

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/01/2013
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NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN 46307
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F000000	<p>This visit was for the Investigation of Complaint IN00138985.</p> <p>Complaint IN00138985-Substantiated. Federal/state deficiencies related to the allegation are cited at F225, F226, F250, and F282.</p> <p>Survey dates: October 31, 2013 and November 1, 2013</p> <p>Facility number: 001198 Provider number: 155637 AIM number: 100471000</p> <p>Survey team: Janet Adams, RN, TC</p> <p>Census bed type: SNF: 19 SNF/NF: 106 Residential: 44 Total: 169</p> <p>Census payor type: Medicare: 18 Medicaid: 87 Other: 64 Total: 169</p> <p>Sample: 5</p>	F000000	F0000 This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the revisions of federal and state law.	

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 November 8, 2013, by Janelyn Kulik, RN.</p>				

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F000225 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 record review and</p>	F000225	Plan of Correction F Tag 225 - D	11/21/2013			

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	<p>interview, the facility failed to ensure an allegation of physical abuse and sexual abuse was reported in an timely manner and thoroughly investigated in a timely manner related to a CNA not reporting an allegation of abuse when it was reported to her, lack of interviewing staff members, and lack of educating staff to ensure the facility policies were followed related to Abuse for 1 of 3 allegations of Abuse reviewed. (Resident #E) (CNA's #2 and #4)</p> <p>Findings include:</p> <p>The closed record for Resident #E was reviewed on 10/31/13 at 11:30 a.m. The resident's diagnoses included, but were not limited to, vascular dementia, anxiety state, congestive heart failure, and depressive disorder.</p> <p>The 10/2013 Nursing Progress Notes were reviewed. An entry made on 10/28/13 at 2:55 p.m. indicated the writer (Resident Care Coordinator) was brought to the resident's room where concerns were brought to her attention. The resident had no apparent signs of distress and increased confusion was noted. The resident stated she was seeing a man</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #E was sent to the hospital on 10/28/13. The noted allegation was reported to the state Agency by the Administrator /Executive Director upon notification by the granddaughter on 10/28/13 per facility policy and procedure which follows state and federal guidance. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Current resident events reviewed to ensure investigations were completed per policy and reported immediately. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Scheduled staff was re-educated prior to the start of their shift and ongoing shifts regarding the Suspicion of a Crime/Mandatory Reporting requirement/Abuse. Re-education of Administrator/designee related to thorough investigation of Suspicion of a Crime/Mandatory Reporting requirement/Abuse.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place. The QCC /designee will audit</p>		

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	<p>in her room during questioning. The resident was observed with bruises on her right hand and was observed banging on the wall with her right hand during the assessment. The resident was then transferred to the Emergency Room with her granddaughter present. A Discharge Note was entered by Nursing on 10/29/13 at 12:05 a.m. This note indicated the resident's vitals were as follows at the time of discharge. Temperature 100.3, Pulse 82, BP 153/84, and Respirations 24.</p> <p>The 10/14/13 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (9). This score indicated the resident's cognitive patterns were moderately impaired. The assessment also indicated the resident required extensive assistance (resident involved in activity, staff provide weight bearing support) of staff for bathing, hygiene, bed mobility, toileting, and transfers.</p> <p>A Care Plan initiated on 5/7/13 indicated the resident was incontinent of bladder. The Care Plan was last updated with a target date of 1/16/2014. A care plan initiated on 4/26/13 indicated the resident</p>		<p>all investigations related to Suspicion of a Crime/Mandatory Reporting requirement/Abuse for thoroughness and accuracy. The QCC/designee will report to QA committee for total of six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p>		

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	<p>required assistance of staff for all of her ADL's (Activities of Daily Living). This care plan was last reviewed with a target goal date of 1/16/2014. Care plan interventions included for the resident to be transferred with the assist of two staff members.</p> <p>A Report of Reasonable Suspicion of a Crime was reviewed on 10/31/13 at 10:30 a.m. The report indicated an allegation of abuse was reported on 10/28/13. The report indicated Resident #E's granddaughter reported an allegation of Abuse to the RCC (Resident Care Coordinator) on 10/28/13. The resident informed the granddaughter of the allegation and then the granddaughter reported the above to the RCC. The resident indicated two people came into the resident's room last night (during the night shift from 10/27/13 at 10:00 p.m. thru 6:00 a.m. on 10/28/13). One of the two persons was a female staff member and the other was her boyfriend. The resident indicated they started to beat her up, then held her down, and started to pull her vagina apart. Social Service then came into the resident's room and also interviewed the resident. During this interview the resident stated the people came into her room late last night and there was "one white</p>			

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	<p>female and a black boyfriend" both wearing nursing clothes. The resident also indicated one of the staff referred to her as a (derogatory term). The report also indicated the resident stated they were looking at "her private parts" and put a finger in her rectum. The report also indicated the resident then began stating there were three people and at the time the resident was also stating she was seeing a man outside her window. Staff present did not see any men outside the window. The report indicated a physical assessment of the resident was completed at this time and the only signs of injury noted were three bruises noted on the resident's right wrist area. The resident's Physician and the local Police authorities were notified and the resident was sent to the hospital Emergency Room.</p> <p>The facility investigation was reviewed. Statements were obtained from various staff members. The statements were typed up by Administrative staff members. One of the typed statement was obtained from CNA #2. CNA #2 was identified as the CNA assigned to care for Resident #E on the night shift 10/27/13 at 10:00 p.m. thru 10/28/13 at 6:00 a.m. The date next the CNA's</p>						

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	<p>statement indicated the interview took place on 10/28/13 at 6:15 p.m. The statement indicated the CNA indicated she had been carrying a care card for Resident #E and stated the care card was not a new one. The statement indicated the CNA was aware that the resident was not to have male caregivers but she thought that issue had been resolved as she had seen other male caregivers in the resident's room with no problems. The statement also indicated the CNA said the resident was "screaming" for her Mom when she was in the room for the the last 2 nights in a row. The CNA statement also indicated the resident screamed for her to leave her alone and the resident told her she gave her a bruise to her hand and pushed her face into the wall whenever she yelled. The CNA statement indicated the CNA did not tell the Nurse but had documented it in the computer and did tell another CNA.</p> <p>The facility investigation also included statement from CNA #4 (a male CNA). A 10/29/13 typed interview indicated the RCC asked the CNA if he cared for Resident #E on the night shift on Sunday 10/27/13 (shift started at 10:00 p.m. on 10/27/13 thru 6:00 a.m. on 10/28/13). The typed</p>			

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	<p>statement indicated CNA #4 responded he had helped CNA #2 turn the resident over to get the resident ready for the day.</p> <p>Resident #E's hospital record was reviewed on 10/31/13 at 3:15 p.m. The record indicated the resident was admitted to the Emergency Room on 10/28/13. The Emergency Department records indicated the resident was interviewed by staff on 10/28/13 at 5:12 p.m. The resident stated "a lady she knows, who has a boyfriend, the lady is named (name of CNA #2), (name of CNA #2) stretched her vagina and looked inside." The resident stated this happened yesterday and also stated "they move my bed away from the wall and look at her" and the resident also said this is not the first time it has happened. The note also indicated the SAN (Sexual Assault Nurse) was called in.</p> <p>When interviewed on 10/31/13 at 9:45 a.m., the facility Administrator indicated she was informed of the 10/28/13 allegation when it occurred that day and an investigation was initiated immediately. The Administrator indicated they began interviewing staff members in person and on phone at the time.</p>			

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	<p>When interviewed on 10/31/13 at 10:20 a.m., the Director of Nursing indicated she spoke with CNA #4 on 10/28/13 at approximately 6:00 p.m. on the telephone and he indicated he assisted CNA #2 with repositioning Resident #E on the night shift 10/27/13 into 10/28/13.</p> <p>The RCC (Nurse Manager for the unit/level Resident #E resided on) was interviewed on 10/31/13 at 10:07 a.m. The RCC indicated the staff Nurse came to her and stated the resident's granddaughter was upset and she needed to come and talk to the granddaughter. The RCC indicated she went to Resident #E's room and granddaughter stated the resident told her "staff beat her up and spread her vagina apart." The RCC indicated she then informed the Administrator, Director of Nursing, and Social Service. The RCC indicated the resident stated the name of the female staff alleged was (name #1). The RCC indicated Social Service then came into the room also. The RCC indicated when staff attempted to assess the resident's vaginal area she started to scream so the RCC was only able to visualize the outer vaginal area and the resident's inner thighs and was unable to visualize the resident's anus</p>			

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	<p>or rectum. The RCC also indicated the name the resident accused was (name #1) which rhymed with CNA #2's name. CNA #2 was the CNA who had been assigned to care for Resident #E on the 10/27/13 midnight shift.</p> <p>When interviewed on 10/31/13 at 9:48 a.m., the DON (Director of Nursing) indicated Resident #E's granddaughter reported the allegation to the RCC on 10/28/13 at approximately 2:55 p.m. and it was reported to her and the Administrator. The DON indicated LPN #1 worked the Evening shift on 10/27/13 and was present in the facility and she interview the LPN at that time. The LPN indicated there were no concerns or problems displayed by the resident on her shift except a concern about her dentures. The DON indicated numerous other staff members who had been working on 10/27/13 were interviewed in person or via telephone beginning then. The DON indicated she reviewed the schedule and had no black males on the schedule for 10/27/13 evening/ night shifts. The DON indicated they had no female staff named (name #1).</p> <p>When interviewed on 10/31/13 at</p>			

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	<p>11:10 a.m., Social Worker #1 indicated the RCC called her to come to the resident's room on 10/28/13 when the allegations was made. The Social Worker indicated she did interview the resident at the time and her BIMS score appeared to be about a (3). A score of (3) indicated the resident's cognitive patterns were severely impaired. The Social Worker indicated the resident seemed a little more confused then unusual. The Social Worker indicated the granddaughter was present in the room and gave permission for the Social Worker to interview the resident. The Social Worker indicated the resident said someone pulled her vagina and said "look at her she's a (derogatory term). The Social Worker indicated she could not get the resident to describe the staff involved or what they were wearing. The Social Worker indicated the resident's statement kept changing regarding the race and the number of females vs males during her conversations. The Social Worker indicated the resident did appear to be anxious. The Social Worker indicated the resident had delusions in the past and did have periods of confusion. The Social Worker indicated the resident also made statements referring to the walls</p>			

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	<p>being hard like metal.</p> <p>The facility Administrator and DON were interviewed again on 10/31/13 at 2:05 p.m. related to the CNA #2's statements pertaining to the resident yelling when the CNA provided care and the resident accusing the CNA giving her a bruise and pushing her face into the wall. The Administrator indicated the CNA had not reported the resident's allegations at the time they were made as per the facility policy. The Administrator indicated there were three CNA's which would have worked the night shifts on 10/26/13 thru the AM of 10/27/13 who had not been interviewed after CNA #2's statement was obtained indicating the resident had been displaying screaming and making allegations the CNA had caused bruising on her hands on days even before the 10/28/13 allegation. The DON indicated she did see the alert noting the resident had behaviors of yelling, hitting, and kicking on Monday mornings daily Meeting on 10/28/13. The DON indicated she had phone calls out to attempt to talk to the Nurse who was assigned to care for the resident on 10/27/13- 10/28/13 as the CNA's were to inform the Nurse of behaviors or type them in on the computer and the typed notification</p>				

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	<p>would come up on the Nurse screen to follow up on.</p> <p>When interview on 11/1/13 at 8:30 a.m., the facility Administrator indicated she did not follow up immediately on the documentation in CNA #2's statement indicated the resident had accused the CNA of giving the resident a bruise to the arms, yelling and screaming and wanting the CNA to leave, and the CNA statement noting other male caregivers had been going into the residents room. The Administrator stated staff Inservicing related to the above and interviewing staff related to the above started 10/31/13.</p> <p>The facility policy titled "Resident Abuse Investigation" was reviewed on 10/31/13 at 1:00 p.m. The policy had a Revision Date of February 22, 2013. The policy indicated that "...all allegations of resident abuse, regardless of the source of abuse will be fully investigated to prevent further incidents." The policy indicated any employee alleged to have committed resident abuse was to be barred from contact with all residents until the allegation is investigated and resolved. The policy indicated staff interviews were to be completed with staff member on all shifts having</p>				

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	<p>contact with the resident during the period of time of the alleged incidents.</p> <p>The facility policy titled "Prevention of Abuse" was reviewed on 10/31/13 at 1:00 p.m. The policy had a revision date of February 22, 2013. The policy indicated staff are to immediately report any type of abuse to the Abuse Coordinator.</p> <p>This federal tag relates to Complaint IN00138985.</p> <p>3.1-28(d)</p>				

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F000226 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 record review and interview, the facility failed to follow the Abuse Policy related to the failure to immediately report an allegation of abuse and the failure to complete a thorough investigation for 1 of 3 allegations of abuse reviewed. (Resident #E) (CNA #2)</p> <p>Findings include:</p> <p>The closed record for Resident #E was reviewed on 10/31/13 at 11:30 a.m. The resident's diagnoses included, but were not limited to, vascular dementia, anxiety state, congestive heart failure, and depressive disorder.</p> <p>The 10/2013 Nursing Progress Notes were reviewed. An entry made on 10/28/13 at 2:55 p.m. indicated the writer (Resident Care Coordinator) was brought to the resident's room where concerns were brought to her attention. The resident had no apparent signs of distress and</p>	F000226	<p>Plan of Correction F Tag 226 – D</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #E was hospitalized on 10/28/13 as part of the investigation of allegation. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: a. Residents' grievances or allegations of abuse will be identified and during investigative process DON/Administrator will review current information daily for potential additional abuse allegations by resident of a caregiver.b. Abuse Coordinator and Social Service will be notified immediately.c. Any investigation will include interviews of scheduled staff the day of the allegation and 24 hours prior to the allegation. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: a. Scheduled staff were re-educated prior to the start of their shift regarding the Suspicion of a Crime/Mandatory Reporting requirement/Abuse</p>	11/21/2013			

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	<p>increased confusion was noted. The resident stated she was seeing a man in her room during questioning. The resident was observed with bruises on her right hand and was observed banging on the wall with her right hand during the assessment. The resident was then transferred to the Emergency Room with her granddaughter present. A Discharge Note was entered by Nursing on 10/29/13 at 12:05 a.m. This note indicated the resident's vitals were as follows at the time of discharge. Temperature 100.3, Pulse 82, BP 153/84, and Respirations 24.</p> <p>A Report of Reasonable Suspicion of a Crime was reviewed on 10/31/13 at 10:30 a.m. The report indicated an allegation of abuse was reported on 10/28/13. The report indicated Resident #E's granddaughter reported an allegation of Abuse to the RCC (Resident Care Coordinator) on 10/28/13. The resident informed the granddaughter of the allegation and then the granddaughter reported the above to the RCC. The report indicated two people came into the resident's room during the night (during the night shift from 10/27/13 at 10:00 p.m. thru 6:00 a.m. on 10/28/13). One of the two persons was a female staff member and the</p>		<p>requirement/Abuse through 11-9-13.b. Correct actions reviewed when resident make allegations of abuse: Immediate notification of Abuse Coordinator and Social Service Interview and physical assessment of resident making allegation Documentation of incident Notification of physician and family Allegations and grievances will be reviewed at morning meeting to assure all steps in policy and procedure have been followed. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place. The QCC as well DON/Administrator/designee will audit all investigations related to allegations of abuse for thoroughness and accuracy. The DON/Administrator/designee will report to QA monthly for total of six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p>				

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	<p>other was her boyfriend. The resident indicated they started to beat her up, then held her down, and started to pull her vagina apart. Social Service then came into the resident's room and also interviewed the resident. During this interview the resident stated the people came into her room late last night and there was "one white female and a black boyfriend" both wearing nursing clothes. The resident also indicated one of the staff referred to her as a (derogatory term). The report also indicated the resident stated they were looking at "her private parts" and put a finger in her rectum. The report also indicated the resident then began stating there were three people and at the time the resident was also stating she was seeing a man outside her window. Staff present did not see any men outside the window. The report indicated a physical assessment of the resident was completed at this time and the only signs of injury noted were three bruises noted on the resident's right wrist area. The resident's Physician and the local Police authorities were notified and the resident was sent to the hospital Emergency Room.</p> <p>The facility investigation was reviewed. Statements were obtained</p>			

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	<p>from various staff members. The statements were typed up by Administrative Staff. One of the typed statement was obtained from CNA #2. CNA #2 was identified as the CNA assigned to care for Resident #E on the night shift 10/27/13 at 10:00 p.m. thru 10/28/13 at 6:00 a.m. The date next the CNA's statement indicated the interview took place on 10/28/13 at 6:15 p.m. The statement indicated the CNA indicated she had been carrying a care card for Resident #E and stated the care card was not a new one. The statement indicated the CNA was aware that the resident was not to have male caregivers but she thought that issue had been resolved as she had seen other male caregivers in the resident's room with no problems. The statement also indicated the CNA said the resident was "screaming" for her Mom when she was in the room for the the last 2 nights in a row. The CNA statement also indicated the resident screamed for her to leave her alone and the resident told her she gave her a bruise to her hand and pushed her face into the wall whenever she yelled. The CNA statement indicated the CNA did not tell the Nurse but had documented it in the computer and did tell another CNA.</p>						

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	<p>The facility investigation also included statement from CNA #4 (a male CNA). A 10/29/13 typed interview indicated the RCC asked the CNA if he cared for Resident #E on the night shift on Sunday 10/27/13 (shift started at 10:00 p.m. on 10/27/13 thru 6:00 a.m. on 10/28/13). The typed statement indicated CNA #4 responded he had helped CNA #2 turn the resident over to get the resident ready for the day.</p> <p>The facility Administrator and DON were interviewed again on 10/31/13 at 2:05 p.m. related to the CNA #2's statements pertaining to the resident yelling when the CNA provided care and the resident accusing the CNA giving her a bruise and pushing her face into the wall. The Administrator indicated CNA had not reported the resident's allegations at the time they were made as per the facility policy. The Administrator indicated there were three CNA's which would have worked the night shifts on 10/26/13 thru the AM of 10/27/13 who had not been interviewed related after CNA #2's statement was obtained indicating the resident had been displaying screaming and making allegations the CNA had caused bruising on her hands on days even</p>				

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	<p>before the 10/28/13 allegation. The DON indicated she did see the alert noting the resident having behaviors of yelling, hitting, and kicking on Monday mornings daily Meeting on 10/28/13. The DON indicated she had phone calls out to attempt to talk to the Nurse who was assigned to care for the resident on 10/27/13-10/28/13 as the CNA's are to inform the Nurse of behaviors or type them in on the computer and they typed notification would come up on the Nurse screen to follow up.</p> <p>The facility policy titled "Resident Abuse Investigation" was reviewed on 10/31/13 at 1:00 p.m. The policy had a Revision Date of February 22, 2013. The policy indicated that "...all allegations of resident abuse, regardless of the source of abuse will be fully investigated to prevent further incidents." The policy indicated any employee alleged to have committed resident abuse was to be barred from contact with all residents until the allegation is investigated and resolved. The policy indicated staff interviews were to be completed with staff member on all shifts having contact with the resident during the period of time of the alleged incidents.</p> <p>The facility policy titled "Prevention of</p>				

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	<p>Abuse" was reviewed on 10/31/13 at 1:00 p.m. The policy had a revision date of February 22, 2013. The policy indicated staff are to immediately report any type of abuse to the Abuse Coordinator.</p> <p>This federal tag relates to Complaint IN00138985.</p> <p>3.1-28(d)</p>			

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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the necessary medically related social services were provided to maintain the resident's highest practical psychosocial well being related to the failure to ensure Psychology services were provide in a timely manner after a resident to resident physical altercation for 1 of 4 residents reviewed for resident to resident altercation in the sample of 5. (Residents #C and #B)</p> <p>Findings include:</p> <p>On 11/1/13 at 9:20 a.m., Resident #C was observed asleep in his room. Resident #B (the wife of Resident #C) was awake and sitting in a chair in their room.</p> <p>A 10/17/13 Incident Report Form related to Residents #B and #C was reviewed on 10/31/13 at 1:00 p.m. The report indicated on 10/17/13 at 8:30 a.m. the two residents were at a table in the large dining room. The</p>	F000250	<p>Plan of Correction F Tag 250 – D</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #B and Resident #C were immediately removed from the dining room and placed on 15 minutes checks to prevent further physical contact. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: a. This social worker is no longer employed at the facility. Resident to resident allegations that occurred within the last three months will be reviewed for psycho-social wellbeing. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: a. Incidents of resident to resident will be discussed daily at the morning meeting involving department heads and nursing managers. b. During daily nursing meeting (M-F) any incident requiring psychosocial wellbeing check, the social service/psychological</p>	11/21/2013			

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	<p>CNA observed Resident #B touching Resident #C's empty cereal bowl and Resident #B informed her to leave his bowl alone. Approximately 10 minutes later Resident #C's portable oxygen tank fell off the back of his wheelchair and Resident #B moved around the table saying "what was that ?" and Resident #C responded "shut up." As Resident #B moved closer to Resident #C he reached out with his foot and made contact with Resident #C's leg as if to push her away. The form indicated the resident's were separated and staff assessed both resident's and no injuries were observed.</p> <p>Follow up to the above incident included 15 minute checks to be completed on each resident. Another preventative measure on the Incident Report Form was for Social Service to meet weekly with Resident #C to monitor his psychosocial needs for the next (4) weeks.</p> <p>The record for Resident #C was reviewed on 10/31/13 at 2:00 p.m. The resident's diagnoses included, but were not limited to, vascular dementia with delusions, depressive disorder, high blood pressure, anemia, and chronic airway obstruction.</p>		<p>counseling progress notes will be reviewed. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place. The DON/Administrator/designee will audit social service progress notes related to psychosocial wellbeing of resident to resident incidents for thoroughness and accuracy. The DON/designee will report to QA monthly for total of six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p>	

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	<p>The 10/1/13 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (11). This score indicated the resident's cognitive patterns were moderately impaired. A care plan dated 10/8/13 indicated the resident had the potential to be argumentative with his wife/spouse. Care plan interventions included for staff to intervene when the behavior escalates and to guide the resident away from the source of any distress.</p> <p>The 10/2013 Nursing Progress Notes were reviewed. An entry made on 10/17/13 at 10:00 a.m. indicated a CNA reported the resident had kicked his wife in her left shin when she was trying to help him at breakfast. The entry also indicated the resident denied kicking his wife.</p> <p>Review of 10/2013 Social Service Progress Notes indicated there were no progress notes related to the 10/17/13 altercation between Resident #C and his wife (Resident #B).</p> <p>Review of the 10/2013 Physician Progress and Consult Notes indicated there were no notes related to the</p>						

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	<p>above 10/17/13 altercation.</p> <p>The record for Resident #B was reviewed on 11/1/13 at 9:00 a.m. The resident's diagnoses included, but were not limited to, senile dementia, depressive disorder, congestive heart failure, and high blood pressure. A 9/25/13 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (6). This score indicated the resident's cognitive patterns were severely impaired.</p> <p>When interviewed on 11/1/13 at 10:22 a.m., Social Worker #1 indicated she found out about the altercation between Residents #B and #C on 10/18/13. Social Worker #1 indicated she spoke with Social Worker #2 who indicated she had spoken with both the residents when the incident occurred. Social Worker #1 indicated she currently could not locate any documentation related to the above and Social Worker #2 was no longer employed at the facility. The Social Worker also indicated Senior Counseling (a contracted Psychological counseling service which provided services at the facility) had been seeing Resident #C prior to 10/17/13 and they were to provide the</p>				

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	<p>weekly Social Service follow up. The Social Worker indicated Senior Counseling comes to the facility once a week.</p> <p>When interviewed on 11/1/13 at 3:40 p.m., Social Worker #1 indicated she could not locate any record of Resident #C being seen by Senior Counseling. The Social Worker indicated there were no Progress Notes to address the resident's Psychosocial needs to assure the facility was meeting the resident's needs after the resident to resident altercation.</p> <p>This federal tag relates to Complaint IN00138985.</p> <p>3.1-34(a)(2)</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to follow the residents plan of care related to males not allowed to provide care for 1 of 1 resident reviewed for an allegation of physical and sexual abuse in the sample of 5. (Resident #E) (CNA's #2 and #4)</p> <p>Findings include:</p> <p>The record for Resident #E was reviewed on 10/31/13 at 11:30 a.m. The resident's diagnoses included, but were not limited to, vascular dementia, anxiety state, congestive heart failure, and depressive disorder.</p> <p>The 10/2013 Nursing Progress Notes were reviewed. An entry made on 10/28/13 at 2:55 p.m. indicated the writer (Resident Care Coordinator) was brought to the resident's room where concerns were brought to her attention. The resident had no apparent signs of distress and increased confusion was noted. The resident stated she was seeing a man</p>	F000282	<p>Plan of Correction F Tag 282 – D</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. a.</p> <p>Resident #E was sent to the hospital on 10-28-13 and did not return to the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: a. Educated staff beginning 10-31-13 related to following residents plan of care.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: a. Nursing staff re-educated on following the resident's plan of care. b. Education utilized resident specific information to assure staff understanding.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place. The DON/Administrator/designee will audit nursing staff randomly three days per week to assure that they are following the plan of care. The</p>	11/21/2013

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	<p>in her room during questioning. The resident was observed with bruises on her right hand and was observed banging on the wall with her right hand during the assessment. The resident was then transferred to the Emergency Room with her granddaughter present. A Discharge Note was entered by Nursing on 10/29/13 at 12:05 a.m. This note indicated the resident's vitals were as follows at the time of discharge. Temperature 100.3, Pulse 82, BP 153/84, and Respirations 24.</p> <p>The 10/14/13 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (9). This score indicated the resident's cognitive patterns were moderately impaired. The assessment also indicated the required extensive assistance (resident involved in activity, staff provide weight bearing support) of staff for bathing, hygiene, bed mobility, toileting, and transfers.</p> <p>A Care Plan initiated on 5/7/13 indicated the resident was incontinent of urine. The Care Plan was last updated with a target date of 1/16/2014. A care plan initiated on 4/26/13 indicated the resident</p>		DON/designee will report to QA monthly for total of six months.If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.		

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NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE 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>required assistance of staff for all of her ADL's (Activities of Daily Living). This care plan was last reviewed with a target goal date of 1/16/2014. Care plan interventions included for the resident to be transferred with the assist of two staff members.</p> <p>The resident Kardex Care Card (list of care interventions to be followed when providing care to each resident) was reviewed. The Kardex Care Card for Resident #E indicated no male caregivers were to provide care for the resident.</p> <p>When interviewed on 10/31/13 at 9:45 a.m., the facility Administrator indicated Resident #E had made an allegation of sexual abuse in February 2013 and the interventions put into place after the allegation were no male caregivers for the resident. The Administrator indicated she was informed of the 10/28/13 allegation when it occurred that day and an investigation was initiated immediately. The Administrator indicated they began interviewing staff members in person and on phone at the time and upon doing the interview it was determined that CNA #4(a male CNA) had assisted CNA #2 (a female CNA) with care for resident on the midnight shift 10/27/13 (10:00</p>						

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	<p>p.m.) thru 10/28/13 (6:00 a.m.).</p> <p>When interviewed on 10/31/13 at 10:20 a.m., the Director of Nursing indicated she spoke with CNA #4 on 10/28/13 at approximately 6:00 p.m. on the telephone and he indicated he assisted CNA #2 with repositioning Resident #E on the night shift 10/27/13 into 10/28/13. The Director of Nursing indicated CNA #4 did not follow the resident's Care Card indicating the resident was not to have any male caregivers.</p> <p>This federal tag relates to Complaint IN00138985.</p> <p>3.1-35(g)(2)</p>			