

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 02/25/2014
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NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00137810 and IN00142636.</p> <p>Complaint IN00137810-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00142636-Substantiated. No deficiencies related to the allegations are cited</p> <p>Survey dates: February 17, 18, 19, 20, 21, 24, 25, 2014</p> <p>Facility number: 00515 Provider number: 155608 AIM number: 100290820</p> <p>Survey team: Jennifer Redlin, RN, TC Caitlyn Doyle, RN Heather Hite, RN Janelyn Kulik, RN - (February 18 and 24, 2014)</p> <p>Census bed type: SNF: 16</p>	F000000		

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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F000465 SS=E	<p>SNF/NF: 132 Total: 148</p> <p>Census Payor type: Medicare: 26 Medicaid: 77 Other: 45 Total: 148</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on February 26, 2014, by Janelyn Kulik, RN.</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview the facility failed to maintain a functional and safe environment related to marred walls, gouged and</p>	F000465	<p>1. What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents have been affected</p>	03/27/2014

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	<p>splintered doors, broken floor tiles, loose molding and cracked caulk on 4 of 7 halls throughout the facility. (200, 300, 600 and 700 Halls).</p> <p>Findings include:</p> <p>During an Environmental tour on 2/24/14 at 3:20 p.m. with the Administrator, Director of Facilities, Director of Maintenance and Director of Housekeeping, the following was observed:</p> <p>1. 200 Hall</p> <p>a. There were gouges to the inside of the bathroom door in Room 202. Two residents resided in this room.</p> <p>b. The bathroom of Room 214 had cracked caulk around the sink and gouges to the inside of the bathroom door. Two residents resided in this room.</p> <p>2. 300 Hall</p> <p>a. The closet door was gouged and splintered in Room 306 and the wall was marred next to the bathroom. Two residents resided in this room.</p> <p>b. There were gouges to the inside of the bathroom door in room 309.</p>		<p>by the alleged deficient practice. The doors in rooms 202, 214, 306, 309, 310, 603, 607, and 713 have been repaired. The caulk in room 214 has been repaired. The walls in rooms 306, 614 and 713 have been repaired. The tile in rooms 607 and 713 has been repaired. The molding in room 614 has been repaired. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. An audit of resident rooms has been conducted and door, wall, tile and molding issues have been identified and repaired. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. Housekeeping & nursing staff have been re-educated on ensuring they are reporting issues with doors, walls, tile and molding to Maintenance through the maintenance books located at the nurse stations. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. Director of Plant Operations to conduct a random audit of 5 rooms per week to ensure repairs are occurring. Above audit will be done monthly for 6 months or until 100% compliance is achieved. Quality Assurance Committee to monitor for trends and compliance. Date of</p>		

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	<p>Two residents resided in this room.</p> <p>c. In room 310, the entry door was gouged and splintered and there were gouges to the closet and bathroom doors. Two residents resided in this room.</p> <p>3. 600 Hall</p> <p>a. The outside of the bathroom door in Room 603 was marred and splintered. Two residents resided in this room.</p> <p>b. The outside of the bathroom door in Room 607 was chipped and the bathroom had broken floor tile. Two residents resided in this room.</p> <p>c. In Room 614, there was loose molding in the bathroom, marred walls in the bathroom and marred walls in the room next to the bathroom. Two residents resided in this room.</p> <p>4. 700 Hall</p> <p>a. There were gouges to the inside of the bathroom door, broken floor tile in the bathroom, and gouges to the walls in Room 713. Two residents resided in this room.</p>		Compliance: 3/27/14	

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	<p>Interview with the Director of Facilities, Maintenance Director and the Administrator at the time of the tour, indicated all of the areas were in need of repair and there was no current maintenance schedule in place.</p> <p>3.1-19(f)</p>				

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F000496 SS=C	<p>483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING</p> <p>Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.</p> <p>Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.</p> <p>If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.</p> <p>Based on record review and interview the facility failed to ensure a CNA had current certification. This had the potential to effect 147 of 147 residents who resided in the</p>	F000496	<p>1. What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by the alleged deficient practice.</p>	03/27/2014			

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	<p>facility. (CNA #1)</p> <p>Findings include:</p> <p>Employee files were reviewed on 2/24/14 at 1:00 p.m. Current certification was not found for CNA #1.</p> <p>The employee file for CNA #1 was reviewed on 2/24/14 at 4:10 p.m. CNA #1 was hired on 4/12/13.</p> <p>Interview with Human Resources Assistant #1 on 2/24/14, at 3:30 p.m., indicated CNA#1 had provided the facility with a certificate of completion of a training program dated 3/8/13. She further indicated CNA#1 had taken the certification test within 120 days of completion of the training program, according to CNA #1. This would have been within 120 days of the 3/8/13 date. Human Resources Assistant #1 indicated that CNA #1 had been working in the facility.</p> <p>Review of the nursing staff schedule for 2/17/14 through 2/24/14 indicated CNA #1 worked in the facility 2/19/14 and 2/20/14. CNA #1 was also scheduled to work on 2/24/14.</p>		<p>C.N.A. #1 was taken off the schedule at 4:15 p.m. on 2/24/14. C.N.A. #1 is no longer employed by the facility. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. An audit of all C.N.A. records was completed on 2/27/14 by Human Resources. The audit verified that all other C.N.A.'s employed by the facility have a current certification. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. Administrator or Designee to verify that all new C.N.A.'s employed and actively working in facility have active licenses through attached audit form. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. Administrator or Designee to randomly audit 5 C.N.A. records per month to ensure all licenses in good standing. Above audit will be done monthly for 6 months or until 100% compliance is achieved. Quality Assurance Committee to monitor for trends and compliance. Date of Compliance: 3/27/14</p>				

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	<p>Interview with the Administrator on 2/24/14 4:06 p.m., indicated CNA #1 had been working in the facility. She indicated she was just made aware of CNA #1 not having current certification.</p> <p>Search of the Indiana Nurse Aide Registry on 2/24/14 at 4:00 p.m., indicated there was no record of CNA #1's certification.</p> <p>3.1-14(f)</p>			