

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155611	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/23/2012
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NAME OF PROVIDER OR SUPPLIER HOOSIER CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 S SUGAR ST BROWNSTOWN, IN 47220
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F0000	<p>This visit was for the Investigation of Complaint IN00118578.</p> <p>This visit was in conjunction with the annual Recertification and State Licensure survey.</p> <p>Complaint IN00118578-Substantiated. Deficiencies related to the allegations are cited at F224, F225, F226</p> <p>Survey date: 10/23/12</p> <p>Facility number: 000277 Provider number:155611 AIM number : 100290530</p> <p>Survey team: Susan Worsham, RN-TC Marla Potts, RN Sharon Whiteman, RN</p> <p>Census bed type: SNF: 9 SNF/NF: 87 Total: 96</p> <p>Census payor type: Medicare: 8 Medicaid: 69</p>	F0000	<p>Please consider this plan of correction as Hoosier Christian Village's credible plan of correction. This plan of correction constitutes a written allegation of substantial compliance under Federal Medicare requirements. Submission of this plan of correction is not an admission that a deficiency exists or that the community agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our residents solely as a requirement of the provisions of Federal and State law. Please accept this evidence in lieu of an onsite follow up visit for Recertification and State Licensure Survey Event ID UOSV11 on October 23, 2012.</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.

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	<p>Other: 19 Total: 96</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2</p> <p>Quality review completed on October 25, 2012 by Bev Faulkner, RN</p>			

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F0224 SS=D	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE</p> <p>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 interview and record review, the facility failed to ensure 1 of 3 residents reviewed for narcotic medication was free from misappropriation of narcotics. (Resident A)</p> <p>Findings Include:</p> <p>During interview of the DON [Director of Nursing] on 10/23/12 at 11:00 a.m., the DON indicated she had an issue with a new RN and a missing narcotic sheet. The DON indicated during morning count of the narcotics the count was correct, but the day shift nurse who had counted the day before indicated she thought there should have been narcotics (MS Contin-Morphine Sulfate) remaining on the old sheet instead of 2 new sheets. The DON indicated she attempted to call the RN, but she would not return the phone call. The DON indicated the missing narcotic sheet was found folded up in [name of RN #1's] report sheet. The DON</p>	F0224	<p>On October 3, 2012, RN #1 was suspended from duty and terminated from employment on October 8, 2012 due to noncompliance with investigation of misappropriation of resident medications. On October 24, 2012, an inservice was presented to nurses that included reporting misappropriation to Administration immediately and expectation of participation with the investigation process. The Director of Nursing, the dayshift RN Supervisor and the evening shift RN Supervisor will complete weekly audits of shift to shift narcotic counts for one month, then every month for three months with any findings being brought to the CQI committee for further review and/or recommendations. On November 26, 2012, the CQI committee reviewed the DON and RN Supervisors weekly audits of shift to shift narcotic count. The narcotic count sheets were updated to include the number of cards for each narcotic. An inservice was given on November 14, 2012, by the Director of Nursing to nurses on instruction</p>	11/06/2012			

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	<p>indicated the nurse had taken 3 MS Contin (narcotic pain medication) tablets from Resident A's medications. The DON indicated an investigation was done, but the occurrence was not reported to ISDH (Indiana State Department of Health). The DON indicated the RN had finished orientation and had worked on the floor for about a week.</p> <p>An investigation sheet was provided by the DON on 10/23/12 at 12:30 p.m. The investigation sheet indicated, "On the morning of 10/03/12 1 South charge nurse [name of LPN #1] reported after morning narcotic count that there was a missing sheet of narcotics then she found a narcotic sign out/count sheet for resident (A) folded between a report sheet belonging to [name of RN #1], RN charge nurse. It was noted on the count sheet that 3 MS Contin 30 mg tabs were left out of 30 tabs received and 27 tabs administered as ordered. The 3 remaining MS Contin 30mg tabs were not located in the locked narcotic box in the locked med [medication] cart. [name of RN #1] had already left the building and was unable to be reached by phone to clarify what happened to the three missing narcotic pills and why the narcotic</p>		<p>of the new narcotic count sheets that included counting and documenting the number of cards. The CQI committee recommended that the DON or a designee continue with monthly audits of the narcotic count sheets ongoing. Any identified issues with compliance with the narcotic count sheets are to be addressed by the DON with the plan of correction for compliance brought to the CQI committee for any further recommendations.</p>				

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	<p>count sheet was not in the book to be check (sic) at shift to shift report as per policy. A message was left on [name of RN #1's] boyfriend per phone by [name of the DON] to return her call a.s.a.p. [as soon as possible] 'to discuss an incident that had happened that morning.' [name of RN #1] did not return the call on 10/03/12. [Name of the DON] left another message on 10/03/2012 evening on [name of RN #1's] cell phone stating that her scheduled shift on 10/03/12 10pm-6am had been covered by another nurse and that she needed to call [name of DON] to discuss an incident before her next scheduled shift on 10/04/2012. Again, [name of RN #1] did not return the call or report to work as scheduled on 10/04/12. [Name of RN #1's] next scheduled shifts were 10/06/12 and 10/07/12 10pm to 6am shift. Another message was left on [name of RN #1's] phone by [name of DON] on 10/05/2012 informing her that she needed to contact [name of DON] prior to returning work (sic) the next night. [Name of RN #1] did not report to work or return the phone calls. On 10/08/2012 [name of DON] left a message on [name of RN #1's] phone stating that since [name of RN #1] had not returned the phone call and did not report to work on her</p>			

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	<p>scheduled shifts of duty that it is considered abandonment of her job and that she has terminated her employment at HCV [Hoosier Christian Village.]"</p> <p>Review of a policy titled "Prevention of Abuse" provided by the facility on 10/16/12. The policy had a "Revision Date" of 10/29/10. The policy indicated, "It is the policy of Christian Homes, Inc. that each resident has the right to be free from abuse by anyone, including, but not limited to: staff members, other residents, consultants, volunteers, staff of other agencies serving the resident....The Administrator serves as the Abuse Prevention Coordinator and is responsible for the coordination of investigations into allegations of abuse or neglect.... It is everyone's responsibility to report suspicions of neglect or abuse to the Abuse Prevention Coordinator immediately....Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent...."</p> <p>This Federal tag is related to Complaint IN00118578.</p>				

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	3.1-28 (a)			

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F0225 SS=D	<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 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 interview and record</p>	F0225	On October 23, 2012,	11/06/2012			

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	<p>review, the facility failed to ensure a misappropriation of narcotic medication was reported to state agencies for 1 of 3 residents reviewed.</p> <p>Findings Include:</p> <p>During interview of the DON [Director of Nursing] on 10/23/12 at 11:00 a.m., the DON indicated she had an issue with a new RN and a missing narcotic sheet. The DON indicated during morning count of the narcotics the count was correct, but the day shift nurse who had counted the day before indicated she thought there should have been narcotics (MS Contin-Morphine Sulfate) remaining on the old sheet instead of 2 new sheets. The DON indicated she attempted to call the RN, but she would not return the phone call. The DON indicated the missing narcotic sheet was found folded up in [name of RN #1's] report sheet. The DON indicated the nurse had taken 3 MS Contin (narcotic pain medication) tablets from Resident A's medications. The DON indicated an investigation was done, but the occurrence was not reported to ISDH (Indiana State Department of Health). The DON indicated the RN had finished orientation and had worked</p>		<p>Administration reported misappropriation to Indiana State Department of Health. On October 23, 2012, surveyors investigated the occurrence and the Office of Attorney General was notified. On October 29, 2012, the Office of Attorney General visited Hoosier Christian Village and investigated the occurrence. The Administrator will report to Indiana State Department of Health as per Hoosier Christian Village policy misappropriation of resident property and complete a thorough investigation. On October 23, 2012, Administration reported misappropriation to Indiana State Department of Health. On October 23, 2012, surveyors investigated the occurrence and the Office of Attorney General was notified. On October 29, 2012, the Office of Attorney General visited Hoosier Christian Village and investigated the occurrence. The Administrator will report to Indiana State Department of Health as per Hoosier Christian Village policy misappropriation of resident property and complete a thorough investigation. 1. Resident A's three missing MS Contin tabs were replaced by the facility. No other residents were found to be effected. 2. All residents had the potential to be effected by RN #1's deficient practice. RN #1 is no longer employed by the facility. The narcotic count policy</p>		

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	<p>on the floor for about a week. The DON indicated she did not report this to the police department.</p> <p>An investigation sheet was provided by the DON on 10/23/12 at 12:30 p.m. The investigation sheet indicated, "On the morning of 10/03/12 1 South charge nurse [name of LPN #1] reported after morning narcotic count that there was a missing sheet of narcotics then she found a narcotic sign out/count sheet for resident (A) folded between a report sheet belonging to [name of RN #1], RN charge nurse. It was noted on the count sheet that 3 MS Contin 30 mg tabs were left out of 30 tabs received and 27 tabs administered as ordered. The 3 remaining MS Contin 30mg tabs were not located in the locked narcotic box in the locked med [medication] cart. [name of RN #1] had already left the building and was unable to be reached by phone to clarify what happened to the three missing narcotic pills and why the narcotic count sheet was not in the book to be check (sic) at shift to shift report as per policy. A message was left on [name of RN #1's] boyfriend per phone by [name of the DON] to return her call a.s.a.p. [as soon as possible] 'to discuss an incident that had</p>		<p>was reviewed by the Director of Nursing with nurses on the 11/14/2012 nurses meeting and will be included in the nurse orientation program to ensure newly employed nurses understand narcotics are monitored closely and nurses are held accountable for accurate count at the end of their shift of duty. The Administrator will report any misappropriation of narcotic medication 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 will be taken. 3. On November 14, 2012, the DON reinserviced nurses on completion of the shift to shift narcotic count and reporting any concerns immediately to the DON and/or Administrator. The Administrator will report any misappropriation of narcotic medication to other officials in accordance to 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 will be taken. 4. The Administrator will review all incidents at the morning clinical meeting with the DON, Dietary Manager, SSD, MDS Coordinator, Rehab Manager,. Any incident with misappropriation of narcotics will be reported to other officials in</p>	

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	<p>happened that morning.' [name of RN #1] did not return the call on 10/03/12. [Name of the DON] left another message on 10/03/2012 evening on [name of RN #1's] cell phone stating that her scheduled shift on 10/03/12 10pm-6am had been covered by another nurse and that she needed to call [name of DON] to discuss an incident before her next scheduled shift on 10/04/2012. Again, [name of RN #1] did not return the call or report to work as scheduled on 10/04/12. [Name of RN #1's] next scheduled shifts were 10/06/12 and 10/07/12 10pm to 6am shift. Another message was left on [name of RN #1's] phone by [name of DON] on 10/05/2012 informing her that she needed to contact [name of DON] prior to returning work (sic) the next night. [Name of RN #1] did not report to work or return the phone calls. On 10/08/2012 [name of DON] left a message on [name of RN #1's] phone stating that since [name of RN #1] had not returned the phone call and did not report to work on her scheduled shifts of duty that it is considered abandonment of her job and that she has terminated her employment at HCV [Hoosier Christian Village.]"</p> <p>Review of a policy titled "Prevention</p>		<p>accordance to state law (including state survey and certification agency) within 5 working days of the incident, and if the alleged violation os verified appropriate corrective action will be taken.</p>				

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	<p>of Abuse" provided by the facility on 10/16/12. The policy had a "Revision Date" of 10/29/10. The policy indicated, "It is the policy of Christian Homes, Inc. that each resident has the right to be free from abuse by anyone, including, but not limited to: staff members, other residents, consultants, volunteers, staff of other agencies serving the resident....Reporting - When staff are aware of any type of abuse, such as witnessing or hearing any action that could constitute abuse, as defined in the 'definitions' section of this policy, they are to immediately report it to the Abuse Coordinator. As soon as possible without delay an initial report will be made to the appropriate state department...."</p> <p>This Federal tag relates to Complaint IN00118578.</p> <p>3.1-28(c)</p>			

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>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 interview and record review, the facility failed to follow facility policy and procedures for reporting misappropriation of narcotic medication for 1 of 3 residents reviewed for narcotic medication. (Resident A)</p> <p>Findings Include:</p> <p>During interview of the DON [Director of Nursing] on 10/23/12 at 11:00 a.m., the DON indicated she had an issue with a new RN and a missing narcotic sheet. The DON indicated during morning count of the narcotics the count was correct, but the day shift nurse who had counted the day before indicated she thought there should have been narcotics (MS Contin-Morphine Sulfate) remaining on the old sheet instead of 2 new sheets. The DON indicated she attempted to call the RN, but she would not return the phone call. The DON indicated the missing narcotic sheet was found folded up in [name of RN #1's] report sheet. The DON</p>	F0226	<p>On October 23, 2012, Administration reported misappropriation to Indiana State Department of Health. On October 23, 2012, surveyors investigated the occurrence and the Office of Attorney General was notified. On October 29, 2012, the Office of Attorney General visited Hoosier Christian Village and investigated the occurrence. The Administrator will report to Indiana State Department of Health as per Hoosier Christian Village policy misappropriation of resident property and complete a thorough investigation. 1. Resident A's three missing MS Contin tabs were replaced by the facility. No other residents were found to be effected. 2. All residents had the potential to be effected by this practice. The Administrator will review all incidents every morning at the clinical meeting. Any incidents with misappropriation of narcotic medication will be reported within 5 working days by the Administrator to other officials in accordance with state law (including state survey and certification survey) and if the alleged violation is verified</p>	11/06/2012			

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	<p>indicated the nurse had taken 3 MS Contin (narcotic pain medication) tablets from Resident A's medications. The DON indicated an investigation was done, but the occurrence was not reported to ISDH (Indiana State Department of Health). The DON indicated the RN had finished orientation and had worked on the floor for about a week. The DON indicated she did not report this to the police department.</p> <p>An investigation sheet was provided by the DON on 10/23/12 at 12:30 p.m. The investigation sheet indicated, "On the morning of 10/03/12 1 South charge nurse [name of LPN #1] reported after morning narcotic count that there was a missing sheet of narcotics then she found a narcotic sign out/count sheet for resident (A) folded between a report sheet belonging to [name of RN #1], RN charge nurse. It was noted on the count sheet that 3 MS Contin 30 mg tabs were left out of 30 tabs received and 27 tabs administered as ordered. The 3 remaining MS Contin 30mg tabs were not located in the locked narcotic box in the locked med [medication] cart. [name of RN #1] had already left the building and was unable to be reached by phone to clarify what</p>		<p>appropriate corrective action will be taken. 3. The systemic change that has been implemented is the review of incidents by the Administrator at the morning clinical meetings as stated in statement 2. 4. The CQI committee will review monthly, ongoing, all incidents to ensure compliance with reporting misappropriation of narcotic medication to other state officials (including state survey and certification agency).</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155611		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/23/2012	
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	<p>happened to the three missing narcotic pills and why the narcotic count sheet was not in the book to be check (sic) at shift to shift report as per policy. A message was left on [name of RN #1's] boyfriend per phone by [name of the DON] to return her call a.s.a.p. [as soon as possible] 'to discuss an incident that had happened that morning.' [name of RN #1] did not return the call on 10/03/12. [Name of the DON] left another message on 10/03/2012 evening on [name of RN #1's] cell phone stating that her scheduled shift on 10/03/12 10pm-6am had been covered by another nurse and that she needed to call [name of DON] to discuss an incident before her next scheduled shift on 10/04/2012. Again, [name of RN #1] did not return the call or report to work as scheduled on 10/04/12. [Name of RN #1's] next scheduled shifts were 10/06/12 and 10/07/12 10pm to 6am shift. Another message was left on [name of RN #1's] phone by [name of DON] on 10/05/2012 informing her that she needed to contact [name of DON] prior to returning work (sic) the next night. [Name of RN #1] did not report to work or return the phone calls. On 10/08/2012 [name of DON] left a message on [name of RN #1's] phone stating that since [name of RN</p>						

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	<p>#1] had not returned the phone call and did not report to work on her scheduled shifts of duty that it is considered abandonment of her job and that she has terminated her employment at HCV [Hoosier Christian Village.]"</p> <p>Review of a policy titled "Prevention of Abuse" provided by the facility on 10/16/12. The policy had a "Revision Date" of 10/29/10. The policy indicated, "It is the policy of Christian Homes, Inc. that each resident has the right to be free from abuse by anyone, including, but not limited to: staff members, other residents, consultants, volunteers, staff of other agencies serving the resident....The Administrator serves as the Abuse Prevention Coordinator and is responsible for the coordination of investigations into allegations of abuse or neglect.... It is everyone's responsibility to report suspicions of neglect or abuse to the Abuse Prevention Coordinator immediately....Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent... Reporting - When staff are aware of any type of abuse, such as</p>			

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	<p>witnessing or hearing any action that could constitute abuse, as defined in the 'definitions' section of this policy, they are to immediately report it to the Abuse Coordinator. As soon as possible without delay an initial report will be made to the appropriate state department...."</p> <p>This Federal tag relates to Complaint IN00118578.</p> <p>3.1-28(a)</p>			