

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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	<p>This visit was for the Investigation of Complaint IN00160385.</p> <p>Complaint IN00160385 - Substantiated. Federal/State deficiencies related to the allegations are cited at F223, F225, and F226.</p> <p>Survey dates: December 15, 16, 17, and 18, 2014</p> <p>Facility number: 000305 Provider number: 155625 AIM number: 100287200</p> <p>Survey team: Barbara Gray, RN-TC Diana Sidell, RN</p> <p>Census bed type: SNF/NF: 70 Total: 70</p> <p>Census payor type: Medicare: 4 Medicaid: 57 Other: 9 Total: 70</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings</p>	F000000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>Facility is respectfully requesting a face to face IDR as we disagree with the scope and severity of F225 and F226</p>	
---------	--	---------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/18/2014	
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240			
(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			
F000223 SS=D	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on December 23, 2014 by Cheryl Fielden, RN.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident was free from verbal abuse, for 1 of 3 residents reviewed for abuse. (Resident #A)</p> <p>Findings include:</p> <p>On 12/15/14 at 1:02 p.m., Resident #A's daughter indicated her mother (Resident #A) had dementia and behaviors. Resident #A's daughter indicated lately Resident #A didn't know who her daughter was at times. Resident #A's</p>	F000223	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · Resident #A psychosocial wellbeing was monitored x 72 hours with no negative effects noted. · All staff in-serviced on abuse policy and procedure and reporting immediately by 1/7/15 	01/07/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
	<p>daughter indicated she was at the facility daily and assisted Resident #A everyday at supper. Resident #A's daughter indicated she could not be sure of the exact date but felt it was around 8/31/14, she noticed some bruising around both of Resident A's wrists and the right side of her mouth. Resident #A had informed Resident #A's daughter "a woman was "roughing her up and talking to her mean." Resident #A's daughter indicated Resident #A bruised easily and she herself had not observed any suspicious bruising prior to that day. Resident #A's daughter indicated CNA #6 informed her she heard Resident #A tell CNA #1 to stay away from her. Resident #A's daughter informed CNA #6 to report the information to the Director of Nursing Services (DNS). Resident #A's daughter indicated she was aware CNA #1 had been terminated but did not know all the details of her termination.</p> <p>On 12/15/14 at 2:47 p.m., Resident #A was observed receiving care by CNA #5. Resident #A yelled out periodically during care "help, help." Resident #A grabbed hold tightly of CNA #5's fingers during care and then Resident #A stated "let go of my hand." Resident #A also made some swinging gestures toward CNA #5 with her arms during care. Resident #A had some faint yellowish</p>		<ul style="list-style-type: none"> · Education regarding abuse policy and procedure was reviewed with resident's POA by Director of Nursing and Executive Director. Resident was unable to be educated due to diagnosis of Dementia and BIMS of 9 <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <ul style="list-style-type: none"> · Residents residing in the facility have the potential to be affected by the alleged deficient practice · All staff in-serviced on abuse policy and procedure by 1/7/15 by Director of Nursing and/or designee · Residents who received care from staff member were interviewed by Social Service Director on 9/3/14 with no concerns voiced. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/18/2014	
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240			
(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			
	<p>discoloration on her abdomen surrounding her navel, some purplish discoloration around both ankles, and a small purplish area of discoloration on the top of her right hand. CNA #5 indicated the purplish area of discoloration on the top of her right hand was because Resident #A had blood drawn.</p> <p>On 12/15/14 at 3:34 p.m., Confidential Staff #7 indicated everyone in the facility knew CNA #1 quit because she had admitted she bruised Resident #A's face. Confidential Staff #7 indicated Resident #A's daughter had confided in her and informed Confidential Staff #7, CNA #1 had grabbed Resident #A's face in September 2014.</p> <p>Resident #A's record was reviewed on 12/15/14 at 12:52 p.m. Diagnoses included, but were not limited to Alzheimer's disease, senile dementia with depression, bipolar disorder, nonorganic psychosis, and anxiety.</p> <p>Resident #A's Quarterly Minimum Data Set (MDS) assessment dated 11/23/14, indicated she was understood and had the ability to understand others. She scored 3 on her Brief Interview for Mental (BIMS) exam, indicating she was severely impaired in her daily decision making</p>		<p>practice does not recur?</p> <ul style="list-style-type: none"> · All staff in-serviced on abuse policy and procedure by 1/7/15 by Director of Nursing and/or designee · All residents that were able to interview were interviewed by the Social Service Director and/or designee regarding abuse and abuse prohibition on 12/17/14 and 12/18/14. (see attachment #2) · Family members were interviewed on 12/17/14 and 12/18/14 for those residents who were unable to be interviewed (see attachment #5) · In-Servicing/auditing will be conducted for all staff on Abuse Policy and Procedure quarterly by the Director of Nursing and/or designee (see attachment #4) · In-Servicing will be conducted on abuse policy and procedure for all new hires during general orientation by the Director of Nursing and/or designee · Executive Director and Social Service Director request invitation to Resident Council quarterly to provide ongoing education/auditing on importance of reporting issues, utilizing grievance forms, and the use of 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
	<p>skills. She had physical and verbal behavioral symptoms directed toward others. She required total dependence of 2 plus persons for bed mobility, transfers, and toileting. She did not walk. She required extensive assistance of 2 plus persons to dress. She required extensive assistance of one person to eat.</p> <p>A nurses note for Resident #A dated 9/2/14 at 3:59 p.m., indicated Resident #A had no edema or skin conditions at that time.</p> <p>A nurses note for Resident #A dated 9/3/14 at 3:30 p.m., documented by the Director of Nursing (DNS) indicated the following: "Daughter reported to this writer that resident had a bruise on right arm and right cheek. Writer went to resident room along with MDS Coordinator to assess area. Noted faint brown discoloration to right inner lower arm. Appears area may have been an old bruise. Resident voiced no c/o pain and had no s/sx pain during asmt. Also assessed all of resident face. No noted bruising or discoloration observed. Resident does have an "age spot" on right cheek but no bruising present. Area has no fading color discoloration. No c/o pain or discomfort or s/sx discomfort during asmt. Assessed rest of resident skin and noted yellow discoloration from</p>		<p>the ASC hotline number</p> <ul style="list-style-type: none"> Executive Director and Social Service Director attended Resident Council on 12/18/14 and provided education on abuse and abuse prohibition. Residents who given a magnet with the ASC hotline number The Director of Nursing Services Specialist from Home Office provided re-education to the Director of Nursing, Clinical Education Coordinator and the Executive Director on the abuse policy and procedure on 12/18/14 <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> An Abuse Prohibition and Investigation CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarterly X1 for at least 6 months (see attachment #1) Audit tools will be submitted to the CQI committee and action plans will be 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/18/2014
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240		
(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	
	<p>old bruising on abdomen r/t routine insulin injections. Spoke with staff caring for resident. CNA's state that last week resident was being very combative and physically aggressive during care and resident grabbed and pinched a CNA upper right arm and wouldn't let go. CNA's state that another aide had to assist resident to let go of staff member to prevent injury. Staff feel this may have been cause of discoloration to resident right arm. Re-educated staff to ensure they report any behaviors to nurse so it can be documented. Staff voiced understanding. Will monitor discoloration on right arm for changes."</p> <p>On 12/15/2014 at 4:30 p.m., the Executive Director (ED) provided a copy of an investigation reported to the Indiana State Department of Health (ISDH) on 9/3/14, with the follow-up reported on 9/8/14. The investigation indicated the following: "Brief Description of Incident: Description added - 9/3/2014 A staff member reported another staff member had been verbally rude to a resident during resident care around 4:15 p.m., on 9/3/14. DNS and ED were immediately notified. MD and POA were notified. Resident psychosocial well-being assessed and no negative effects were noted. Type of Injury: Type of injury added - 9/3/2014 Resident was</p>		developed as needed if threshold of 100% is not met		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/18/2014	
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240			
(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			
	<p>assessed for injuries and none were noted. Immediate Action Taken: Action taken added - 9/3/2014 1) DNS and ED immediately notified. 2) Social Service Director immediately notified. 3) POA and MD notified. 4) Employee immediately suspended pending investigation. 5) Resident assessed for injuries and none were noted. 6) Resident psychosocial well-being assessed and no negative effects noted. 7) Social Service Director initiated investigation and interviews with other residents who employee cared for.</p> <p>Preventive Measures Taken: Type of prevention measures added - 9/3/2014 1) Employee suspended pending investigation. 2) Opened hot charting to monitor resident psychosocial well-being for 72 hours. 3) Resident psychosocial well-being assessed and no negative effects noted. 4) Social Service Director/DNS conducting investigation and interviews with other residents who employee cared for. 5) DNS, ED, POA, MD, SSD immediately notified."</p> <p>A statement included in the investigation dated 9/3/14, signed by the DNS, indicated the following: "I had just left the building when I received a phone call from the administrator. She stated that we had an allegation of abuse and that I needed to come back to the building. I</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
--------------------	--	---------------	---	----------------------

	<p>immediately came back to the building. (Name of CNA #6), the administrator, and the Social Service Director were waiting in the administrators office when I arrived. I asked (name of CNA #6) what happened and she stated that (name of CNA #1) had called (name of Resident #A) a witch when they were getting her up and ready for dinner. She stated that (name of Resident #A) was swatting at (name of CNA#1) and told her to get out of her room. I asked what time it happened and she stated around 4:15 p.m. I asked if (name of Resident #A) was upset by this and she stated yes. She said (name of Resident #A) told (name of CNA #1) not to call her a witch. (Name of CNA #6) stated that at that point (name of CNA #1) looked at her and made a face and then said, "I wasn't talking to you (name of Resident #A) I was talking to (name of CNA #6)." "I asked (name of CNA #6) why she felt (name of CNA #1) would say that and she stated she felt (name of CNA #1) was trying to back track because (name of Resident #A) had called her out on it."</p> <p>A statement included in the investigation dated 9/3/14, signed by the DNS, indicated the following: "I called the (name of CNA #1) today at 5:35 p.m., and asked her to please come back to the building to speak with myself and the</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
	<p>Administrator. She said she would be there in a few minutes. When the (name of CNA #1) arrived I explained to her that we have had a complaint from a resident that she had been verbally abusive with. The (name of CNA #1) at first stated that she couldn't think of anything that happened that day. I asked her if there was something that happened that could have been interpreted as verbal abuse. She stated, "well maybe with (name of Resident #A)." "I asked her what happened. She said, "when (name of Resident #A) was pinching I said under my breath quit being a little witch. I didn't mean anything out of the way by it though." "I asked her if the resident heard her or was upset by it. She said the resident told her "don't call me a witch!" "The (name of CNA #1) stated that she then told the resident she didn't mean anything by it. I asked (name of CNA #1) what time that happened and she said it was probably around 4:00 p.m." "(Name of CNA #1) was upset and stated that she had helped (name of CNA #6) when she needed help and she couldn't believe that she would say that. The administrator then said that the complaint came from the resident. I explained to (name of CNA #1) that at this point she would be suspended pending investigation because all allegations are taken seriously. She stated she</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
	<p>understood. She asked how long it would take to do the investigation. I told her that it usually takes around 3 business days but that I would call her as soon as it was finished. (Name of CNA #1) was suspended at 6:45 p.m. She signed her suspension write up. I told her she could write any comments that she wanted on the employee portion and she declined."</p> <p>A statement included in the investigation dated 9/3/14, signed by the DNS, indicated the DNS had spoke with Resident #A's daughter in the facility at 6:50 p.m. "I informed her that there had been an accusation of a staff member being verbally rude to her mother. She stated she already knew because her mother told her when she came to visit. She asked if the staff member had been fired. I explained to her that we were currently conducting an investigation and she would be notified at the conclusion of the investigation. I did tell her that the employee was suspended pending investigation. She stated she thought this staff member, (CNA #1's name), seems to be rude and a "little rough around the edges." "She stated that she just wants her mother to be taken care of. I told her that I wanted that as well."</p> <p>The investigation documentation included interviews with 15 residents and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/18/2014	
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240			
(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			
	<p>all 15 residents interviewed denied any concerns related to the care they received by staff, including Resident #A.</p> <p>The follow-up investigation report dated 9/8/14, indicated the following: " Follow up: Follow up added - 9/8/2014 1) Employee was terminated on 9/5/14, after conclusion of investigation. 2) Resident psychosocial well-being was monitored x 72 hours with no negative effects noted. 3) Social Service Director conducted resident interviews: no concerns from residents regarding how they are treated, how other residents are treated, or about the staff."</p> <p>Ongoing documentation by several nurses indicated the area of discoloration to the right inner lower arm continued to fade but no facial bruising was documented.</p> <p>An interview with the DNS on 12/16/14 at 11:30 a.m., indicated Resident #A's daughter had reported to the DNS on 9/3/14, Resident #A had bruising on her face. The DNS indicated herself and the MDS Coordinator had assessed Resident #A's skin. The DNS indicated she had informed Resident #A's daughter by telephone on 9/3/14, herself and the MDS Coordinator could not visualize any areas of bruising on Resident #A's face but did</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
	<p>visualize a brown area of discoloration on Resident #A's arm. The DNS indicated herself and the ED had reported to Resident #A's daughter a CNA had been reported to call Resident #A a witch. The DNS indicated CNA #1 had been terminated because she admitted calling Resident #A a "witch." The DNS indicated after the investigation was completed she had informed Resident #A's daughter by telephone CNA#1 had been terminated. The DNS indicated no one had reported to her CNA #1 had grabbed Resident #A's face but after she informed Resident #A's daughter of CNA #1's termination, Resident A's daughter stated "that's probably how mom got that bruise on her face." The DNS indicated she informed Resident #A's daughter again no bruising was visualized on Resident #A's face.</p> <p>3 Other resident, including 2 who resided in the same hall Resident #A resided in, and another resident's family member was interviewed and no concerns were voiced related to care received by staff or care they had observed other residents receive by staff. 9 Other staff members were interviewed and no concerns were voiced they had observed Resident #A being mistreated or abused.</p> <p>A policy, titled "Abuse Prohibition,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
	<p>Reporting, and Investigation", was provided by the Executive Director on 12/15/14 at 10:13 a.m. The policy indicated, but was not limited to: "It is the policy of American Senior Communities to protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or funds. Definition of Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish. This includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain, or mental anguish... Verbal Abuse - defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples would include, but are not limited to: threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/18/2014	
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240			
(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			
F000225 SS=J	<p>family member again; or scolding and/or speaking to them in harsh voice tones...Policy/Procedure: 1. American Senior Communities will not permit residents to be subjected to abuse by anyone, including employees, other residents, consultants, volunteers, staff or personnel of other agencies serving the resident, family members, legal guardians, sponsors, friends, or other individuals...."</p> <p>This Federal tag relates to Complaint IN00160385.</p> <p>3.1-27(a)(1)</p> <p>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.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
	<p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>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.</p> <p>Based on record review and interview, the facility failed to immediately report and thoroughly investigate an allegation of verbal and physical abuse. This affected 1 of 3 residents reviewed who met the criteria for abuse and had the potential to affect all 70 residents in the facility. (Resident #B)</p> <p>This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy was identified on 12/16/14, and began on 11/29/13. The Administrator and the Director of Nursing Services</p>	F000225	<p>Facility is respectfully requesting a face to face IDR as we disagree with the scope and severity of F225</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #B psychosocial wellbeing was monitored for 72 hours with no negative effects</p>	01/07/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
	<p>(DNS) were notified of the Immediate Jeopardy, related to verbal and physical abuse, at 5:10 p.m., on 12/16/14. The Immediate Jeopardy was removed on 12/18/14, but the facility remained out of compliance at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy based on deficient practice related to not investigating and reporting an allegation of verbal and physical abuse.</p> <p>Findings include:</p> <p>During an interview, on 12/15/14, at 1:02 p.m., a family member indicated she heard RN #1 tell Resident #B to "shut up", then heard Resident #B say "You b*****d nurse, you hit me." The family member indicated she didn't see anything, she just heard it and that later on that night after supper, she noticed Resident #B had a bruise near her mouth. The family member indicated she reported this to the DNS on 11/29/14 by text message, but the family member thought the event happened around Thanksgiving and had already been reported. The family member indicated she didn't report it right away because she didn't want to get involved.</p> <p>During a confidential interview, a facility</p>		<p>noted</p> <ul style="list-style-type: none"> · Resident #B was seen by psych on 11/25/14 with medication changes made. Resident scheduled to follow up with psych on 01/12/15 · All staff in-serviced on abuse policy and procedure and reporting immediately on 12/16/14, 12/17/14, and 12/18/14 · Residents and staff were interviewed regarding abuse and reporting on 12/16/14, 12/17/14, and 12/18/14 <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <ul style="list-style-type: none"> · Residents residing in the facility have the potential to be affected by the alleged deficient practice · All staff in-serviced on abuse policy and procedure by 1/7/15 by Director of Nursing and/or designee · Residents and families were interviewed on abuse and reporting by Social Service Director and/or designee; Any 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
	<p>nurse indicated a family member told her that she had heard RN #1 yelling at Resident #B on the weekend of 11/22/14. The family member reported this a week after the event because she did not want to get involved. She indicated Resident #B had never had any self inflicted injuries, but couldn't say she didn't hit herself that evening.</p> <p>During an interview, on 12/16/14 at 11:04 a.m., the DNS indicated she had heard from a family member via text message on 11/29/14 and follow up phone call on 11/30/14. The family member indicated she had concerns about RN #1, felt he was abusive and the DNS needed to listen to staff about him. The DNS asked the family member if she witnessed him be abusive, and she said "Yes, with Resident #B", and told her RN #1 took Resident #B to her room and she heard Resident #B say "that b*****d hit me". Following the incident, RN #1 came into the dining room and sat with Resident #B. The family member then told the DNS Resident #B ended up with a bruise on her lip. The DNS called the Executive Director and told her what the family reported. The Executive Director asked the DNS to call the family member and request she come in and give a statement. The family member declined this request. The DNS said she did not</p>		<p>concerns received from interviews were immediately addressed by the Director of Nursing and/or designee</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · All staff in-serviced on abuse policy and procedure by 1/7/15 by Director of Nursing and/or designee · All new or returning residents interviewed regarding abuse by Social Service Director and/or designee; Any concerns received from interviews were immediately addressed by the Director of Nursing and/or designee · All staff interviewed regarding abuse by Director of Nursing and/or designee; Any concerns received from interviews were immediately addressed by the Director of Nursing and/or designee (see attachment #3) · All residents that were able to interview were interviewed by the Social Service Director and/or designee regarding abuse and 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
	<p>document the text she received from the family member on 11/29/14.</p> <p>The DNS indicated they did not do an investigation into this allegation of abuse received on 11/29/14. The DNS indicated it was not investigated because it had already been investigated with the determination the bruise on the resident's face was due to her self injurious behavior. On 12/16/14 at 4:50 p.m., the ED indicated they initially investigated the event on 11/23/14 with Resident #B hitting herself in the mouth. None of this was reported to ISDH.</p> <p>During an interview, on 12/16/14, at 12:45 p.m., RN #3 indicated a family member reported she had heard a conversation between RN #1 and Resident #B. The family member told RN #3 she heard RN #1 tell Resident #B to "shut up", then heard Resident #B say "You hit me you b*****d." The family member told RN #3 the day after she heard this verbal exchange she saw Resident #B had a bruise on her face. RN #3 indicated she called the DNS, because it was the weekend. She did not remember the day, but thought it was on a Sunday. The family member told her the incident had happened approximately one week prior to when she was reporting it to her. RN #3 indicated when she</p>		<p>abuse prohibition on 12/17/14 and 12/18/14. (see attachment #2)</p> <ul style="list-style-type: none"> · Family members were interviewed on 12/17/14 and 12/18/14 for those residents who were unable to be interviewed (see attachment #5) · In-Servicing/auditing will be conducted for all staff on Abuse Policy and Procedure quarterly by the Director of Nursing and/or designee (see attachment #4) · In-Servicing will be conducted on abuse policy and procedure for all new hires during general orientation by the Director of Nursing and/or designee · Executive Director and Social Service Director request invitation to Resident Council quarterly to provide ongoing education/auditing on importance of reporting issues, utilizing grievance forms, and the use of the ASC hotline number · Executive Director and Social Service Director attended Resident Council on 12/18/14 and provided education on abuse and abuse prohibition. Residents were given a magnet with the ASC hotline number · The Director of Nursing Services Specialist from Home Office provided re-education to 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
	<p>called the DNS, the DNS told her the family member had already talked to her and she would take care of it. RN #3 indicated RN #1 was not working the day she reported what the family member had told her, and she was never questioned any further.</p> <p>During an interview, on 12/16/14 at 11:55 a.m., the Social Service Director (SSD) indicated the family member told her in a phone conversation on Monday 12/1/14, that she didn't witness RN #1 and Resident #B's situation, but was reporting what she had heard. The SSD further indicated the event of Resident #B's face being bruised that occurred, on 11/23/14, had been investigated as a behavior with Resident #B hitting herself in the mouth.</p> <p>Resident #B's record was reviewed on 12/15/14 at 2:06 p.m. The record indicated Resident #B was admitted with diagnoses that included, but were not limited to, senile dementia with depression, high blood pressure, esophageal reflux, senile psychosis, and depressive disorder.</p> <p>An Annual Minimum Data Set assessment, dated 9/30/14, indicated Resident #B was severely impaired, rarely/never made decisions in cognitive</p>		<p>the Director of Nursing, Clinical Education Coordinator and the Executive Director on the abuse policy and procedure on 12/18/14</p> <p>The Executive Director and/or the Director of Nursing will ensure all allegations of abuse, neglect, or misappropriation of residents funds/property will be reported and thoroughly investigated immediately per the abuse policy and procedure including: suspension of employee(s), immediate reporting to ISDH; notification of family and physician, and initiation of investigation to gather further information.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>An Abuse Prohibition and Investigation CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarterly X1 for at least 6 months (see attachment #1)</p> <p>Audit tools will be</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/18/2014	
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240			
(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			
	<p>skills for daily decision making, and had poor long term, and short term memory.</p> <p>A care plan, initiated 11/24/14, indicated: "Resident at risk for self harm d/t (due to) smacks self in mouth, smacks objects in hallway knocking items off wall, rolls w/c into wall while sitting in it. Goal: Will have no harm. Approach: Assure resident is safe."</p> <p>A care plan, initiated 11/24/14, indicated: "Resident is at risk for bruising related to use of anticonvulsant medication, will head butt staff, hit objects off the wall, or hit self. Goal: Resident will remain free from bruising. Approach: Staff to ask resident not to hit self or objects as it could cause bruising. Document abnormal findings and notify MD. Medications as ordered. Observe for increased bleeding, bruising, headaches, diarrhea, fatigue, dizziness, stomach pains, black tarry stools, ringing in the ears."</p> <p>A policy, titled "Abuse Prohibition, Reporting, and Investigation", was provided by the Executive Director on 12/15/14 at 10:13 a.m. The policy indicated, but was not limited to: "It is the policy of American Senior Communities to protect residents from abuse including physical abuse, sexual</p>		<p>submitted to the CQI committee and action plans will be developed as needed if threshold of 100% is not met</p> <p>The Vice President of Operations/Director of Operations and/or designee will review all reported incidents and grievances at each visit, no less than monthly.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
	<p>abuse, verbal abuse, mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or funds. Definition of Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish. This includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain, or mental anguish. Physical Abuse - includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment. Verbal Abuse - defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples would include, but are not limited to: threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family member again; or scolding and/or speaking to them in harsh voice tones...Policy/Procedure: 1. American Senior Communities will not</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
--------------------	--	---------------	---	----------------------

	<p>permit residents to be subjected to abuse by anyone, including employees, other residents, consultants, volunteers, staff or personnel of other agencies serving the resident, family members, legal guardians, sponsors, friends, or other individuals...4. Residents and their families are educated as to whom and how to report allegations, incidents, and/or complaints without fear of retribution. Residents and families are also educated on the process of receiving feedback/resolution regarding concerns that have been expressed. This education will occur at admission, and during resident and family council meetings...6. The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed. In the absence of the Executive Director, this responsibility will be delegated to the Director of Nursing Services. 7. The Executive Director/designee will report all unusual occurrences, which include allegations of abuse, immediately, to the Long Term Care Division of the Indiana State Department of Health. Upon completion of the investigation, which must occur within 5 working days of the reporting of an occurrence, a report of the investigation must be forwarded to the Long Term Care Division of the Indiana</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/18/2014	
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240			
(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			
	<p>State Department of Health. Copies of the completed investigation must also be sent to Adult Protective Services, Ombudsman, and Director of Operations.</p> <p>8. A comprehensive record of the abuse investigation is to be kept by the facility Executive Director and/or Director of Nursing Services...Resident Abuse - Staff member, volunteer, or visitor: Policy: It is the policy of American Senior Communities to assure appropriate interventions are in place and followed to assure safety of the resident (s) is maintained if abuse is identified or suspected. Procedure: If resident abuse is identified or suspected, the following guidelines will be followed: 1. The resident (s) involved in the incident will be protected and/or removed from the situation immediately...3. Any staff member implicated in the alleged abuse will be removed from the facility at once and will remain suspended until an investigation is completed...."</p> <p>An Immediate Jeopardy was identified on 12/16/14. The Immediate Jeopardy began on 11/29/14 when a nurse was not immediately reported for verbal and physical abuse and continued to work, residents were not protected while the nurse was working, and there was no thorough investigation of the occurrence of physical and verbal abuse. The</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/18/2014	
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240			
(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			
F000226 SS=J	<p>Administrator and Director of Nursing Services were notified of the Immediate Jeopardy, related to verbal and physical abuse, at 5:10 p.m. on 12/16/14.</p> <p>Through observations, interviews, and record reviews, it was determined the facility's corrective actions had removed the immediate jeopardy situation on 12/18/14. Even though the immediate was removed, the facility remained out of compliance at patterned scope and level of no actual harm, with potential for more than minimal harm that is not immediate jeopardy, based on deficient practice related to not investigating and reporting an allegation of verbal and physical abuse.</p> <p>This Federal tag relates to Complaint IN00160385.</p> <p>3.1-28(c)</p> <p>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.</p> <p>Based on record review and interview,</p>	F000226	Facility is respectfully requesting	01/07/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/18/2014
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240		
(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	
	<p>the facility failed to implement their policies and procedures regarding investigating and reporting abuse, in that no thorough investigation of an allegation of physical and verbal abuse was done, the residents did not have a safe environment while the RN continued to work, and the allegations of abuse were not reported immediately to the ISDH and other agencies. This affected all 70 residents residing in the facility.</p> <p>This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy was identified on 12/16/14, and began on 11/29/14. The Administrator and Director of Nursing Services (DNS) were notified of the Immediate Jeopardy, related to verbal and physical abuse, at 5:10 p.m. on 12/16/14. The Immediate Jeopardy was removed on 12/18/14, but the facility remained out of compliance at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy based on deficient practice related to not following their policy and procedure for investigating, keeping residents safe while the nurse continued to work, and reporting an allegation of verbal and physical abuse.</p> <p>Findings include:</p>		<p>a face to face IDR as we disagree with the scope and severity of F226</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · Resident #B psychosocial wellbeing was monitored for 72 hours with no negative effects noted · Resident #B was seen by psych on 11/25/14 with medication changes made. Resident scheduled to follow up with psych on 01/12/15 · All staff in-serviced on abuse policy and procedure and reporting immediately on 12/16/14, 12/17/14, and 12/18/14 · Residents and staff were interviewed regarding abuse and reporting on 12/16/14, 12/17/14, and 12/18/14 <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
	<p>During an interview on 12/15/14, at 1:02 p.m., a family member indicated she heard RN #1 tell Resident #B to "shut up" then heard Resident #B say "You b*****d nurse, you hit me." The family member indicated she didn't see anything, she just heard it and then later on that night after supper, she noticed Resident #B had a bruise near her mouth. The family member indicated she reported this to the DNS on 11/29/14 by text message, but the family member thought the event happened around Thanksgiving and had already been reported. The family member indicated she didn't report it right away because she didn't want to get involved.</p> <p>During a confidential interview, a facility nurse indicated a family member told her that she had heard RN #1 yelling at Resident #B on the weekend of 11/22/14. The family member reported this a week after the event because she did not want to get involved. She indicated Resident #B had never had any self inflicted injuries, but couldn't say she didn't hit herself that evening.</p> <p>During an interview, on 12/16/14 at 11:04 a.m., the DNS indicated she had heard from a family member via text message on 11/29/14 and follow up phone call on 11/30/14. The family</p>		<ul style="list-style-type: none"> · Residents residing in the facility have the potential to be affected by the alleged deficient practice · All staff in-serviced on abuse policy and procedure by 1/7/15 by Director of Nursing and/or designee · Residents and families were interviewed on abuse and reporting by Social Service Director and/or designee; Any concerns received from interviews were immediately addressed by the Director of Nursing and/or designee <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · All staff in-serviced on abuse policy and procedure by 1/7/15 by Director of Nursing and/or designee · All new or returning residents interviewed regarding abuse by Social Service Director and/or designee; Any concerns received from interviews were 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/18/2014	
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240			
(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			
	<p>member indicated she had concerns about RN #1, felt he was abusive and the DNS needed to listen to what staff said about him. The DNS asked the family member if she witnessed him be abusive, and she said "Yes, with Resident #B", and told her RN #1 took Resident #B to her room and she heard Resident #B say "that b*****d hit me". Following the incident, RN #1 came in and sat in the dining room with Resident #B. The family member then told the DNS Resident #B ended up with a bruise on her lip. The DNS called the Executive Director and told her what the family reported. The Executive Director asked the DNS to call the family member and request she come in and give a statement. The family member declined this request. The DNS said she did not document the text message she received from the family member on 11/29/14.</p> <p>The DNS indicated they did not do an investigation into this allegation of abuse received on 11/29/14. The DNS indicated it was not investigated because it had already been investigated with the determination the bruise on the resident's face was due to her self injurious behavior. On 12/16/14 at 4:50 p.m., the ED indicated they initially investigated the event on 11/23/14 with Resident #B hitting herself in the mouth. None of this</p>		<p>immediately addressed by the Director of Nursing and/or designee</p> <ul style="list-style-type: none"> · All staff interviewed regarding abuse by Director of Nursing and/or designee; Any concerns received from interviews were immediately addressed by the Director of Nursing and/or designee (see attachment #3) · All residents that were able to interview were interviewed by the Social Service Director and/or designee regarding abuse and abuse prohibition on 12/17/14 and 12/18/14. (see attachment #2) · Family members were interviewed on 12/17/14 and 12/18/14 for those residents who were unable to be interviewed (see attachment #5) · In-Servicing/auditing will be conducted for all staff on Abuse Policy and Procedure quarterly by the Director of Nursing and/or designee (see attachment #4) · In-Servicing will be conducted on abuse policy and procedure for all new hires during general orientation by the Director of Nursing and/or designee · Executive Director and Social Service Director request invitation to Resident Council 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
	<p>was reported to ISDH.</p> <p>During an interview, on 12/16/14, at 12:45 p.m., RN #3 indicated a family member reported she had heard a conversation between RN #1 and Resident #B. The family member told RN #3 she heard RN #1 tell Resident #B to "shut up", then heard Resident #B say "You hit me you b*****d." The family member told RN #3 the day after she heard this verbal exchange she saw Resident #B had a bruise on her face. RN #3 indicated she called the DNS, because it was the weekend. She did not remember the day, but thought it was on a Sunday. The family member told her the incident had happened approximately one week prior to when she was reporting it to her. RN #3 indicated when she called the DNS, the DNS told her the family member had already talked to her and she would take care of it. RN #3 indicated RN #1 was not working the day she reported what the family member had told her, and she was never questioned any further.</p> <p>During an interview, on 12/16/14 at 11:55 a.m., the Social Service Director (SSD) indicated the family member told her in a phone conversation on Monday, 12/1/14, that she didn't witness RN #1 and Resident #B's situation, but was</p>		<p>quarterly to provide ongoing education/auditing on importance of reporting issues, utilizing grievance forms, and the use of the ASC hotline number</p> <ul style="list-style-type: none"> · Executive Director and Social Service Director attended Resident Council on 12/18/14 and provided education on abuse and abuse prohibition. Residents were given a magnet with the ASC hotline number · The Director of Nursing Services Specialist from Home Office provided re-education to the Director of Nursing, Clinical Education Coordinator and the Executive Director on the abuse policy and procedure on 12/18/14 · The Executive Director and/or the Director of Nursing will ensure all allegations of abuse, neglect, or misappropriation of residents funds/property will be reported and thoroughly investigated immediately per the abuse policy and procedure including: suspension of employee(s), immediate reporting to ISDH; notification of family and physician, and initiation of investigation to gather further information. <p>How will the corrective</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
	<p>reporting what she had heard. The SSD further indicated the event of Resident #B's face being bruised on 11/23/14 had been investigated and determined to be due to Resident #B's behavior of hitting herself in the mouth.</p> <p>RN #1's timecard was provided by the Executive Director, on 12/16/14 at 3:35 p.m. The timecard indicated RN #1 had worked the following hours since the allegation of verbal and physical abuse on 11/29/14: 12/1/14 from 5:45 a.m. to 6:20 p.m., 12/3/14 from 5:46 a.m. to 8:38 p.m., 12/5/14 from 5:43 a.m. to 6:34 p.m., 12/8/14 from 5:42 a.m. to 6:46 p.m., 12/11/14 from 5:47 a.m. to 8:41 p.m., and 12/12/14 from 5:45 a.m. to 7:58 p.m.</p> <p>A policy, titled "Abuse Prohibition, Reporting, and Investigation", was provided by the Executive Director on 12/15/14 at 10:13 a.m. The policy indicated, but was not limited to: "It is the policy of American Senior Communities to protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or funds. Definition of Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation</p>		<p>action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> · An Abuse Prohibition and Investigation CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarterly X1 for at least 6 months (see attachment #1) · Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 100% is not met · The Vice President of Operations/Director of Operations and/or designee will review all reported incidents and grievances at each visit, no less than monthly. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
---	---

(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
	<p>or punishment with resulting physical harm or pain, or mental anguish. This includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain, or mental anguish. Physical Abuse - includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment. Verbal Abuse - defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples would include, but are not limited to: threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family member again; or scolding and/or speaking to them in harsh voice tones...Policy/Procedure: 1. American Senior Communities will not permit residents to be subjected to abuse by anyone, including employees, other residents, consultants, volunteers, staff or personnel of other agencies serving the resident, family members, legal guardians, sponsors, friends, or other</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/18/2014
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240		
(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	
	<p>individuals...4. Residents and their families are educated as to whom and how to report allegations, incidents, and/or complaints without fear of retribution. Residents and families are also educated on the process of receiving feedback/resolution regarding concerns that have been expressed. This education will occur at admission, and during resident and family council meetings...6. The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed. In the absence of the Executive Director, this responsibility will be delegated to the Director of Nursing Services. 7. The Executive Director/designee will report all unusual occurrences, which include allegations of abuse, immediately, to the Long Term Care Division of the Indiana State Department of Health. Upon completion of the investigation, which must occur within 5 working days of the reporting of an occurrence, a report of the investigation must be forwarded to the Long Term Care Division of the Indiana State Department of Health. Copies of the completed investigation must also be sent to Adult Protective Services, Ombudsman, and Director of Operations. 8. A comprehensive record of the abuse investigation is to be kept by the facility</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/18/2014	
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240			
(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			
	<p>Executive Director and/or Director of Nursing Services...Resident Abuse - Staff member, volunteer, or visitor: Policy: It is the policy of American Senior Communities to assure appropriate interventions are in place and followed to assure safety of the resident (s) is maintained if abuse is identified or suspected. Procedure: If resident abuse is identified or suspected, the following guidelines will be followed: 1. The resident (s) involved in the incident will be protected and/or removed from the situation immediately...3. Any staff member implicated in the alleged abuse will be removed from the facility at once and will remain suspended until an investigation is completed...."</p> <p>An Immediate Jeopardy was identified on 12/16/14. The Immediate Jeopardy began on 11/29/14 when a nurse was not immediately reported for verbal and physical abuse and continued to work, residents were not protected while the nurse was working, and there was no thorough investigation of the occurrence of physical and verbal abuse. The Administrator and Director of Nursing Services were notified of the Immediate Jeopardy, related to verbal and physical abuse, at 5:10 p.m. on 12/16/14.</p> <p>The Immediate Jeopardy was removed on</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/18/2014	
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240			
(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			
	<p>12/18/14, but the facility remained out of compliance at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy based on deficient practice related to not following their policy and procedure for investigating, keeping residents safe while the nurse continued to work, and reporting an allegation of verbal and physical abuse.</p> <p>This Federal tag relates to Complaint IN00160385.</p> <p>3.1-28(c)</p>						