STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE HEALTH CARE FACILITY	337 GRACE VILLAGE DR WINONA LAKE, IN 46590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for the Investigation of a Complaint #IN00137739. Complaint #IN00137739 - Substantiated - Federal/State findings are cited at F225 and F226. Survey Dates: October 10 & 11, 2013 Facility Number: 000501 Provider Number: 155635 AIM Number: 100266260 Survey Team: Debora Kammeyer, RN-TC Lora Swanson, RN Julie Wagoner, RN Census Bed Type SNF: 15 SNF/NF: 71 Residential: 44 Total: 130 Census Payor Type Medicare: 20 Medicaid: 42 Private: 68 Other: 0 Total: 130 Sample: 3	F000000	Submission and implementation of this plan of correction shall not constitute an admission by Grace Village Health Care to any allegations of deficiency as stated in the "Summary Statement of Deficiencies" or an agreement with any conclusions therein. Rather, this plan of correction is submitted in accordance with State and Federal requirements.	

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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 reflect state findings cited in accordance with 410 IAC 16.2. Quality Review completed on October 21, by Brenda Meredith, R.N.			

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	155635	A. BUILDING 00 B. WING	10/11/2013

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F000225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further 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	F000225	Grace Village is disputing the	11/10/2013

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	interviews, the facility failed to report and thoroughly investigate an allegation of abuse in 1 of 2 allegations reviewed for abuse. (Resident #C) Finding includes: During an interview on 10-11-13 at 9:25 A.M., Resident #C indicated a CNA #2 entered the room on 10-1-13 around 2 A.M. and said "What do you want". Resident #C asked for pajama bottoms, underwear, and a pad, as she had experience an incontinence episode. CNA #2 returned to the Resident's room and "tossed" the items from the bathroom door to the resident while she was in the restroom. He then turned and left the room. During an interview on 10-1-13 at 10:20 A.M., Employee #1 indicated the resident had mentioned to her about CNA #2 "throwing" items at her. Employee #1 could not give a time of the day that the allegation was revealed to her; however, she indicated she wrote an email to the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON) that evening. On 10-1-13 at 10:30 A.M., review of		citation of F225 according to the IDR process.CORRECTIVE ACTIONS TAKEN: Resident C was admitted on 9/30/13 and discharged to her Independent Living apartment the following afternoon. Administration has conducted a thorough investigation into the complaint lodged by Resident C. OTHER RESIDENTS POTENTIALLY AFFECTED: Cognitive residents on the same hall have been interviewed by the social service designee as to any concerns regarding treatment by facility staff. All twelve of those residents expressed that they were happy with the care and assistance they receive in the facility and that they have never felt afraid because of the way they or another resident had been treated. MEASURES IMPLEMENTED TO PREVENT REOCCURENCE: The facility policy on prevention of abuse has been reviewed and has been determined to adequately address all regulatory requirements. Direct care and administrative staff will be given an additional in-service on abuse prevention policy and procedure. All newly hired staff are in-serviced on the abuse prevention policy during their orientation and all staff are required to participate in an annual in-service on abuse prevention. Any agency staff used by the facility are required to	

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	an email dated 10-1-13 at 7:07 P.M., indicated that Employee #1 had sent an email to the Administrator, DON, and ADON, to inform them of the allegation regarding CNA #2. On 10-1-13 at 1:30 P.M., a review of CNA #2's schedule indicated the CNA worked the night shift on 9/3, 10/1, 10/2 and 10/3/13. An interview on 10-1-13 at 2:30 P.M., with the DON indicated she talked with CNA #2 on the morning of 10/3/13. She discussed with him the allegation of throwing items to Resident #C; however, he indicated that he didn't work that hallway. No further investigation was completed after his statement. Review of the facility policy and procedure, titled "Abuse Policy and Orientation" undated, but indicated as current on 10/11/13, included the following: "...2. Should an occurrence of abusive behavior be reported or witnessed, the Administrator, CEO (Chief Executive Officer), DON (Director of Nursing) (if a Health Care or Assisted Living resident) and Director of Human Resources shall be notified immediately. 3. Appropriate documentation should be completed		attend training (including the abuse prevention policy) with the Staff Education Coordinator before they are allowed to work a shift. MONITORING: The DNS, or her designee, will review the in-servicing logs and orientation documentation weekly for thirty days and then monthly for a minimum of six months to ensure that all the aforementioned staff have participated in the abuse prevention training. The facility administrator will review any alleged abuse investigations conducted to ensure that the investigation procedure has been followed according to policy. The QA Committee will review the results of this monitoring. If there are any instances of the abuse prevention policy not being followed, the QA Committee will determine if any other systemic measures are necessary and the monitoring will continue. The QA Committee will only allow the routine monitoring to be discontinued when at least a six month period with no instances of non-compliance has been demonstrated. IDR SUMMARY FOR F225: The State has erroneously concluded that a complaint voiced by Resident #C constituted an allegation of abuse and cited the facility for failure to report and investigate the complaint as such. Grace Village	

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	relative to the individual incident (i.e. report of concern, incident/accident report, etc.) 4. Should the incident be deemed an "unusual occurrence", the state survey and certification/licensure agencies shall be notified as well as the ombudsman and/or Adult Protective Services as applicable. 5. The alleged violation shall be thoroughly investigated by the Administrator or his/her designee. The investigation will include, but not be limited to, interviews with any and all staff who witnessed an alleged abusive situation, interviews with other staff working with the alleged abuser and interviews of interviewable residents. The facility must prevent further potential abuse while the investigation is in process. For example, an individual who has been alleged as exhibiting abusive behavior should not be permitted to continue to care for residents until an investigation has been completed and the allegation found to be unsubstantiated. An employee accused of any kind of abuse will be suspended from work without pay during an investigation of any alleged abuse cases. If the investigation results in an unsubstantiated case, the employee will be allowed to return to work and any missed wages for scheduled work will be paid. 6. The		Administration holds that the complaint was not an allegation of abuse according to the ISDH's own policy entitled "Reportable Unusual Occurrences", which is why it was not reported and investigated according to the facility's "Abuse" policy and procedure. The State defines abuse in that document as "…the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish." (See Attachment A) Neither the report that Resident #C gave to the Director of Social Services, SSD (Employee #1) nor the report she gave to the Surveyor who interviewed her indicates that the definition of abuse was met. (See the 2nd and 3rd paragraphs, page 3 of the CMS-2567 - Attachment B.) Our Director of Social Services is a resident advocate with 19 years of experience as an SSD. She knows this resident quite well as Resident #C has been a resident of the facility's Independent Living for many years and because Resident #C's mother also resided on the HC unit for about a year. When there is an actual allegation of abuse, Grace Village Administration does not hesitate to treat abuse as the serious matter that it is and adheres to the State's standards of reporting and investigating. Neither the SSD, nor the Director of Nursing,	

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	results of all investigations shall be reported to the state survey and certification/licensure agencies as well as other related agencies within five (5) working days of the incident and/or reporting of the incident...." This federal tag relates to complaint #IN00137739. 3.1-28(2)(c) 3.1-28(2)(d)		nor the Administrator believed the complaint to have been an allegation of abuse based upon the details provided by Resident #C and the SSD's understanding of what Resident #C meant when she said CNA #2 "threw" underwear and a pad "at" her. It was understood by the SSD and by Administration that she did not mean this literally. In the documentation of the interview with the Surveyor this very point is proven, as Resident #C herself used the terms "tossed" and "to" instead of "threw at" to describe the event in question. (See Attachment B – paragraph 2, page 3 of the CMS-2567) The complaints brought forth by Resident #C are certainly serious concerns in the eyes of facility Administration, but they are concerns of customer service, common courtesy and professionalism not of abuse. Administration has conducted a thorough investigation into Resident #C's complaints as part of its Plan of Correction for the cited deficiency. All staff working on the unit that night were interviewed. None of them witnessed or had any information about the alleged incident. All other interviewable residents on the hall were interviewed. There were no complaints of abuse among them and all expressed satisfaction with the care and assistance they receive at Grace Village. The male employee	

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			identified by Resident #C to have "tossed" the pajama bottoms, underwear and pad "to" her while she was in the bathroom did not work on that unit during the time of the alleged incident. There was another male aide (Aide #1) who was on the unit but who was also not working on Resident #C's hall. Aide #1 did acknowledge responding to her call light once during the night shift when the female aide assigned to that hall was busy with another resident. According to Aide #1's statement, Resident #C asked for some water, which he got and brought to her. That was the one and only interaction Aide #1 had with Resident #C. He denies bringing any clothing or incontinence supply to her and there is no charting indicating that he brought her any supply item. He has been employed by the facility for over two years, has had no previous complaints made against him or warnings in his personnel file, and is a favorite of many residents. There is, however, plenty of documentation from the female aide assigned to the hall which does document the incontinence episodes and related supplies. This is the same female aide that Resident #C described as "an angel" when talking to the SSD about her complaint. Based on the case made above and the supporting documentation, Grace Village Administration respectfully	

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			requests that F225 be removed.	

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F000226 SS=D	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 review and interviews, the facility failed to follow their policy and procedure regarding abuse for 1 of 2 allegations reviewed. (Resident #C) Finding includes: Interview with Employee #1, on 10/11/13 at 10:20 A.M., indicated on 10/01/13 during the course of the day, Resident C voiced several complaints. Employee #1 indicated one of Resident C's complaints involved a male CNA, Employee #2, throwing clean cloths and hygiene items at her from the room door while she was in the bathroom. Employee #1 indicated after she had worked with Resident C and her family on discharge needs, throughout the day on 10/01/13, she wrote up a summarization of Resident C's complaints, including the mistreatment by CNA #2, and emailed the note to the Administrator, Director of Nursing, and Assistant Director of Nursing.	F000226	Grace Village is disputing the citation of F226 according to the IDR process. CORRECTIVE ACTIONS TAKEN: Resident C was admitted on 9/30/13 and discharged to her Independent Living apartment the following afternoon. Administration has conducted a thorough investigation into the complaint lodged by Resident C. OTHER RESIDENTS POTENTIALLY AFFECTED: Cognitive residents on the same hall have been interviewed by the social service designee as to any concerns regarding treatment by facility staff. All twelve of those residents expressed that they were happy with the care and assistance they receive in the facility and that they have never felt afraid because of the way they or another resident had been treated. MEASURES IMPLEMENTED TO PREVENT REOCCURENCE: The facility policy on prevention of abuse has been reviewed and has been determined to adequately address all regulatory requirements. Direct care and administrative staff will be given an additional in-service on abuse	11/10/2013

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	Review of a copy of an email, dated 10/01/13 at 7:07 P.M., included the following: "...On the other hand, she did not have the same experience with [CNA #2's first name] [night shift CNA]. She said she had an incontinent episode and was in the bathroom of [room number identified] [the room she was moved to in the middle of the night]. She put on her light and [CNA #2's first name] came to answer it. She told him that she had this episode and asked if he would go to the room next door [where she had started] and get her a clean pair of underwear and a pad. She said he said nothing, but did return with the underwear and pad. She said he threw them at her in the bathroom and left, again not saying a word." Interview with the Administrator, on 10/11/13 at 11:34 A.M., indicated he did recall Resident C had complained of several things including a CNA being "rude" and "throwing things at her." He indicated he had no written investigation or any documentation regarding the incident. He indicated the SSD (Social Service Director), Employee #1 and the Director of Nursing were "handling" the issues with Resident C. He indicated he		prevention policy and procedure. All newly hired staff are in-serviced on the abuse prevention policy during their orientation and all staff are required to participate in an annual in-service on abuse prevention. Any agency staff used by the facility are required to attend training (including the abuse prevention policy) with the Staff Education Coordinator before they are allowed to work a shift. MONITORING: The DNS, or her designee, will review the in-servicing logs and orientation documentation weekly for thirty days and then monthly for a minimum of six months to ensure that all the aforementioned staff have participated in the abuse prevention training. The facility administrator will review any alleged abuse investigations conducted to ensure that the investigation procedure has been followed according to policy. The QA Committee will review the results of this monitoring. If there are any instances of the abuse prevention policy not being followed, the QA Committee will determine if any other systemic measures are necessary and the monitoring will continue. The QA Committee will only allow the routine monitoring to be discontinued when at least a six month period with no instances of non-compliance has been demonstrated.	

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	would not consider "rudeness" abuse. Interview with the Director of Nursing, on 10/11/13 2:30 P.M., indicated she had interviewed CNA #2 about the alleged incident during the day shift on 10/03/13. CNA #2 indicated he was not assigned to the hall in which Resident C was on for the night of 09/30/13 - 10/01/13. The Director of Nursing did not indicate any further investigation had been completed. She indicated she did not consider the allegation as possible abuse. She gave several scenarios which would have explained why a staff member would throw or "toss" items to a resident in a non-abusive manner but there was no documentation she had investigated the allegation to negate any possible abuse. Review of the facility policy and procedure, titled "Abuse Policy and Orientation" undated, but indicated as current on 10/11/13, included the following: "...2. Should an occurrence of abusive behavior be reported or witnessed, the Administrator, CEO (Chief Executive Officer), DON (Director of Nursing) (if a Health Care or Assisted Living resident) and Director of Human Resources shall be notified immediately. 3. Appropriate		IDR SUMMARY FOR F226: The State has erroneously concluded that a complaint voiced by Resident #C constituted an allegation of abuse and cited the facility for failure to report and investigate the complaint as such. Grace Village Administration holds that the complaint was not an allegation of abuse according to the ISDH's own policy entitled "Reportable Unusual Occurrences", which is why it was not reported and investigated according to the facility's "Abuse" policy and procedure. The State defines abuse in that document as "…the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish." (See Attachment A) Neither the report that Resident #C gave to the Director of Social Services, SSD (Employee #1) nor the report she gave to the Surveyor who interviewed her indicates that the definition of abuse was met. (See the 2nd and 3rd paragraphs, page 3 of the CMS-2567 - Attachment B.) Our Director of Social Services is a resident advocate with 19 years of experience as an SSD. She knows this resident quite well as Resident #C has been a resident of the facility's Independent Living for many years and because Resident #C's mother also resided on the HC unit for about a	

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	documentation should be completed relative to the individual incident (i.e. report of concern, incident/accident report, etc.) 4. Should the incident be deemed an "unusual occurrence", the state survey and certification/licensure agencies shall be notified as well as the ombudsman and/or Adult Protective Services as applicable. 5. The alleged violation shall be thoroughly investigated by the Administrator or his/her designee. The investigation will include, but not be limited to, interviews with any and all staff who witnessed an alleged abusive situation, interviews with other staff working with the alleged abuser and interviews of interviewable residents. The facility must prevent further potential abuse while the investigation is in process. For example, an individual who has been alleged as exhibiting abusive behavior should not be permitted to continue to care for residents until an investigation has been completed and the allegation found to be unsubstantiated. An employee accused of any kind of abuse will be suspended from work without pay during an investigation of any alleged abuse cases. If the investigation results in an unsubstantiated case, the employee will be allowed to return to work and any missed wages for		year. When there is an actual allegation of abuse, Grace Village Administration does not hesitate to treat abuse as the serious matter that it is and adheres to the State's standards of reporting and investigating. Neither the SSD, nor the Director of Nursing, nor the Administrator believed the complaint to have been an allegation of abuse based upon the details provided by Resident #C and the SSD's understanding of what Resident #C meant when she said CNA #2 "threw" underwear and a pad "at" her. It was understood by the SSD and by Administration that she did not mean this literally. In the documentation of the interview with the Surveyor this very point is proven, as Resident #C herself used the terms "tossed" and "to" instead of "threw at" to describe the event in question. (See Attachment B – paragraph 2, page 3 of the CMS-2567) The complaints brought forth by Resident #C are certainly serious concerns in the eyes of facility Administration, but they are concerns of customer service, common courtesy and professionalism not of abuse. Administration has conducted a thorough investigation into Resident #C's complaints as part of its Plan of Correction for the cited deficiency. All staff working on the unit that night were interviewed. None of them witnessed or had any information	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	scheduled work will be paid. 6. The results of all investigations shall be reported to the state survey and certification/licensure agencies as well as other related agencies within five (5) working days of the incident and/or reporting of the incident...." This federal tag relates to complaint #IN00137739. 3.1-28(2)(c)		about the alleged incident. All other interviewable residents on the hall were interviewed. There were no complaints of abuse among them and all expressed satisfaction with the care and assistance they receive at Grace Village. The male employee identified by Resident #C to have “tossed” the pajama bottoms, underwear and pad “to” her while she was in the bathroom did not work on that unit during the time of the alleged incident. There was another male aide (Aide #1) who was on the unit but who was also not working on Resident #C’s hall. Aide #1 did acknowledge responding to her call light once during the night shift when the female aide assigned to that hall was busy with another resident. According to Aide #1’s statement, Resident #C asked for some water, which he got and brought to her. That was the one and only interaction Aide #1 had with Resident #C. He denies bringing any clothing or incontinence supply to her and there is no charting indicating that he brought her any supply item. He has been employed by the facility for over two years, has had no previous complaints made against him or warnings in his personnel file, and is a favorite of many residents. There is, however, plenty of documentation from the female aide assigned to the hall which does document the incontinence episodes and	

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			related supplies. This is the same female aide that Resident #C described as “an angel” when talking to the SSD about her complaint. Based on the case made above and the supporting documentation, Grace Village Administration respectfully requests that F226 be removed.	