

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF THE WILLOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ELIZABETH DR VALPARAISO, IN 46383
---	--

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

F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00206492.</p> <p>Complaint IN00206492 - Substantiated. Federal/State deficiencies related to the allegations are cited at F225 & F226.</p> <p>Survey date: August 16, 2016</p> <p>Facility number: 000078 Provider number: 155158 AIM number: 100289310</p> <p>Census bed type: SNF/NF: 70 Total: 70</p> <p>Census Payor type: Medicare: 12 Medicaid: 52 Other: 6 Total: 70</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 32883 on 8/18/16.</p>	F 0000	<p>The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusion set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of Appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility. This facility respectfully requests</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: 155158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF THE WILLOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ELIZABETH DR VALPARAISO, IN 46383
---	--

(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
F 0225 SS=D Bldg. 00	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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 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</p>		consideration of paper compliance for the cited deficiencies	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF THE WILLOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ELIZABETH DR VALPARAISO, IN 46383
---	--

(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>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 staff failed to report an allegation of abuse timely to the Administrator and/or Director of Nursing (DON) of the facility for 1 of 3 residents reviewed for abuse, in a total sample of 6. (Resident #G)</p> <p>Finding includes:</p> <p>An Indiana State Department of Health Reportable Incident, dated 06/13/16, indicated Resident #G informed the Therapist that staff were rough with care on 06/12/16. Resident #G indicated a CNA twisted her ring finger for no reason and the other CNA in the room also twisted her finger. The resident indicated the midnight shift CNA pushed her down in the bed and poked her in the chest. The Therapist reported the allegation to the DON.</p> <p>The DON's investigation of the allegation, dated 06/13/16, indicated CNA #1 (Night Shift CNA) was interviewed by the DON. CNA #1 indicated she went into Resident #G's room around 10:15 p.m. to provide care</p>	F 0225	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident G had no negative outcomes as abuse was unsubstantiated. CNA # 1 was placed on administrative leave pending investigation. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Other residents have the potential to be affected therefor SSD conducted interviews with alert and oriented resident's on CNA # 1 assignment findings negative no other residents effected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: In servicing to be completed for staff to include the following: Resident abuse and neglect, reporting alleged abuse per facility policy, resident rights will be complete by 09/02/2016 How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Social Service / designee</p>	09/06/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF THE WILLOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ELIZABETH DR VALPARAISO, IN 46383
---	--

(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>on 06/12/16 and Resident #G alleged CNA #1 had abused her. CNA #1 indicated she provided care to the resident and the resident went to sleep and again provided care on 06/13/16 at approximately 3 a.m. and Resident #G had no complaints. CNA #1 indicated between 5 a.m. and 6 a.m. on 06/13/16, the resident was yelling and CNA #1 went to the resident's room to care for the resident. Resident #G was yelling for the call light and CNA #1 informed the resident it was clipped to her gown and had the call light in her hand then Resident #G started yelling CNA #1 was abusing her and she was going to report CNA #1.</p> <p>During an interview on 08/16/16 at 3:55 p.m., the DON indicated to her knowledge CNA #1 had not reported the allegations of abuse to the Nurse on duty. The DON indicated she was not aware of an allegation of abuse until the Therapist reported it to her.</p> <p>During an interview on 08/16/16 at 4:10 p.m., CNA #1 indicated she was, "pretty sure" she told the Nurse on duty about the abuse allegation.</p> <p>During an interview on 08/16/16 at 4:50 p.m., the Administrator indicated she had not been notified of the abuse allegation</p>		<p>will interview 2 alert and oriented random residents weekly to ensure that residents have no concerns with abuse or neglect and call 1 cognitively impaired residents responsible party. Executive Director will interview 2 staff members weekly to ensure they know the proper abuse and neglect protocol. This will be an ongoing audit for 6 months. Audit results and system components will be reviewed by the QA Committee with subsequent plans of correction developed and implemented as deemed</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF THE WILLOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ELIZABETH DR VALPARAISO, IN 46383
---	--

(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
F 0226 SS=D Bldg. 00	<p>on the night shift of 06/12/16-06/13/16.</p> <p>This Federal Tag relates to Complaint IN00206492.</p> <p>3.1-28(c) 3.1-28(d)</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. Based on record review and interview, the facility failed to ensure the facility's abuse policy was followed, related to staff not immediately reporting an allegation of abuse to the Administrator and/or Director of Nursing (DON) of the facility for 1 of 3 residents reviewed for abuse in a total sample of 6. (Resident #G)</p> <p>Finding includes:</p> <p>An Indiana State Department of Health Reportable Incident, dated 06/13/16, indicated Resident #G informed the</p>	F 0226	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>ResidentG had no negative outcomes as abuse was unsubstantiated. CNA # 1 was placed on administrative leave pending investigation</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p>	09/06/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155158	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF THE WILLOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ELIZABETH DR VALPARAISO, IN 46383
---	--

(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>Therapist that staff were rough with care on 06/12/16. Resident #G indicated a CNA twisted her ring finger for no reason and the other CNA in the room also twisted her finger. The resident indicated the midnight shift CNA pushed her down in the bed and poked her in the chest. The Therapist reported the allegation to the DON.</p> <p>The DON's investigation of the allegation, dated 06/13/16, indicated CNA #1 (Night Shift CNA) was interviewed by the DON. CNA #1 indicated she went into Resident #G's room around 10:15 p.m. to provide care on 06/12/16 and Resident #G alleged CNA #1 had abused her. CNA #1 indicated between 5 a.m. and 6 a.m. on 06/13/16, the resident was yelling, CNA #1 entered the room and Resident #G started yelling CNA #1 was abusing her and she was going to report CNA #1.</p> <p>During an interview on 08/16/16 at 3:55 p.m., the DON indicated to her knowledge CNA #1 had not reported the allegations of abuse to the Nurse on duty. The DON indicated she was not aware of an allegation of abuse until the Therapist reported it to her.</p> <p>During an interview on 08/16/16 at 4:10 p.m., CNA #1 indicated she was, "pretty</p>		<p>Other residents have the potential have the potential to be effected therefor SSD conducted interviews with alert and orientated resident's on CNA # 1 assignment findings negative no other residents effected.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>In servicing to be completed for staff to include the following: Resident abuse and neglect, reporting alleged abuse per facility policy, resident rights will be complete by 09/02/2016</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Social Service / designee will interview 2 alert and oriented random residents weekly to ensure that residents have no concerns with abuse or neglect and call 1 cognitively impaired residents responsible party. Executive Director will interview 2 staff members weekly to ensure they know the proper abuse and neglect protocol. This will be an ongoing audit for 6 months. Audit results and system</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/16/2016
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF THE WILLOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ELIZABETH DR VALPARAISO, IN 46383		
(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>sure" she told the Nurse on duty about the abuse allegation.</p> <p>During an interview on 08/16/16 at 4:50 p.m., the Administrator indicated she had not been notified of the abuse allegation on the night shift of 06/12/16-06/13/16.</p> <p>A facility policy, dated 02/2009, titled, "Reporting Alleged Abuse", received from the Administrator as current, indicated, "...All alleged or suspected violations involving mistreatment, abuse neglect...will be promptly reported to the administrator (sic) and/or director of nursing (sic)..."</p> <p>This Federal Tag relates to Complaint IN00206492.</p> <p>3.1-28(a)</p>		<p>components will be reviewed by the QA Committee with subsequent plans of correction developed and implemented as deemed</p>		