STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155472	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOOSIER VILLAGE	9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268

(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 Complaint IN00137650. Complaint IN00137650 substantiated, state deficiencies related to the allegations are cited at F9999 Survey dates: October 15, 16, 2013 Facility number: 000548 Provider number: 155472 AIM number: N/A Survey team: Connie Landman RN-TC Census bed type: SNF: 15 NCC: 61 Residential: 86 Total: 162 Census payor type: Medicate: 8 Other: 154 Total: 162 Sample: 3 Hoosier Village Retirement Center was found to be in compliance with 42 CFR Part 483, Subpart B, in regard to the Investigation of	F000000		

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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	Complaint IN00137650. Quality review completed on 10/23/2013 by Brenda Marshall Nunan, RN,			

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F009999	3.1-27 Abuse and neglect (a) The resident has a right to be free from: (1) sexual, physical, and mental abuse This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 3 residents reviewed for behaviors was kept safe from physical abuse by a staff member in a sample of 3 (Resident B). Findings include: The record for Resident B was reviewed on 10/16/13 at 10:30 A.M. Resident B's diagnoses included, but were not limited to, hypertension, high cholesterol, vascular dementia with behavioral disturbance. A health care plan, dated 1/16/13, indicated the resident had a problem of being physically abusive, and another, dated 12/31/12, indicated he was resistive to care. Interventions for these 2 problems included, but were not limited to, provide consistent	F009999	1. The incident that occurred with Resident B was immediately addressed. Nurse aides #2 and #3 followed policy and procedure by ensuring that nurse aide #1 left the resident's room and reported the incident to the nurse. The Director of Nursing and Executive Director were notified immediately and investigations were initiated the same night. Family of the resident was also immediately notified. Nurse aide #1 was told to leave the facility immediately following the incident and as a result of the investigation her employment was terminated.2. Immediately following the incident, the social services designee interviewed other residents on the unit. No other resident voiced concerns about care provided by the staff, in particular care provided by nurse aide #1. Therefore no other residents were affected. 3. As a means to ensure ongoing compliance the facilities policy and procedures regarding abuse is reviewed with all new employees upon hire with signature required and then again on an annual basis. All new employees also agree to and sign the Zero tolerance campaign regarding abuse. The facility also performs a criminal history check on any potential new hires. Furthermore, from 4/8/13-4/11/13, the facility	11/08/2013

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	caregiver, find out why he is resisting care, explain what you are going to do before you do it, do not touch him when he is upset, and reapproach at a later time. During an interview with the Administrator on 10/15/13 at 11:40 A.M., she indicated the one abuse investigation she provided at that time was the only abuse investigation they had in the last 6 months, and it was 1 abuse investigation too many. The abuse investigation indicated Resident B had been punched in the face by CNA #1 on 4/6/13 at 2:00 A.M. This was witnessed by CNA #2 and CNA #3. Resident B had been incontinent, and all 3 CNAs had given him incontinent care and returned him to his bed when he started kicking and hitting the CNAs. CNAs #2 and #3 witnessed CNA #1 punch Resident B in the face. CNA #2 and CNA #3 told CNA #1 to stop hitting him, which she did, and they left Resident B's room with her. CNA #1 went to the Nurses Station, and CNA #2 and CNA #3 immediately reported the incident to RN #4, who had CNA #1 escorted from the building. The DON (Director of Nursing) and the Administrator were informed, and ISDH (Indiana State Department of		conducted an in-service with signature required for all direct care givers reviewing the topic of 'strategies for dealing with aggressive residents'. 4. As a means of quality assurance, the Administrator or designee will review any/all investigations conducted with the Quality Assurance Committee to ensure that all investigations are thorough and are reported to the proper officials as was indicated for this incident.	

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	Health) was notified of the incident. The facility investigated, including statements from the witnesses, and other residents who had been cared for by CNA #1. The statement by the 2 CNA witnesses indicated the abuse had occurred. The statements by the other residents did not indicate they had a problem with the care they received from CNA #1. As a result of the investigation, CNA #1 was terminated. A current facility policy, titled "Abuse Prevention Program", undated, was provided by the Administrator on 10/15/13 at 10:45 A.M. It indicated: "Primary Policy Abuse Prohibition Policy: It shall be the policy of (name of facility) to assure that all residents of this facility are free from verbal, sexual, physical and mental abuse, corpora; punishment and involuntary seclusion...." This state tag relates to Complaint IN00137650. 3.1-27(a)(1)			