

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307
---	--

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

F0000	<p>This visit was for the Investigation of Complaint IN00117245.</p> <p>Complaint IN00117245 - Substantiated. Federal/state deficiency related to the allegations is cited at F279.</p> <p>Survey dates: October 15 & 16, 2012</p> <p>Facility number: 000515 Provider number: 155608 AIM number: 100290820</p> <p>Survey team: Janet Adams, RN</p> <p>Census bed type: SNF: 16 SNF/NF: 132 Total: 148</p> <p>Census payor type: Medicare: 26 Medicaid: 71 Other: 51 Total: 148</p> <p>Sample: 4</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC</p>	F0000		
-------	--	-------	--	--

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: 155608	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307		
(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	
	16.2. Quality review 10/18/12 by Suzanne Williams, RN				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307		
(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	
F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure care plans were developed to address a relationship between a female resident and a male resident including being in bed with one another, for 2 of 2 residents reviewed for care plans related to relationships in the sample of 4. (Residents #C & #D)</p> <p>Finding include:</p> <p>1. The record for Resident #C was reviewed on 10/15/12 at 10:05 a.m.</p>	F0279	<p>F279 1. What corrective action(s) will be accomplished for those residents found to have been affected by alleged deficient practice? Comprehensive care plans were for resident #C and #D updated with and Intimacy care plan on 10/16/2012</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Any resident who need to express intimacy and sexuality with another resident have the potential to be affected by the deficient practice All residents</p>	10/29/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307		
(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 resident's diagnoses included, but were not limited to, cerebral vascular accident (stroke), diabetes mellitus, and Alzheimer's disease. The 8/30/12 Minimum Data Set quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was 15. This indicated the resident's cognitive patterns were intact. The assessment also indicated the resident displayed no behaviors or indicators of psychosis. The assessment also indicated the resident required assistance of one staff person for dressing and transfers.</p> <p>The 8/12 Social Service Notes were reviewed. An entry made on 8/9/12 (no time) indicated the Social Worker spoke to the resident's daughter to discuss the resident's recent statements about wanting to get married to another resident at the facility.</p> <p>The 9/12 Social Service Progress Notes were reviewed. An entry made on 9/18/12 (no time documented) indicated a Nurse notified the Social Worker that Resident #C had been found in bed with another resident with minimal clothes on. The notes also indicated the resident stated it</p>		<p>were reviewed 10/25/12 no other residents intimacy and sexuality needs at this time. See attachment A Revised comprehensive care plan policy 10/23/2012 to include review of a need for Resident expression of intimacy and sexuality guidelines. See Attachment B Nursing Staff to be in-serviced on comprehensive care plan policy and resident intimacy and sexuality guidelines on 10/25/2012 and 10/26/2012 See Attachment C 3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practices do not recur? Nursing Staff to be in-service on 10/25/2012 and 10/26/2012 Comprehensive care plan policy revised 10/23/12 Intimacy care plan audit created 10/23/12 See Attachment D 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice does not recur, i.e. what quality assurance program will be put into place? Intimacy care audit to be done weekly for one month, then monthly for 3 months, then quarterly for 6 months. by Social Services QA to check quarterly for compliance The Administrator will oversee quality assurance compliance. Completion Date: October 29, 2012</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307
---	--

(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 her idea and she "threw" herself into the bed and caused a skin tear. The note also indicated the other resident had his clothes on and was touching the resident and Resident #C indicated she had full knowledge of actions. An entry made on 9/24/12 indicated the local Ombudsman was at the facility on this date and the DON and ADON met with him and they reviewed the resident's diagnoses, BIMS score and decision making skills and he reported the resident would be able to make decisions about her relationship.</p> <p>The 10/12 Social Service Progress Notes were reviewed. An entry made on 10/10/12 indicated the Social Worker was notified that Resident #C was observed in the bed with the same male resident as on 9/18/12 with her pants down. The resident voiced no concerns at this time.</p> <p>The resident's current care plans were reviewed. A typed care plan, initiated on 9/21/12, indicated the resident was at risk for psychosocial distress related to being an alleged victim of maladaptive behavior as evidenced by being verbally threatened by her son-in-law via the telephone. There were 6 typed care plan approaches for this care plan.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307
---	--

(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 the line below the above identified there was a hand written note, which indicated the resident was good friends with another resident and prefers to spend most of her time with him, and her family becomes upset. There was no care plan in place addressing the occurrence when the resident was in bed with her male friend. There were no interventions or approaches of the protocol staff were to follow when observing the residents in bed together.</p> <p>When interviewed on 10/15/12 at 2:30 p.m., the Social Worker indicated Resident #C was hospitalized in July with a new diagnosis of Bells Palsy and the resident had been spending less time in activities and eating more of her meals in her room. The Social Worker indicated the resident started talking with Resident #D in the hallway and spending more time together. The Social Worker indicated she was not aware of any physical contact between the two residents at that time. The Social Worker indicated the facility met with the Ombudsman on 9/24/12 and it was determined both residents were capable of voicing when they wanted privacy. The Social Worker indicated she left messages on the care tracker</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307		
(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>system that staff were to provide privacy to the residents. She indicated the care tracker is where staff sign in to do some documentation.</p> <p>When interviewed on 10/15/12 at 12:45 p.m., CNA #1 indicated she was working on the hall and assigned to care for Residents #C and #D. The CNA indicated the residents spend time with each other in their rooms. The CNA indicated she is to report to the Nurse if she observes them in bed together. The CNA indicated she has never witnessed Resident #D being abusive or mean toward Resident #C.</p> <p>When interviewed on 10/16/12 at 9:00 a.m., the DON indicated staff Nurses were to report to Social Services if residents were observed in bed together. The DON indicated Resident #C was been instructed to ask staff for assistance and staff were to assist to transfer Resident #C in and out of beds if she requests. The DON indicated there was no care plan in place addressing staff interventions for reporting when the residents were in bed and assisting the residents if needed.</p> <p>2. The record for Resident #D was reviewed on 8/15/12 at 9:40 a.m. The</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/16/2012	
NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307			
(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>resident's diagnoses included, but were not limited to, history of CVA (stroke), Alzheimer's disease, peripheral vascular disease, and diabetes. The 8/15/12 Minimum Data Set annual assessment indicated the resident BIMS (Brief Interview for Mental Status) score was 13. This indicated the resident's cognitive patterns were intact and did not display any delusions or hallucinations.</p> <p>The 8/12 Social Service Progress Notes were reviewed. An entry made on 8/9/12 (no time documented) indicated the resident was asking how residents can go about getting married and writer explained that depending on the residents, the Physician may have to review to see if the decision can be made by the resident.</p> <p>The 9/12 Social Service Progress Notes were reviewed. An entry made on 9/18/12 (no time documented) indicated Resident #C had transferred herself into the resident's bed with minimal clothes on and the resident was calm when staff redirected Resident #C to put her clothes on.</p> <p>The 10/12 Social Service Progress Notes were reviewed. An entry made</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307		
(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 10/10/12 (no time documented) indicated Social Service met with the resident related to a report that Resident #C was noted in the resident's bed the last evening with pants down. The note indicated Social Services reviewed resident's rights to privacy with staff. The note also indicated the resident voiced no concerns and was aware how to contact the Social Worker for any questions or concerns, and the resident would be observed for any changes or signs of distress.</p> <p>The resident's current care plans were reviewed. There was no care plan available related to the above occurrences and how staff were to address the episodes of Resident #C being in Resident #D's bed not fully clothed.</p> <p>When interviewed on 10/16/12 at 9:00 a.m., the DON indicated there was no care plan in place addressing staff interventions for reporting when the residents were in bed and assisting the residents if needed.</p> <p>This federal tag relates to Complaint IN00117245.</p> <p>3.1-35(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307
---	--

(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