STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155246		03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF DUNELAND, THE	110 BEVERLY DR CHESTERTON, IN 46304

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F 000 Bldg. 00	This visit was for the Investigation of Complaint IN00170087. Complaint IN00170087- Substantiated. Federal/State deficiencies related to the allegations are cited at F225 and F226. Survey date: March 30, 2015 Facility number: 000150 Provider number: 155246 AIM number: 100267000 Survey team: Janet Adams, RN-TC Census bed type: SNF/NF: 83 Total: 83 Census payor type: Medicare: 17 Medicaid: 59 Other: 7 Total: 83 Sample: 4 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 000	000-Preparation and/or execution of the plan of correction in general, or this corrective action in particular does not constitute an admission agreement by the faciity of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This POC is to serve as the Waters of Duneland's credible allegation of compliance.	

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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	Quality review completed on April 5, 2015, by Janelyn Kulik, RN.			
F 225 SS=D Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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. 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). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be			

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	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.			
	Based on record review and interview, the facility failed to ensure all allegations of possible mistreatment were investigated in a timely manner related to a staff member not reporting an allegation of abuse to the facility Administrator at the time the allegation was first verbalized for 1 of 3 allegations of abuse reviewed. (Resident #E) (CNA #1 and CNA #2). Finding includes: The record for Resident #E was reviewed on 3/30/15 at 1:31 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, depressive disorder, osteoporosis, systemic lupus, and joint pain. Review of the 3/20/15 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (15). A score of (15) indicated the resident's cognitive patterns were intact. The assessment indicated the resident	F 225	It is the policy of this facility to ensure that all allegations of possible mistreatment are investigated in a timely manner. Further, any allegation of abuse or possible abuse is to be reported to the Adiministrator or DON (who will report it to the Administrator) as soon as the occurence is witnessed or reported or suggested as having happened and this occurance is reported to any staff member. Additionaly, the facility's protocol as per the Abuse Policy is to be immediately implemented including but not limited to securing the safety of the residnt(s) involved and initiating a thourough investigation. Resident E has had no other concerns or complaints with any incidents or unacceptable treatment or behavior from any other staff member since the cited incident. CNA #1 was going to be disciplined and further trained in the requirement to report any report of abuse, but CNA #1 called the facility and terminated herself before this could happen. CNA #2 who exhibited the behavior, was immediately suspended when	04/29/2015

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	was always incontinent of bowel and bladder. The assessment also indicated the resident required extensive assistance of one staff member for personal hygiene and bed mobility. The assessment also indicated the resident had impairment in range of motion of both her upper and both her lower extremities. Review of an Incident Report Form dated 3/25/15 indicated during a Social Service visit, Resident #E expressed a concern about a care giver to the Social Worker. The Social Worker immediately informed the facility Administrator, an investigation was initiated, and the CNA named by the resident was suspended pending an investigation. Review of the 3/25/15 Resident Interview form completed by the Social Worker, indicated Resident #E was interviewed on 3/25/15. The form indicated the resident stated during the midnight shift, the new male CNA thought she had urinated on purpose and he threw the washcloth and threw the door open. The facility investigation of the above allegation was initiated on 3/25/15. Staff interviews were obtained by the Director of Nursing. CNA #2 was identified as the staff member caring for Resident #E at the time the alleged abuse		staff learned of his actions. CNA #2 did not report to work and was therefore terminated due to excessive absenteeism. He was in his probationary period. All residents who were interviewable on the unit were interviewed as to their care and treatment. Non-interviewable residents were assessed head-to-toe for any signs of abuse. No negative findings were obtained. Note:CNA #2 had only worked on this unit. All staff to be inserviced on all requirements of the Abuse Policy with emphasis on the need to immediately report any abuse or alleged or suspected abuse to the Adiministrator or DON (who will report it to the Administrator) so that the protocol in the Abuse Policy can be initiated at that time. Any staff who fail to comply with the points of the Abuse Policy will be further educated and progressively disciplined up to and including termination. -See Exhibit A (26 pages) The facility has developed a new process of documentation at the end of each shift which ensures that no complaints of abuse or alleged abuse occured on that shift. This is a double check to clarify that no unaddressed incident of abuse or alleged abuse took place on shift to shift monitoring. Shoud such an incident occur, the form directs staff to immediately report as per policy. -See Exhibit B (4 pages) The Social Service Director will	

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	occurred. The Director of Nursing interviewed Resident #E on 3/25/15 regarding care provided by CNA #2 on 3/22/15. The resident reported the CNA had put down the wash cloth roughly and she felt he swung the door of the room closed roughly and this startled her. The resident also reported the CNA returned and did care for her a little while later that morning without incident. The Director of Nursing interviewed CNA #1 on 3/25/15. CNA #1 indicated she was getting residents up in the morning of 3/22/15 and went into Resident #E's room to talk to the resident. The resident then stated CNA #2 threw a wash cloth with frustration during care and flung the door closed. CNA #1 indicated she asked Resident #E if she felt frightened and the resident told her she did not. CNA #1 also indicated the resident was laughing when she told her about the above incident. The facility Administrator spoke to CNA #1 on 3/25/15 and informed the CNA he was suspended during the investigation. The CNA did not return to the facility. An Employee Memorandum report was completed for CNA #1. The form		conduct 3 interviews at random weekly (CMS Form 20050) Plus, the SSD/Designee will monitor (daily) the shift to shift tool for tracking any allegations of abuse. All results of these monitorings will be discussed in the daily CQI meetings to see that all proper protocol was followed. Note: Any concerns will have been addressed as discovered. Should any concerns be found not to have been appropriately addressed, the Administrator will begin an investigation as to why and then appropriate education and/or disciplinary action will be taken. This process will remain ongoing on the CQI agenda. The Quality Assurance Committee will be responsible for oversight of facility and administrator compliance with investigation of abuse or possible abuse, monthly, ongoing.	

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	indicated the CNA had failed to report a fellow CNA putting a wash cloth down roughly and closing the door. When interviewed on 3/30/15 at 1:45 p.m., the Social Worker indicated she interviewed Resident #E on 3/25/15 about an upcoming care plan meeting. The Social Worker indicated the resident then told her she had a concern with care from a CNA. The resident reported she felt CNA #2 felt she had urinated on purpose when he was giving her care and CNA #2 then took the wash cloth and threw it and walked out. When interviewed on 3/30/15 at 12:45 p.m., the Director of Nursing indicated she was first made aware of the Resident #E's allegation on 3/25/15 when the Social Worker was interviewing the resident and the resident voiced dissatisfaction by a care giver. The Director of Nursing indicated the alleged episode occurred on 3/22/15 and was first investigated on 3/25/15. The Director of Nursing indicated the investigation noted CNA #2 cared for the resident on 3/22/15. CNA #1 was also interviewed during the investigation and CNA #1 indicated she went in and talked to Resident #E on 3/22/15 and the resident told her that she felt the male CNA was frustrated because the resident urinated			

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	with care and the male CNA (CNA#2) became frustrated. CNA #1 said she talked to the resident and the resident informed her she was not afraid. CNA #1 also indicated Resident #E was laughing when she told her about what occurred and CNA #1 never told anyone else at the time the resident told her on 3/22/15. Continued interview with the Director of Nursing indicated CNA #1 told her she did not feel the resident was in danger from CNA #2 and did not inform anyone at the time. The Director of Nursing indicated the CNA should have reported the allegation on 3/22/15 as per the facility Abuse Policy. When interviewed on 3/30/15 at 12:55 p.m., the facility Administrator indicated the CNA #1 should have reported the concerns the resident voiced to her on 3/22/15 at the time they occurred. This Federal tag relates to Complaint IN00170087. 3.1-28(c) 3.1-28(e)			

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F 226 SS=D Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, record review and interview, the facility failed to follow their Abuse Policy and protocols related to lack of documentation and reporting allegations of potential abuse to the Administrator immediately resulting in an allegation of abuse by a resident not being investigated in a timely manner. (Resident #E) (CNA #1 and CNA#2) Finding includes: Review of an Incident Report Form dated 3/25/15 indicated during a Social Service visit, Resident #E expressed a concern about a care giver to the Social Worker. The Social Worker immediately informed the facility Administrator, an investigation was initiated, and the CNA named by the resident was suspended pending an investigation. Review of the 3/25/15 Resident Interview form completed by the Social Worker,	F 226	It is the policy of this facility to ensure that all allegations of possible mistreatment are investigated in a timely manner. Further, any allegation of abuse or possible abuse is to be reported to the Adiministrator or DON (who will report it to the Administrator) as soon as the occurence is witnessed or reported or suggested as having happened and this occurance is reported to any staff member. Additionaly, the facility's protocol as per the Abuse Policy is to be immediately implemented including but not limited to securing the safety of the residnt(s) involved and initiating a thourough investigation. Resident E has had no other concerns or complaints with any incidents or unacceptable treatment or behavior from any other staff member since the cited incident. CNA #1 was going to be disciplined and further trained in the requirement to report any report of abuse, but CNA #1 called the facility and	04/29/2015

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	indicated Resident #E was interviewed on 3/25/15. The form indicated the resident stated during the midnight shift, the new male CNA thought she had urinated on purpose and he threw the washcloth and threw the door open. The facility investigation of the above allegation was initiated on 3/25/15. Staff interviews were obtained by the Director of Nursing. CNA #2 was identified as the staff member caring for Resident #E at the time the alleged abuse occurred. The Director of Nursing interviewed Resident #E on 3/25/15 regarding care provided by CNA #2 on 3/22/15. The resident reported the CNA had put down the wash cloth roughly and she felt he swung the door of the room closed roughly and this startled her. The resident also reported the CNA returned and did care for her a little while later that morning without incident. The Director of Nursing interviewed CNA #1 on 3/25/15. CNA #1 indicated she was getting residents up in the morning of 3/22/15 and went into Resident #E's room to talk to the resident. The resident then stated CNA #2 threw a wash cloth with frustration during care and flung the door closed. CNA #1		terminated herself before this could happen. CNA #2 who exhibited the behavior, was immediately suspended when staff learned of his actions. CNA #2 did not report to work and was therefore terminated due to excessive absenteeism. He was in his probationary period. All residents who were interviewable on the unit were interviewed as to their care and treatment. Non-interviewable residents were assessed head-to-toe for any signs of abuse. No negative findings were obtained. Note:CNA #2 had only worked on this unit. All staff to be inserviced on all requirements of the Abuse Policy with emphasis on the need to immediately report any abuse or alleged or suspected abuse to the Adiministrator or DON (who will report it to the Administrator) so that the protocol in the Abuse Policy can be initiated at that time. Any staff who fail to comply with the points of the Abuse Policy will be further educated and progressively disciplined up to and including termination.-See Exhibit A (26 pages) The facility has developed a new process of documentation at the end of each shift which ensures that no complaints of abuse or alleged abuse occured on that shift. This is a double check to clarify that no unaddressed incident of abuse or alleged abuse took place on shift to shift monitoring. Shoud such an incident occur, the form directs	

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	indicated she asked Resident #E if she felt frightened and the resident told her she did not. CNA #1 also indicated the resident was laughing when she told her about the above incident. The facility Administrator spoke to CNA #1 on 3/25/15 and informed the CNA he was suspended during the investigation. The CNA did not return to the facility. An Employee Memorandum report was completed for CNA #1. The form indicated the CNA had failed to report a fellow CNA putting a wash cloth down roughly and closing the door. When interviewed on 3/30/15 at 1:45 p.m., the Social Worker indicated she interviewed Resident #E on 3/25/15 about an upcoming care plan meeting. The Social Worker indicated the resident then told her she had a concern with care from a CNA. The resident reported she felt CNA #2 felt she had urinated on purpose when he was giving her care and CNA #2 then took the wash cloth and threw it and walked out. When interviewed on 3/30/15 at 12:45 p.m., the Director of Nursing indicated she was first made aware of the Resident #E's allegation on 3/25/15 when the Social Worker was interviewing the		staff to immediately report as per policy. Exhibit B (4 pages) The Social Service Director will conduct 3 interviews at random weekly (CMS Form 20050) Plus, the SSD/Designee will monitor (daily) the shift to shift tool for tracking any allegations of abuse. All results of these monitorings will be discussed in the daily CQI meetings to see that all proper protocol was followed. Note: Any concerns will have been addressed as discovered. Should any concerns be found not to have been appropriately addressed, the Administrator will begin an investigation as to why and then appropriate education and/or disciplinary action will be taken. This process will remain ongoing on the CQI agenda. The Quality Assurance Committee will be responsible for oversight of facility and administrator compliance with investigation of abuse or possible abuse, monthly, ongoing.	

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	resident and the resident voiced dissatisfaction by a care giver. The Director of Nursing indicated the alleged episode occurred on 3/22/15 and was first investigated on 3/25/15. The Director of Nursing indicated the investigation noted CNA #2 cared for the resident on 3/22/15. CNA #1 was also interviewed during the investigation and CNA #1 indicated she went in and talked to Resident #E on 3/22/15 and the resident told her that she felt the male CNA was frustrated because the resident urinated with care and the male CNA (CNA#2) became frustrated. CNA #1 said she talked to the resident and the resident informed her she was not afraid. CNA #1 also indicated Resident #E was laughing when she told her about what occurred and CNA #1 never told anyone else at the time the resident told her on 3/22/15. Continued interview with the Director of Nursing indicated CNA #1 told her she did not feel the resident was in danger from CNA #2 and did not inform anyone at the time. The Director of Nursing indicated the CNA should have reported the allegation on 3/22/15 as per the facility Abuse Policy. When interviewed on 3/30/15 at 12:55 p.m., the facility Administrator indicated			

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	the CNA #1 should have reported the concerns the resident voiced to her on 3/22/15 at the time they occurred. The facility Abuse Prevention Prevention policy was reviewed on 3/30/15 at 12:55 p.m. The policy had a revised date of 9/15/13. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated all personnel were required to report any incident, allegation or suspicion of potential abuse, neglect or mistreatment they observed, hear about, or suspect to the Administrator. The policy also indicated the Administrator or person in charge were required to immediately start an investigation of the incident. Federal tag relates to Complaint IN00170087. 3.1-28(c) 3.1-28(e)			