STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155490	A. BUILDING 00 B. WING	01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMBASSADOR HEALTHCARE	705 E MAIN ST CENTERVILLE, IN 47330

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00251671 Complaint IN00251671 -- Substantiated. Federal/state deficiency related to the allegations is cited at F600. Survey dates: January 30 and 31, 2018 Facility number: 000456 Provider number: 155490 AIM number: 100288750 Census bed type: SNF/NF: 118 Total: 118 Census payor type: Medicare: 9 Medicaid: 91 Other: 18 Total: 118 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 7, 2018	F 0000		
F 0600 SS=D 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,			

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

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	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 observation, interview and record review, the facility failed to prevent physical and mental abuse of a cognitively impaired resident as witnessed and reported by a staff member of another staff member spraying an aerosol into the resident's face, placing a blanket over the resident's head, holding the blanket in place and striking the resident on the face for 1 of 3 residents reviewed for abuse. (Resident B) Findings include: In an interview with CNA 4 on 1-30-18 at 6:16 a.m., she indicated on 1-19-18, at approximately 5:50 a.m., she and CNA 6 entered the room of Resident B. CNA 4 asked CNA 6 what was wrong with his eyes, as his eyes appeared "red-rimmed and swollen, with the whites of his eyes pink, watery and swollen." Resident B was awake. CNA 4 indicated CNA 6 "said she had sprayed him in the face with deodorant and covered his face with his blankets [earlier]. She then pulled the blankets over his face and then put her hand over the blankets and his face, to hold them there. I then uncovered his face. We then proceeded to get him ready for the day, made sure he was dry and clean, then assisted each other to transfer him into the wheelchair. He has involuntary tremoring of his tongue and lips. She then reached over and flicked his lip and it was hard enough to make a popping sound. I told her 'no, [name of CNA 6],	F 0600	F 600 FREE FROM ABUSE, NEGLECT, AND EXPLOITATION I. Resident B was treated twice with saline wash to the eyes. Social services checked on Resident B's well-being with no concerns. Resident B was seen by his family physician, the facility psychiatrist, and the eye doctor without any concerns or ill-effects from incident. II. Current residents residing at the facility were interviewed and/or observed by the Director of Nurses to ensure that all other residents are being treated appropriately. III. A systematic change includes training for	03/02/2018

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	don't do that." She then did it again and I told her not to do it again. As we continued to get him ready, she reached over and grabbed the spray deodorant and sprayed him on the right side of the lip of a single squirt. I told her, [name of CNA 6], don't, again. She told [name of Resident B] to stop, kind of bluntly and harsh tone when his lip started tremoring. As soon as I could, I got him out into the dining room and away from [name of CNA 6]. I had to wait until all of third shift left and for my Unit Manager to come on duty to report this. I didn't want it to get out and spread, before the proper authorities to arrive. Was worried it would not be reported to the right people. He instantly went to check on [name of Resident B], then directly reported to the Director of Nursing [DON]. I couldn't report to the Executive Director or DON immediately, because they had not arrived." CNA 4 indicated Resident B periodically will put a sheet or blanket over his face. "When we entered the room, [name of Resident B] was awake and he had nothing over his face. He did not say anything, just kind of flinched a little bit when she flicked his lip. This was about his normal. He has fairly advanced dementia. Generally, he seems to be a pretty happy person." She explained she left the facility on 1-19-18, at approximately 8:00 p.m., and noted "his eyes were still red-rimmed and puffy and the whites of his eyes were still pink." She noted when she returned to work on 1-22-18, his eyes appeared to "normal looking." CNA 4 indicated an inservice regarding abuse, abuse prevention and resident rights had been conducted on the day before this, on 1-18-18. In an interview with LPN 5 on 1-30-18 at 7:30 a.m., he indicated he received the report of abuse		all employees to be completed upon hire and yearly. This education includes using the CMS Hand in Hand 1 – 6 Modules on Dementia and Abuse. This education is intended to emphasize person centered care in the care of persons with dementia and the prevention of abuse. In addition, monthly education and training will be provided to all staff using the 12 Facilitator Instructional Modules on Adult Abuse and Neglect Prevention Training Program. This training will include 1 module per month for a full year of training on prevention of abuse and neglect. The facility initiated re-in-servicing all nursing staff on 2/1/18 on abuse and neglect and the consequences of such actions. The local ombudsman, Paul Register, also held an in-service on abuse and resident rights on 2/15/18. IV. Social Services/designee will	

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	allegation on Resident B on 1-19-18, around 6:30 a.m., from CNA 4. "She said she had not reported this earlier, because she was concerned that the third shift staff were all friends and was worried that they might not take care of the situation or even if they were aware of the situation. I assessed him immediately. Saw his eyes were red, which his eyes are sometimes red, not sure if it was worse than usual. Before I assessed him, I reported to the DON first...As the day progressed, I did not notice any change in his eyes, as far as redness or swelling. We have had some problems with his eyes, because he has had a colostomy and has gotten feces on his hands and will rub his eyes." LPN 5 indicated he washed Resident B's eyes with water and a wet washcloth prior to the attending physician being notified and that another nurse assisted him by notifying the attending physician. LPN 5 indicated Resident B "can be a challenge to take care of. Day and night, he will try to crawl out of bed, so we will get him up and within moments, he will want back to bed. When he is up, he will continually mess with his seat belt alarm and it will go off. Never known him to put a blanket over his head." LPN 5 indicated CNA 6 had worked at the facility for about one year. "From my experience, [name of CNA 6] talks loud, has had some issues with work ethic, it could be better. I would certainly trust [name of CNA 4] for her honesty. [I had] No prior concerns for abuse with [name of CNA 6]." An interview was conducted with CNA 6 on 1-30-18 at 10:22 a.m. She indicated she has been a CNA for 4 years, and has only worked at this facility since becoming a CNA, working off and on on the secured dementia unit. CNA 6 indicated, "For starters, things were not		interview each resident based on their MDS schedule. This interview will include a specific questionnaire relating to psychosocial wellbeing and treatment. The interview questionnaire is completed with any areas of concern being brought to the attention of the administrator/DON for follow up immediately. V. The results of these audits will be discussed at the facility Quality Assurance Performance Improvement meeting and frequency and duration of reviews will be adjusted as needed. Completion Date: March 2, 2018	

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	like I was accused of. I had gone into [Resident B's] room around midnight to get him cleaned up. His colostomy bag broke and was a mess and smelled really bad. So, after I got done cleaning him up, I did what a lot of us aides have done and used his spray deodorant to spray around his chest and colostomy area to help with the smell. The other aide said I had told her I had sprayed deodorant in his face and covered up his face when I had gone in for bed check during the night. I never told her any of that and I didn't do it. I was able to tell my side of the story to the Administrator and the DON later that same day. I was suspended at that point and they let me go yesterday. While I was suspended, I wasn't allowed back in the building...It was pretty normal, nearly every night, for him to sleep with the blanket or sheet over his face. Most days, he can't remember much of anything. He's not able to speak very good, because he has this thing where he pushes his tongue out, kind of like a tremor. And, he usually will start to rub his eyes every morning when he starts to wake up and this makes them red. He has a history of trying to climb out of bed when he is in bed and starting to wake up." A written note by CNA 6, dated 1-19-18, indicated, "I went into [name of Resident B's] room with other CNA this morning to help get him up before I left because he was climbing out of bed. I told her that his eyes have been red all night before and after I changed and clean him up. I told her I sprayed his deodrant [sic] on him than [sic] covered him back up and he was climbing out of bed all night. I helped get him into his chair than [sic] sprayed deodrant [sic] onto his new clothes after getting him up." In an interview on 1-30-18 at 5:55 a.m., with the DON, she indicated, "[An officer from] The police			

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	department came in that morning and took pictures and then came back 4 or 5 days later for more pictures. The officer said his eyes certainly looked much better when he came back for more pictures. The morning this all was reported, his eyes were red and swollen. From what I understand, he has a history of rubbing his eyes of a morning and them being a little red, but that resolves pretty quick. That morning, his eyes were very red and swollen and not like someone who had rubbed their eyes." In an interview on 1-30-18 at 4:55 a.m., with LPN 2, she indicated she was on duty on the morning there was an allegation of abuse regarding Resident B. "It was not reported to me. A dayshift aide had gone into his room to provide care with one of the nightshift aides. The dayshift aide, from what I was told, reported to the Unit Manager around 6:30 a.m. that the nightshift aide had abused the resident. Apparently, it happened between 5:50 a.m. and 6:00 a.m. She said she didn't feel comfortable reporting it to me, because she felt the nightshift staff were kind of a clique and was afraid it wouldn't be dealt with. I was here that morning till close to 6:30 a.m." In a continued interview with LPN 2 at 1-30-18 at 5:38 a.m., she indicated she "never had any encounters with [name of CNA 6] that made me think there were ever any problems. Never heard or seen her be rough with residents or heard her speak roughly. Some of the residents will say they don't like her waking them up to get checked and changed, mostly because she tends to be almost too happy and some people don't like that in the middle of the night. The whole thing was very shocking to me. That morning, around 5:00 a.m., [name of CNA 6]			

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	had asked me to check [name of Resident B's] eyes because they looked red to her. When I looked at his eyes, they were red, but not swollen. Most mornings, he tends to rub his eyes, sometimes until after breakfast, and they were looking normal for him. They were red, but not swollen. She told me the resident had a mess with his colostomy and it smelled awful. She said she sprayed him with the deodorant [while pointing to mid-abdominal area and up to nipple area]. I've even done that myself. I'm sure because of the mist of the spray, it might have drifted towards his face. Then, from what I was told, less than an hour later, all this supposedly happened. I heard the dayshift aide ask [name of CNA 6] if she could help her get him up and nothing was ever said to me about anything. [Name of CNA 6] left around her normal time...I feel awful that the dayshift aide didn't feel comfortable enough to report anything to me. From what the ADON [Assistant Director of Nursing] said, she [dayshift aide] felt like we, [the nightshift staff], were kind of a clique and was afraid nothing would be done if she reported this to me....He does have a history of occasionally sleeping with his sheet or blanket over his face." In an interview with CNA 3 on 1-30-18 at 5:02 a.m., she indicated she was working the early morning of 1-19-18, when there was an issue with Resident B, but did not work with him that shift. "He requires total care due to advanced dementia. He has a colostomy. If he has lots of gas or the bag breaks open, it can be very strong, foul smelling. Usually he sleeps most of the night, generally fairly quiet...I've worked with [name of CNA 6] quite a bit and never saw anything that ever made me think she might be abusive. If I had noticed anything, you can bet I would have said something to her and reported it. Last inservice			

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	on abuse had been done either that night or the night before of a handout with a post test." An observation of Resident B was conducted on 1-30-18 at 5:28 a.m. His eyes appeared clear with no redness or edema. An interview was attempted at this time with Resident B. His speech was garbled and not understandable. However, he maintains good eye contact and smiled throughout the attempted interview. Another observation was conducted on 1-31-18 at 9:15 a.m. Resident B was lying in bed, holding onto a sheet and bedspread, pulled over head. The employee record of CNA 6 was reviewed on 1-31-18 at 3:08 p.m. It indicated she began employment with the facility on 2-1-13. It indicated her most recent abuse and resident rights education occurred on 1-18-18, and most recent dementia training of 3 hours occurred on 12-31-17. In addition to the written suspension, effective 1-19-18, and subsequent termination, effective 1-29-18, CNA 6 had one other unsubstantiated allegation of neglect in November, 2017, for the past year. The clinical record of Resident B was reviewed on 1-30-18 at 7:01 a.m. It indicated he has resided on a secured dementia unit since admission over 4 years ago. His diagnoses included, but were not limited to, dementia with behaviors, Alzheimer's disease, diabetes, obsessive compulsive disorder, pseudobulbar affect, colon cancer with colostomy, generalized muscle weakness and anxiety. His most recent Minimum Data Set assessment, dated 12-23-17, indicated he is severely cognitively impaired, with unclear speech, and sometimes can understand and sometimes can be understood. He has a colostomy and is always incontinent of urine,			

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	requiring extensive assistance of 2 or more persons with toileting. The most recent attending physician note, dated 1-24-18, indicated the resident had a recent event in which deodorant had gotten into his eyes, but was resolved. On 1-30-18 at 9:56 a.m., the Executive Director provided a copy of a policy entitled, "Abuse Prevention Policy," which has a revision date of August, 2006, and was identified as the current policy utilized by the facility. This policy indicated "Our residents have the right to be free from abuse, neglect..." This Federal tag relates to Complaint IN00251671. 3.1-27(1)(a)			