

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155473	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/31/2012
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NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY ST BERNE, IN 46711
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F0000	<p>This visit was for the Investigation of Complaint IN00115475.</p> <p>This visit was in conjunction with the Recertification and State Licensure Survey</p> <p>Complaint IN00115475 - Substantiated. Federal/state deficiencies related to the allegations are cited at F225 and F226.</p> <p>Survey dates: 8/29/12, 8/30/12 and 8/31/12.</p> <p>Facility number: 000546 Provider number: 155473 AIM number: 100267370</p> <p>Survey Team: Shelley Reed, RN</p> <p>Census bed type: SNF/NF: 35 Total: 35</p> <p>Census payor type: Medicare: 3 Medicaid: 23 Other: 9 Total: 35</p> <p>Sample: 4</p>	F0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirement under the state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

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>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 7, 2012 by Bev Faulkner, RN</p>				

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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	I. The facility acknowledges	09/20/2012			

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	<p>review, the facility failed to report an elopement incident to the state agency for 1 of 1 residents reviewed for elopement. (Resident # 41).</p> <p>Findings include:</p> <p>During a confidential interview on 8/29/12 at 3:49 p.m., the interviewee indicated he was hired to do some repair work during the Spring of 2012. He indicated he was often at the nurses station doing some repair work and would often hear staff members talking to one another about residents. He indicated he overheard two staff members talking about Resident #41 and how she had gotten outside of the building. He indicated one staff member indicated she had charted the information in the required daily Medicare charting for the resident. The other staff member indicated she should not have put that into the chart because the Administrator would not want to have to report it to the Indiana State Department of Health.</p> <p>During a confidential interview on 8/30/12 at 11:05 a.m., an employee indicated Resident #41 did get out of the facility in the spring and was found to be in the front of the building. She indicated the resident was sent</p>		<p>that there was a known incident which occurred on 5/26/12, on which date (as reflected in the behavior memo referenced on the 2567) the resident exited the front entrance. However, the resident was in view of, and followed by a staff member who re-directed her back into the facility. Unfortunately, contracted and other employees interviewed were not the staff member who followed the resident and redirected the resident, thus, were not aware of the specifics of the incident. The incident was reviewed upon occurrence by administration. However, did not meet the definition in that the resident's whereabouts had been known, as staff had followed the resident out of the facility, redirected the resident back into the facility, and the resident was never out of the line of sight of the staff member.</p> <p>II. As all resident s could be affected, the following corrective actions shall be taken:</p> <p>III. Administrative staff of the facility has again reviewed the reportable unusual occurrence guidance. Thorough investigation shall be conducted following a report of any such occurrence, with a summary of witness statements, etc., addressing the factual account as given by those staff members who witnessed the said occurrence. Should an incident occur which appears that it could meet the guidance, the</p>		

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	<p>to a behavior facility and since returning has had improved behavior.</p> <p>During a confidential interview on 8/30/12 at 11:10 a.m., an employee indicated Resident #41 slipped out one evening with another resident and their family. The employee indicated the incident had occurred within the past three months.</p> <p>During an interview on 8/30/12 at 11:18 a.m., the Administrator indicated the resident had never gotten out of the building. She indicated the resident was seen by staff to have gotten out the first set of doors, but never made it out the second set of doors that lead to the front of the building. She indicated the resident was then sent to a behavioral center and has since returned. The elopement incident was not report to the state agency.</p> <p>During record review on 8/31/12 at 3:30 p.m., a mood and behavior communication memo, dated 5/26/12 at 9:35 a.m., indicated Resident #41 proceeded out the front entrance behind another resident who was with their family. Resident was redirected back to room, to restroom, then to chair by nurses station. She was then referred to Life Bridge for a 14</p>		<p>incident will be immediately reviewed with the Regional Director to further clarify. Should the administrative staff still yet remain uncertain as to need to report, the ISDH Area Supervisor may be contacted and clarification sought in an effort to remain in compliance with reporting per ISDH guidance.</p> <p>IV. As a means of quality assurance, a regulatory consultant shall review all incidents reported as unusual occurrences at the time of reporting, in an effort to verify ongoing compliance with reporting incidents to ISDH as per the reportable unusual occurrence guidance. The assigned nurse consultant shall review all incidents occurring at the facility on a weekly basis (See exhibit A). Should there be concerns as to facility failure to recognize an incident as meeting the reportable unusual occurrence guidance, the same shall be addressed immediately upon discovery and corrective action taken, as warranted.</p>		

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	<p>day stay. Nursing progress note, dated 5/26/12 at 11:50 a.m., indicated resident was redirected back to room four times then moved to another room away from the front door. A monthly behavior flow record was reviewed and indicated Resident #41 had an elopement on 5/26/12.</p> <p>This Federal tag relates to Complaint IN00115475</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 implement their policy related to reporting to state agencies an elopement for 1 of 1 residents reviewed for elopement. (Resident #41).</p> <p>Findings include:</p> <p>During a confidential interview on 8/29/12 at 3:49 p.m., the interviewee indicated he was hired to do some repair work during the Spring of 2012. He indicated he was often at the nurses station doing some repair work and would often hear staff members talking to one another about residents. He indicated he overheard two staff members talking about Resident #41 and how she had gotten outside of the building. He indicated one staff member indicated she had charted the information in the required daily Medicare charting for the resident. The other staff member indicated she should not have put that into the chart because the Administrator would not want to have</p>	F0226	<p>I. The facility acknowledges that there was a known incident which occurred on 5/26/12, on which date (as reflected in the behavior memo referenced on the 2567) the resident exited the front entrance. However, the resident was in view of, and followed by a staff member who re-directed her back into the facility.</p> <p>Unfortunately, contracted and other employees interviewed were not the staff member who followed the resident and redirected the resident, thus, were not aware of the specifics of the incident. The incident was reviewed upon occurrence by administration. However, did not meet the definition in that the resident's whereabouts had been known, as staff had followed the resident out of the facility, redirected the resident back into the facility, and the resident was never out of the line of sight of the staff member.</p> <p>II. As all resident s could be affected, the following corrective actions shall be taken:</p> <p>III. Administrative staff of the facility has again reviewed the reportable unusual occurrence guidance as well as facility policy</p>	09/20/2012

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	<p>to report it to the Indiana State Department of Health.</p> <p>During a confidential interview on 8/30/12 at 11:05 a.m., an employee indicated Resident #41 did get out of the facility in the Spring and was found to be in the front of the building. She then indicated the resident was sent to a behavior facility and since returning has had improved behavior.</p> <p>During a confidential interview on 8/30/12 at 11:10 a.m., an employee indicated Resident #41 slipped out in the evening with another resident and their family. The employee indicated the incident had occurred within the past three months.</p> <p>During an interview on 8/30/12 at 11:18 a.m., the Administrator indicated the resident had never gotten out of the building. She indicated the resident was seen by staff to have gotten out the first set of doors but never made it out the second set of doors that lead to the front of the building. She indicated the resident was then sent to a behavioral center and has since returned.</p> <p>During record review on 8/31/12 at 3:30 p.m., a mood and behavior</p>		<p>which mandates adherence with the reportable unusual occurrence guidance. Thorough investigation shall be conducted following a report of any such occurrence, with a summary of witness statements, etc., addressing the factual account as given by those staff members who witnessed the said occurrence. Should an incident occur which appears that it could meet the guidance, the incident will be immediately reviewed with the Regional Director to further clarify. Should the administrative staff still yet remain uncertain as to need to report, the ISDH Area Supervisor may be contacted and clarification sought in an effort to remain in compliance with reporting per ISDH guidance.</p> <p>IV. As a means of quality assurance, a regulatory consultant shall review all incidents reported as unusual occurrences at the time of reporting, in an effort to verify ongoing compliance with reporting incidents to ISDH as per the reportable unusual occurrence guidance. The assigned nurse consultant shall review all incidents occurring at the facility on a weekly basis. (See exhibit A) Should there be concerns as to facility failure to recognize an incident as meeting the reportable unusual occurrence and report as per facility policy, the same shall be addressed immediately upon</p>		

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	<p>communication memo, dated 5/26/12 at 9:35 a.m., indicated Resident #41 proceeded out the front entrance behind other resident who was with their family. The resident was redirected back to room, to restroom, then to chair by nurses station. She was then referred to Life Bridge for a 14 day stay. Nursing progress note, dated 5/26/12 at 11:50 a.m., indicated resident was redirected back to room four times then moved to another room away from the front door. A monthly behavior flow record was reviewed and indicated Resident #41 had an elopement on 5/26/12.</p> <p>Review of the clinical record for Resident # 41 on 8/31/12 at 3:40 p.m., indicated diagnoses of Alzheimer's disease, anxiety and depression. The Minimum Data Set (MDS) assessment of 6/20/12 indicated the resident was unable to complete the Brief Interview for Mental Status (BIMS) assessment.</p> <p>Review of a current facility policy, dated 2/10, and titled "Reporting Unusual Occurrences to the State" which was provided by the Director of Nursing on 8/31/12 at 11:30 a.m., indicated the following:</p> <p>"This facility shall insure that the</p>		discovery and corrective action taken, as warranted.				

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	<p>division is immediately informed, within twenty-four (24) hours, of unusual concurrences that directly threaten the welfare, safety or health of the residents, including, but not limited to, any...Resident Elopement-</p> <p>(A) A cognitively impaired resident who was found outside the facility and whose whereabouts had been unknown.</p> <p>This Federal tag relates to Complaint IN00115475</p> <p>3.1-28(a)</p>				