She told CNA 6 about the incident. An Admission Minimum Data Set (MDS) assessment, dated 1/19/18, indicated Resident J was cognitively intact. During an interview on 2/19/18 at 9:26 p.m., CNA 6 indicated she came to work at 10:00 p.m. on 1/30/2018 and worked until 1/31/18 at 6:00 a.m. During her shift, she saw LPN 7 coming out of Resident J's room. When she made her way back to Resident J's room, she was crying and said the nurse made her take her medications again. The resident said she told the nurse she had already taken them. The resident was afraid and did not want her to leave her. CNA 6 indicated she notified the charge nurse, LPN 5, that Resident J stated she had taken her medication twice. LPN 5 told her to report it. During a telephone interview on 2/20/18 at 11:41 a.m., LPN 5 indicated CNA 6 did tell her that Resident J supposedly took her medication twice. She did not go and assess the resident, but called the unit manger that evening at home. On 2/21/18 at 11:13 a.m., Unit Manager 4, DON, Administrator and Corporate Nurse were interviewed. The Corporate Nurse indicated she was told during the day by the therapist that the next door roommate to Resident J was heard saying Resident J received two doses of her		been abused to determine if their allegation was handled promptly. The Administrator, or designee, will interview 5 random staff members on various shifts weekly for 12 weeks, then monthly for 9 months to ensure they are aware of and understand the procedure for reporting abuse. Results of these audits and interviews will be reported to the QA committee monthly and ongoing frequency will be adjusted as needed if compliance is below 100%. **V. Plan of Correction completion date 03/19/18.** Facility Administrator will be responsible for ensuring compliance.	

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medication. She indicated they immediately assessed Resident J and spoke to CNA 6, who indicated she did not say anything to the next door roommate about Resident J.

On 2/21/18 at 12:31 p.m., the DON indicated she had spoken to LPN 5. LPN 5 went to the North Hall to get something and CNA 6 told her that LPN 7 gave Resident J two doses of medicine. She did not assess her and was unaware the resident was tearful. The DON indicated LPN 5 stated she did call Unit Manager 4 at home. She had interviewed Resident J. The resident denied saying she was scared or tearful, but did state the nurse "just stuck it in my mouth."

A current facility policy, dated October 2014 and revised August 2016, titled "Abuse Policy," provided by the DON on 2/20/18 at 8:50 a.m., indicated the following:
"It is the policy...to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion...."

...IV. IDENTIFYING & RECOGNIZING SIGNS AND SYMPTOMS OF ABUSE
Policy Statement
Our facility will not condone any form of resident abuse or neglect. To aid in abuse prevention, all personnel are to report any signs and symptoms of abuse/neglect to their supervisor immediately who will report to the Administrator or authorized designee immediately.

...VII. REPORTING ABUSE TO:
A. Administrator

Policy Statement
It is the responsibility of our employees...to

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	immediately report any incident or suspected incident of neglect or abuse...to the Administrator or Designee if the Administrator is unavailable. ..a. Abuse is defined as the willful infliction of injury; unreasonable confinement; intimidation; punishment with resulting physical harm; pain or mental anguish; or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. ...e. Involuntary seclusion is defined as separation of a resident from other residents or from his or her room..." The Immediate Jeopardy (IJ) that began on 1/31/18 was removed on 2/22/18 when interviews with staff confirmed the facility had begun inservicing staff on abuse, restraints and the reporting process. The noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all employees had not been inserviced. This Federal tag relates to Complaint IN00250160. 3.1-28(c)			
F 0610 SS=K Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.			

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	§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 thoroughly investigate allegations of abuse by a staff member (Resident D). This deficient practice allowed Resident D to remain restrained and uncovered for approximately 4 hours. This deficient practice had the potential to affect 56 residents who lived on the North Hall of 86 who resided in the facility. The immediate jeopardy began on 1/31/18 when staff reported allegations of abuse and the facility failed to thoroughly investigate the allegations. The Administrator was notified of the immediate jeopardy on 2/21/18 at 1:20 p.m. Findings include: 1. The clinical record for D was reviewed on 2/19/18 at 5:38 p.m. Diagnoses included, but were not limited to, dementia with behaviors, Alzheimer's disease, chronic kidney disease, dysphagia, and anemia. Resident D was admitted to the facility on 1/18/18. A 14-day Minimum Data Set (MDS) assessment, dated 1/30/18, indicated Resident D was severely cognitively impaired. Resident D required extensive assistance with 2 person assistance for bed mobility, transfers, walking, dressing and hygiene. Resident D used a wheelchair as his mobility device.	F 0610	F 610 We respectfully request a face to face IDR for this citation to present additional evidence for review. **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Resident D no longer resides in the facility. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents residing at Rawlins	03/19/2018

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	A current health care plan, dated 1/22/18, indicated Resident D exhibited wandering behaviors. Interventions included, but were not limited to, provide a magazine or book, walk the facility with the resident or join an activity. Review of the staff schedule for 1/30/18, LPN 7 was assigned to the North Hall from 2:00 p.m. until 6:00 a.m. on 1/31/18. Review of an Indiana State Department of Health reportable, dated 1/31/18 at 8:40 a.m., indicated Resident D was placed in a "geri chair in a reclined position. A staff member was concerned the resident would not be able to get up on his own." The report stated the incident was immediately reported to the Administrator. LPN 7 was suspended pending an investigation. Review of the facility investigation, a statement, dated 2/1/18, by CNA 10, indicated she was told by LPN 7 to get a Broda chair (reclining chair on wheels) from another hall. She asked the nurse if a resident needed an order and the nurse stated "It doesn't matter, he won't stay still." CNA 10 went to find a Broda chair on another hall and when she returned, LPN 7 had already retrieved one. CNA 10 indicated she did help remove Resident D into the Broda chair because she did not want LPN 7 to transfer him herself. During review of the video surveillance of January 31, 2018 starting at 2:06 a.m., along with the Administrator, Director of Nursing and Corporate Nurse, several staff member were seen in the video during the time Resident D was in the Broda chair. The following was observed: At 2:06 a.m., Resided D was seen sitting in his		House have the potential to be affected by the alleged deficient practice. The facility grievance logs and other reportables for the past 30 days have been reviewed and missing items added if available. **III. The facility will put into place the following systemic changes to ensure that the deficient practice does not recur.** The Administrator and DON received Corporate Directed training on CarDon's abuse policy and the structural components of a complete investigation. The Administrator and DON were provided with a copy of the investigative checklist, which guides them to complete a full investigation of abuse allegations and were instructed how to complete the checklist with each and every abuse allegation. . For each abuse allegation, the Administrator will scan a copy of the complete investigative file including the completed checklist to the Regional Director of Operations, Director of Clinical	

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	wheelchair at the nurses' station. At 2:08 a.m., CNA 10 brought a Broda chair to the North Hall. At 2:32 a.m., Resident D was moved from his wheelchair into the Broda chair by CNA 10 and LPN 7. CNA 10 reclines the Broda chair completely back and placed a sheet over him. At 3:05 a.m., CNA 2 was seen walking around Resident D. At 3:51 a.m., Laundry 16 was seen in the video with her laundry carts near Resident D while he was seated in the Broda chair, leaned back. No other staff person was present. At 4:44 a.m., LPN 3 was seen bringing another resident in a Broda chair to be weighed. She moved Resident D out of the way, then pushed the other resident to the scales to weigh and left. At 4:46 a.m., CNA 10 removed Resident D's brief while he was tilted back in the Broda chair. At 5:05 a.m., Resident D appeared to only have socks on his feet and no other clothing item. Resident D remained at the nurses' station. At 5:29 a.m., CNA 8 walked by Resident D, picked up his sheet that was on the floor and tossed it back over the resident. At 5:30 a.m., CNA 9 walked past Resident D to place her items at the nurses' station. At 5:55 a.m., CNA 10 and CNA 8 removed Resident D from the view of the video and he returned at 6:03 a.m. wearing a shirt and jeans. At		Services, and the Clinical Specialist to ensure all necessary components are present. No employee suspended for an allegation of abuse will be returned without prior approval from the Regional Director of Operations. **IV The facility will monitor the corrective action by implementing the following measures.** A third party consulting firm, Lacy Beyl, will review all allegations of abuse monthly ongoing with no current end date to ensure a thorough investigation is completed. The Regional Director of Operations and Corporate Clinical Specialist will oversee all allegations of abuse daily or for each occurrence ongoing, including review of the investigative file with no current end date to ensure a thorough investigation is completed.	

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	6:05 a.m., Resident D was transferred from the Broda Chair to his wheelchair. An employee communication form, dated 2/2/18, indicated LPN 7 was terminated only for "Failure to ensure resident safety, sleeping on clock on unit." During an interview on 2/22/18 at 10:40 a.m., the Administrator and Director of Nursing were not aware of the three employees shown in the video. They were not aware the statement provided by CNA 10, which indicated she did not bring the Broda chair to the unit, did not match the video surveillance and that no statements were provided from CNA 2, LPN 3, Laundry Aid 10 related to the allegation. On 2/22/18 at 12:24 p.m., the Corporate Administrator indicated CNA 10 had been terminated today for her contributions to the abusive conduct A current facility policy, dated October 2014 and revised August 2016, titled "Abuse Policy," provided by the DON on 2/20/18 at 8:50 a.m., indicated the following: "It is the policy...to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion...." ...V. ABUSE INVESTIGATIONS Policy Statement All reports of resident abuse, neglect and injuries of an unknown source shall be immediately and thoroughly investigated by the facility management. 1. Should an incident or suspected incident of resident abuse...will notify the following persons		Results of these audits will be reported to the QA committee monthly and the need for additional training or monitoring will be adjusted as needed if compliance is below 100%. **V. Plan of Correction completion date 03/19/18.** Facility Administrator will be responsible for ensuring compliance.	

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	or agencies of such incident when applicable: a. The State licensing/certification agency.... ...7. Employees of this facility who have been accused of resident abuse will be suspended from duty...." The Immediate Jeopardy (IJ) that began on 1/31/18 was removed on 2/22/18 when interviews with staff confirmed the facility had begun inservicing staff on abuse, restraints and the reporting process. The noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all employees had not been inserviced. This Federal tag relates to Complaint IN00250160. 3.1-28(d)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on, interview and record review, the facility failed to ensure residents who were dependent on staff for toileting, received those services for 2 of 6 residents reviewed for Activities of Daily Living (ADL) assistance (Resident D and Resident G). Findings include: 1. The clinical record for D was reviewed on 2/19/18 at 5:38 p.m. Diagnoses included, but were not limited to, dementia with behaviors, Alzheimer's disease, chronic kidney disease,	F 0677	**F 677** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**	03/19/2018

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	dysphagia, and anemia. Resident D was admitted to the facility on 1/18/18. A 14-day Minimum Data Set (MDS) assessment, dated 1/30/18, indicated Resident D was severely cognitively impaired. Resident D required extensive assistance with two person assistance for bed mobility, transfers, walking, dressing and hygiene. A current health care plan, dated 1/28/18, indicated Resident D was unable to perform late loss Activities of Daily Living (ADL) related to weakness and debility. He required two person assistance with transfers and toileting. Interventions included, but were not limited to, provide incontinence care after being toileted. During review of the video surveillance of January 31, 2018 starting at 2:06 a.m., along with the Administrator, Director of Nursing (DON) and Corporate Nurse, Resided D was seen sitting in a Broda chair (reclining wheel chair on wheels) from 2:06 a.m. through 6:05 a.m., Resident D was not toileted and a new brief was not placed on Resident B. Review of Resident D's ADL charting, CNA 10 did not document any care provided after 1:03 a.m. on 1/31/18. 2. The clinical record for Resident G was reviewed on 2/20/18 at 8:40 a.m. Diagnoses included, but were not limited to, orthopedic aftercare, pain in right leg, pulmonary heart disease, anxiety and insomnia. An 14-day Minimum Data Set (MDS) assessment, dated 1/24/18, indicated Resident G was cognitively intact. A current health care plan, dated 1/19/18,		Resident D no longer resides at the facility. Resident G is receiving assistance with toileting. CNA 10 employment has been terminated. LPN 7 employment has been terminated. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Other residents residing at Rawlins House who are dependent on staff for toileting have the potential to be affected by the alleged deficient practice, ADL scores, care plans and assignment sheets are being reviewed to identify residents who are dependent on staff for toileting to ensure the staff are aware of toileting needs and are providing the assistance needed.	

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	indicated Resident G was unable to perform late loss ADL's related to weakness and debility. She required extensive assistance with one person assistance for toileting. Another health care plan, dated 1/14/18, indicated Resident D was a fall risk. Interventions included, but were not limited to, assist with ADL's as needed to meet needs. During an interview on 2/19/18 at 6:25 p.m., Resident G indicated she had to wait 90 minutes one night for her call light to be answered and urinated in her brief about two or three weeks ago. One nurse, LPN 7, would not help answer call lights. The resident indicated she would occasionally take herself to the bathroom, but was not supposed to. She did complain to the DON and was told the nurse was no longer employed at the facility. A current facility policy, dated January 1, 2018, titled "ACTIVITIES OF DAILY LIVING...," provided by the DON on 2/23/18 at 2:24 p.m., indicated the following: "...POLICY The interdisciplinary management team must take reasonable steps to ensure the accurate daily documentation of ADLs by facility nursing staff. Due to the need for accuracy in ADL documentation and coding as it relates to care planning and reimbursement, adherence to this policy is essential." 3.1-38(a)(2)(C)		**III. The facility will put into place the following systemic changes to ensure that the deficient practice does not recur.** Nursing staff will be educated on providing assistance to residents who are dependent on staff for toileting. Staff will be educated regarding promptly responding to call lights. Newly hired staff members will be educated regarding providing assistance to residents who are dependent on staff for toileting as well as promptly responding to call lights and the staff member will be randomly observed to ensure competence. **IV The facility will monitor the corrective action by implementing the following measures.** The DON or designee will interview 5 cognitively intact residents who are dependent on staff for toileting to ensure call lights are being responded to and assistance is	

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			being provided on various shifts. The DON or designee will observe 5 cognitively impaired residents who are dependent on staff for toileting to ensure toileting assistance is being provided on various shifts. This audit will occur for 5 residents daily for 4 weeks, then 5 residents weekly for 8 weeks, then 5 residents monthly for 9 months for a total of 12 months of monitoring. Results of these observations and interviews will be reported to the QA committee monthly and ongoing frequency will be adjusted as needed if compliance is below 100%. **V. Plan of Correction completion date 03/19/18.** Facility Administrator will be responsible for ensuring compliance.	
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services			

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	The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.			
	Based on record review and interview, the facility failed to follow physician orders for medication administration for 2 of 6 residents reviewed for physician's orders. (Resident D, Resident G) Findings include: 1. The clinical record for Resident D was reviewed	F 0726	**F726** **I. The corrective actions to be accomplished for those residents found to have**	03/19/2018

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	on 2/19/18 at 5:38 p.m. Diagnoses included, but were not limited to, dementia with behaviors, Alzheimer's disease, chronic kidney disease, dysphagia, and anemia. Resident D was admitted to the facility on 1/18/18. A 14-day Minimum Data Set (MDS) assessment, dated 1/30/18, indicated Resident D was severely cognitively impaired. He required extensive assistance with two person assistance for bed mobility, transfers, walking, dressing and hygiene. The resident used a wheelchair as his mobility device. Review of Resident D's physician orders, provided by the Director of Nursing on 2/23/18 at 2:34 p.m., indicated an order for levothryroxine (thyroid hormone) 75 mcg to be given one time daily from 5:00 a.m. through 6:00 a.m. During review of the video surveillance of January 31, 2018 starting at 2:06 a.m., along with the Administrator, Director of Nursing and Corporate Nurse, Resided D was seated at the nurses station and remained there until 5:55 a.m., when CNA 10 and CNA 8 removed Resident D from the view of the video and he returned at 6:03 a.m. wearing a shirt and jeans. Review of the Medication Administration Record, LPN 7 charted she administered levothryroxine to Resident D between 5:00 a.m. and 6:00 a.m. on 1/31/18. The video did not show LPN 7 administer any medication to Resident D. 2. The clinical record for Resident G was reviewed on 2/20/18 at 8:40 a.m. Diagnoses included, but were not limited to, orthopedic aftercare, pain in right leg, pulmonary heart disease, anxiety and insomnia. An 14-day Minimum Data Set (MDS)		**been affected by the deficient practice.** Resident D no longer resides in the facility. Resident G is receiving medication per MD order and received psychosocial support with no negative outcomes. LPN 7 employment has been terminated. Med error report completed with MD notification for Resident G and Resident D. No negative outcomes noted for Resident D or Resident G. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Other residents are residing at Rawlins House have the potential to be affected by the alleged deficient practice. The medication administration report for the last 30 days is being reviewed for	

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	assessment, dated 1/24/18, indicated Resident G was cognitively intact. During an interview on 2/19/18 at 6:25 p.m., Resident G indicated LPN 7 gave her Ambien (hypnotic medication) at 4:00 p.m. She was supposed to get the medication in the evening. LPN 7 was always gave medication way too early. Confidential interviews for staff working 2/19/18 through 2/23/18 were completed. Employee 1 indicated LPN 7 was the worst nurse ever by being mean and rude to the residents and would refuse to give them their medication. Employee 2 indicated LPN 7 would pre-pull medication and then tell residents it was not their medication. The Administrator and Director of Nursing (DON) were aware of the concerns with LPN 7. He/She thought the nurses' were passing along the information, but felt it stopped with the Administrator and Director of Nursing (DON). Employee 3 indicated LPN 7 did not treat residents in a "good way" by not giving them their pain medicine. He/She thought management was aware that LPN 7 was abusive. He/She indicated staff often refused to work with LPN 7. Employee 4 indicated he/she often heard complaints of LPN 7 not giving residents their pain medication. Employee 6 indicated he/she heard a lot of complaints about LPN 7 withholding pain medication. LPN 7 should have been gone a long time ago. He/She heard LPN 7 say "if they are going to laugh and joke with me, I am not giving them their pain medicine."		administration per MD order. Medication error reports will be completed for any concerns noted. **III. The facility will put into place the following systemic changes to ensure that the deficient practice does not recur.** Licensed nurses and Qualified Medication Aids will be educated on medication administration per physicians order including, but not limited to, documentation of medication administration at time of administration, administering medication within time frame per physician order and not presetting medications. **IV The facility will monitor the corrective action by implementing the following measures.**	

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	During an interview on 2/22/18 at 10:40 a.m., when questioned, the Administrator and Director of Nursing were not aware LPN 7 did not administer any medication from 2:06 a.m. until she left at 6:22 a.m. During a telephone interview on 2/22/18 at 3:22 p.m., LPN 7 indicated she would sometimes chart that she administered the medication, but because she was busy through the night, the day shift nurse actually gave the medication. She provided no other explanation as to why she was not seen administering any medication from 2:06 a.m. until she left at 6:22 a.m on 1/31/18. A current, undated, facility policy, titled "Licensed Nurse Med Pass Clinical Skills Validation," provided by the DON on 2/21/18 at 4:10 p.m., indicated the following: "...5. Bring medication cart to an area adjacent to resident room. ...29. Medication was given within the 60 minutes before or after the time designated unless otherwise directed by the physician." This Federal tag relates to Complaint IN00250160 and IN00255183. 3.1-17(a)		The DON or designee will observe medication administration for 5 residents on various shifts to ensure medications are being administered per physicians' order, at the correct time, medications are not pre-set, and the documentation of medication administration is occurring at the time of administrations daily for 4 weeks, then 5 residents weekly for 8 weeks, then 5 residents monthly for 9 months for a total of 12 months of monitoring. Results of these audits will be reported to the QA committee monthly and ongoing frequency will be adjusted as need if compliance is below 100%. **V. Plan of Correction completion date 03/19/18** Facility Administrator will be responsible for ensuring compliance.	

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F 9999 Bldg. 00	410 IAC 16.2-3.1-14 Personnel: (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. Based on record review and interview, the facility failed to a ensure the required annual three hour dementia training was complete for 3 of 5 employee records reviewed. (LPN 7, CNA 8 and CNA 10) Findings include: Review of Employee records began on 2/20/18 at 2:10 p.m. The following noncompliance was found: LPN 7 had a hire date of 12/7/16. Her employment record did not indicate completion of dementia training for 2017. LPN 7 worked a total of 233 hours in January. CNA 8 had a hire date of 7/12/17. Her employment record did not indicate completion of dementia training for 2017. CNA 8 worked a total of 72 hours in January.	F 9999	**F9999** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** LPN 7 employment has been terminated. CNA 10 employment has been terminated. CNA 8 has completed the required annual three hour dementia training. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Other residents residing at Rawlins House with a	03/19/2018

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	CNA 10 had a hire date of 7/18/16. Her employment record did not indicate completion of dementia training for 2017. CNA 10 worked a total of 83 hours in January. On 2/22/18 at 12:31 p.m., the Director of Nursing indicated LPN 7 would normally work on the North Hall or Center Hall. She would rarely work on the South Hall or Memory Unit. During an interview on 2/23/18 at 9:36 a.m., Human Resource 15 indicated staff get paid to do their required in-services. The computer will flag when a task is due. She has a staff list and a list of tasks that were due. There is no good way to run a report, she just has to look at each employee. She inherited a mess when she was hire in last May. Review of a policy, "ISDH Educational Requirements," provided by the Corporate Nurse on 2/23/18 at 2:34 p.m., indicated the following: ...(u) In addition to the required inservice...dementia-specific training...and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents...."		diagnosis of dementia have the potential to be affected by the alleged deficient practice. Audit completed of all staff members to ensure annual three hour dementia training is completed. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Human resources director will provide list of staff members due for with annual three hour dementia training due to the administrator. Staff members will be educated regarding dementia training requirement and provided an opportunity to complete training. **IV The facility will monitor the corrective action by implementing the following measures.**	

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			Administrator or designee will audit the completion of annual dementia training weekly for 12 weeks then monthly for 9 months. Results of these audits will be reported to the QA committee monthly and ongoing frequency will be adjusted as need if compliance is below 100%. **V. Plan of Correction completion date 03/19/18** Facility Administrator will be responsible for ensuring compliance.	