

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 06/04/2014
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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 a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00148289.</p> <p>Complaint IN00148289 - Substantiated. No deficiencies related to the allegation are cited.</p> <p>Survey dates: May 28, 29, 30, and June 2, 3, and 4, 2014</p> <p>Facility number: 001198 Provider number: 155637 AIM number: 100471000</p> <p>Survey team: Jennifer Redlin, RN, TC Caitlyn Doyle, RN Julie Ferguson, RN Yolanda Love, RN</p> <p>Census bed type: SNF: 21 SNF/NF: 83 Residential: 46 Total: 150</p> <p>Census Payor type: Medicare: 18</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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F000241 SS=D	<p>Medicaid: 67 Other: 65 Total: 150</p> <p>Residential sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on June 6, 2014, by Janelyn Kulik, RN.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure each residents' dignity was maintained related to being called "honey" and "feeders" during 2 of 2 meals observed in the Haven and Reclaim dining rooms. (Resident's #18, #140, and #141)</p> <p>Findings include:</p> <p>On 5/28/14 at 11:25 a.m., in the Haven dining room, CNA #1 called Resident's #18, #140, and #141 "honey".</p>	F000241	<p>F 241 Request Desk Review</p> <p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>a. Resident #18 #140 and #141 were assessed on 6/4/14 to determine that they had suffered no ill effects as a result of being call "honey:.</p> <p>b. C.N.A. #2 received on 6/11/14 re-education related to maintaining the dignity and respect of the resident by not</p>	06/25/2014

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	<p>On 5/28/14 at 12:30 p.m., in the Reclaim dining room connected to the Assisted Living dining room, CNA #2 pointed and referred to the residents in the Main Reclaim dining room as "feeders".</p> <p>Interview with the Director of Nursing (DoN) on 6/4/14 at 12:38 p.m., indicated staff should address the residents by their names not by "honey" or "feeders."</p> <p>3.1-3(t)</p>		<p>referring to any resident as "feeder".</p> <p>2. 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.</p> <p>a. Residents within the facility have the potential to be affected by the same deficient practice.</p> <p>b. Audit conducted with interview able residents present in facility at time of audit to assure choices regarding use of "endearments."</p> <p>c. Non-interviewable residents families will be contacted re: choices.</p> <p>3. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recur:</p> <p>a. Scheduled staff re-education beginning 6/6/14 regarding residents dignity and respect of individuality policy.</p> <p>b. Statement regarding use of "endearments/nicknames" will be addressed upon admission/readmission and care planned accordingly.</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; and by what date the systemic changes will be completed.</p>	

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F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure a resident was free from accidents related to a bed alarm not plugged in for a resident with a high risk of falls for 1 of 4 residents reviewed for accidents. (Resident #10)	F000323	a. Update current choice sheets to include "endearment" upon admission/readmission to ensure compliance. b. Unit managers/designee will audit during meal service to ensure compliance with plan and report findings to DON/designee for reviews. c. Audit tools will be submitted to the Quality Assurance Committee and continue to be conducted for six months three times per week, different meals to assure continued compliance. Compliance by June 25, 2014. REQUEST DESK REVIEW FOR THIS DEFICIENCY. F Tag 323 Request Desk Review 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice	06/25/2014

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	<p>Findings include:</p> <p>An observation on 6/2/14 at 10:04 a.m., Resident #10 was sitting in a wheelchair in the dining room watching television, with chair alarm observed on back of wheelchair hooked up.</p> <p>An observation on 6/2/14 at 12:05 p.m., Resident #10 was sitting in a wheelchair in the dining room eating lunch, with chair alarm observed on back of wheelchair hooked up.</p> <p>Resident #10's record was reviewed on 5/30/14 at 1:00 p.m. The resident's diagnoses included, but were not limited to, dementia, heart failure, anxiety and depression.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment, dated 3/26/14, indicated the resident was cognitively impaired.</p> <p>A care plan dated 9/18/13, indicated the resident was a high risk for falls related to confusion, psychoactive drug use, and gait/balance problems. The interventions included, but were not limited to, alarm to wheelchair and bed.</p> <p>A care card for the CNA's, dated 2/16/14, indicated Resident #10 required assistance of one for transfers and</p>		<p>a. Resident #10 bed pad alarm was placed per care plan.</p> <p>b. Certified Nursing Assistant has been disciplined following the investigation of the fall related to her failure to follow facility protocol.</p> <p>2. 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:</p> <p>a. Residents with safety alarm devices have the ability to be affected.</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:</p> <p>a. The nursing staff will be re-educated by 6/25/14 regarding safety alarm devices from care cards, and hourly safety rounds. .</p> <p>b. Unit managers will review all current safety fall interventions to ensure that all devices are in place, on care plans and care cards. This review will be</p>	

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	<p>ambulation and had an alarm to the wheelchair and bed.</p> <p>A Nursing Note, dated 5/15/14 at 8:40 a.m., indicated the nurse heard a loud noise and Resident #10 was yelling. The resident was found on her right side with her back to the nightstand. The resident was yelling to get her up, was moving all extremities, had a facial grimace and was rubbing her right lower extremity. The resident verbally indicated she hurt and was tearful and yelling out. The nurse indicated although the resident was moving her right lower extremity it appeared shorter and rotated out. The physician was called and a new order was received to send the resident to the emergency room for an evaluation.</p> <p>A hospital lab test result, CT (a diagnostic scan) of the right hip, dated 5/15/14, indicated no acute fractures were seen.</p> <p>A fall investigation, received from the Director of Nursing (DoN), dated 5/15/14, indicated the resident's bed pad alarm did not function due to being unplugged. The root cause for the fall was determined to be from a failed self transfer.</p> <p>During an interview with the DoN on</p>		<p>completed by 6/25/14.</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.</p> <p>a. DON/Designee staff will monitor/audit three times a week utilizing audit tool 10% of each nursing unit to ensure that safety alarms are correct and functioning appropriately for six months beginning 6/13/14.</p> <p>b. The monitoring will be done Tuesday, Thursday and Saturday for six months..</p> <p>c. The monitoring/audits will be submitted to the Quality Assurance Committee and continue to be conducted monthly to assure continued compliance with staff knowledge and competency of the policies until the compliance is maintained as determined by the Quarterly Assurance Committee review.</p> <p>d. Reports of the audits will be reported to the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plan of action to correct and recommend continued monitoring until corrections are effective. Compliance by 6/25/14.</p>	

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	<p>5/30/14 at 1:35 p.m., she indicated Resident #10's bed alarm was not sounding at the time of the fall due to the alarm was not plugged in. She indicated the CNA's were supposed to check the residents alarms every hour to make sure the alarms were hooked up and functioning. She further indicated the staff failed to check that Resident #10's bed alarm was plugged in.</p> <p>During an interview with LPN #2 on 6/2/14 at 10:00 a.m., she indicated the nurses should check every shift to make sure residents alarms were on and functioning. She further indicated the CNA's should check residents alarms hourly to make sure they were on and functioning.</p> <p>3.1-45(a)(2)</p> <p>1</p>						
F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in</p>						

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	<p>sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review, and interview, the facility failed to ensure an expired multi dose vial of insulin was not in use for 1 of 6 medication carts and medication was labeled properly for 2 of 32 medications given to 2 of 11 residents observed during the Medication Administration Observation. (Resident #113, #94, #33, and Eden Unit)</p>	F000431	F Tag 431 Request Desk Compliance 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice	06/25/2014

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	<p>Findings include:</p> <p>1. On 6/4/14 at 11:00 a.m., one of three multi dose vials of insulin observed in the Eden Unit D Hall Medication Cart were expired. Resident #113's multi dose vial of Humalog insulin was labeled with an open date of 5/1/14.</p> <p>Interview with LPN #1 at the time of the observation, indicated the vial was expired. She indicated she would dispose of it properly and reorder the insulin. She further indicated the insulin expired 28 days after the vial was opened.</p> <p>A facility policy on Injectable Medications, undated, and received as current from the Director of Nursing (DoN) indicated, "...Humalog...once opened, refrigerated or not, product must be used within 28 days..."</p> <p>2. During a Medication Administration Observation on 5/30/14 at 4:04 p.m., LPN #1 prepared Resident #94's medications. The medication bottle label indicated to administer 10 milliliters (ml) of Megestrol Acetate Suspension (an appetite stimulant) every afternoon.</p>		<p>a. Resident 113 Humalog insulin was discarded and reordered.</p> <p>b. Resident #94 Megace had a "direction change refer to order" sticker applied to direct nursing staff to the physician order.</p> <p>c. Resident #33 over-the-counter Fiber Con had a label applied according indicating name of resident, physician</p> <p>2. 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:</p> <p>a. No resident's were adversely affected by this action.</p> <p>b. Corporate nurse consultant conducted an audit to assure that no outdated medication was found, all orders and medication were accurate and that any over the count medication were labeled.</p> <p>b. Corporate nurse consultant conducted an audit to assure that no</p>	

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	<p>During the observation LPN #1 checked the Physician's Order on the Medication Administration Record (MAR) and indicated the order on the MAR was to give Megestrol Acetate Suspension 5 ml. LPN #1 indicated the MAR had the most current medication orders so she would give the medication according to the instructions on the MAR. During the observation LPN #1 administered 5 ml of Megestrol Acetate Suspension to Resident #94.</p> <p>An interview with LPN #1 following the medication administration, indicated the label on the Megestrol Acetate Suspension was not correct and there should have been a "direction change" label on the bottle.</p> <p>Resident #94's record was reviewed on 5/30/14 at 4:30 p.m. The Physician's Orders and MAR, dated 5/2014, indicated an order for "Megestrol Acetate Suspension 400 milligrams (mg) / 10 ml, give 5 ml by mouth in the afternoon."</p> <p>An interview with the DoN on 6/2/14 at 1:45 p.m., indicated when medications are delivered from Pharmacy the nurse receiving the medications should check to make sure the labels match the Physician's</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:</p> <p>a. The nursing staff will be re-educated by 6/16/14 regarding checking for outdated medication, application of "Direction change refer to order" labels on any medication package which differs from physician order and over the counter medication are to have the appropriate label attached stating resident name/physician name/initial of nursing staff member.</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.</p> <p>a. DON/designee will audit medication carts for outdated meds, "Direction change refer to Order" labels, and over the counter medication labels. The audits will be conducted Tuesday, Thursday and Saturday for six months.</p> <p>b. Any deficits will be turned into the DON/designee for correction and possible counseling of staff.</p> <p>c. The monitoring/audits will be submitted to the Quality Assurance</p>	

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	<p>Orders. She further indicated if any problems were noticed by the nurse they should put a "direction change" sticker on the medication label.</p> <p>A facility policy titled Reordering, Changing & Discontinuing Medication Orders, dated 4/1/06, and received as current from the DoN, indicated "...3...if the current supply of medication is useable, attach a "Direction Change" sticker to the label (or indicate on the label that the order has been changed) and continue to use the medication...."</p> <p>3. During a Medication Administration Observation on 6/2/14 at 4:06 p.m., RN #1 prepared Resident #33's medications. The medications included an over the counter medication, Fiber Con 625 mg. The Fiber Con bottle was not labeled with Resident #33's name or Physician. RN #1 indicated the resident's family provided her medications and the Fiber Con bottle should have the resident's name on it.</p> <p>An interview with the DoN on 6/3/14 at 2:35 p.m., indicated there was not a facility policy for labeling over the counter medications. She further indicated the resident's name should</p>		<p>Committee and continue to be conducted monthly to assure continued compliance with staff knowledge and competency of the policies until the compliance is maintained as determined by the Quality Assurance Committee review.</p> <p>d. Reports of the audits will be reported to the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plan of action to correct and recommend continued monitoring until corrections are effective. Compliance by 6/25/14.</p>	

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F000441 SS=E	<p>have been on the bottle.</p> <p>3.1-25(j) 3.1-25(k)(5)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the</p>						

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	<p>disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation and interview the facility failed to provide an environment with sanitary conditions for 3 of 3 unties related to uncover wash basins and took brushes left uncover in the bathrooms. (Haven Unit , Reclaim Unit, and Eden Unit)</p> <p>During the Environmental tour on 6/3/14 from 8:30- 9:30 a.m., with the Director of Nursing (DoN), Housekeeping/Laundry Supervisor and the Maintenance Supervisor, the following was observed.</p> <p>1. Haven Unit:</p> <p>a. In Room B there were 2 uncovered wash basins in the shower and 2 toothbrushes were observed uncovered, stored on the back of the bathroom sink. Two residents resided in this room..</p> <p>b. In Room C, a toothbrush was stored on the back of the bathroom sink uncovered. Two resident resided in this room.</p>	F000441	<p>F Tag 441 Request Desk Compliance</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <p>a. Two uncovered wash basins from Room B Haven unit discarded and replaced immediately.</p> <p>b. Toothbrushes found stored on the back of Room B, C, and Rm 145 replaced and placed in resident's new emesis basin and placed in top drawer of their nightstand.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and</p>	06/25/2014

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	<p>2. Reclaim Unit</p> <p>a. In Room 145, a toothbrush was stored on the back of the bathroom sink, uncovered. Two residents resided in this room.</p> <p>3. Eden Unit</p> <p>a. In Room 145, a toothbrush was stored on the back of bathroom sink uncovered. Two residents resided in this room.</p> <p>Interview with the DoN, Housekeeper/Laundry Supervisor and the Maintenance Supervisor at the time of the tour, indicated all of the areas were in need of cleaning.</p> <p>3.1-18(j)</p>		<p>what corrective action(s) will be taken:</p> <p>a. No residents were adversely affected by this action as it relates to infection control.</p> <p>b. Residents received new labeled emesis basins and toothbrushes which were placed in their top drawer of their nightstand.</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:</p> <p>a. The nursing staff will be re-educated by 6/16/14 regarding providing safe clean environment to prevent development of infection as it relates to handling of wash basins and toothbrushes.</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.</p> <p>a. Ambassador's visiting</p>	

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F000465 SS=E	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 an environment that was safe, clean and in a state of good	F000465	rooms will check location and condition of wash basins and toothbrushes, three times a week for three weeks, then two times a week for three weeks, then weekly for a total of six months. location and condition of wash basins and toothbrushes. b. Deficits will be turned into the DON/designee for correction and possible counseling of staff. c. The monitoring/audits will be submitted to the Quality Assurance Committee and continue to be conducted monthly to assure continued compliance with staff knowledge and competency of the policies until the compliance is maintained as determined by the Quarterly Assurance Committee review. d. Reports of the audits will be reported to the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plan of action to correct and recommend continued monitoring until corrections are effective. Compliance by 6/25/14. F 465 Request Desk Review	06/25/2014	

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	<p>repair related to marred walls and doors, chipped door frames, wallpaper coming off walls, gouged walls and doors, rusted toilet paper holders, towel racks, vents and safety equipment, ripped carpets, green discoloration around faucets on sinks in bathrooms, and a brown substance on call light pull cords on 3 units throughout the facility. (Reclaim, Haven and Eden Units).</p> <p>Findings include:</p> <p>During the Environmental tour on 06/03/14 from 8:30-9:30 a.m., with the Director of Nursing (DoN), Housekeeping/Laundry Supervisor and the Maintenance Supervisor, the following was observed:</p> <p>1. Reclaim Unit</p> <p>a. A raised commode seat was rusted in Room 275. Two residents resided in this room.</p> <p>b. A raised commode seat was rusted, the inside of the bottom of the bathroom door had gouges, and the outside of the bathroom door frame had paint chipped off in Room 259. Two residents resided in this room.</p> <p>c. The carpet was ripped between the TV</p>		<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>a. Raised commode seat with rust in room 140, 145, 275 and 259 were discarded and replaced.</p> <p>b. Carpeting in room 269, 273 was replaced.</p> <p>c. Marks and chipping on bathroom doors in 147, 257, 259, 273, 275, 277, 269, B, C repaired.</p> <p>d. Rusty toilet paper holder, towel rack and ceiling vent in 142, 145, 255, C, E, J, M, O, cleaned and vent re-painted.</p> <p>e. Closet door in room 275 repaired.</p> <p>f. Caulking on wall in room C repaired</p> <p>g. In Room E, G burned out lights changed.</p> <p>h. Wall cleaned in room G.</p> <p>i. Room J was thoroughly cleaned wall paper removed.</p> <p>j. Call light cords replaced in 140, 143, 145</p> <p>k. Bathroom fixtures</p>	

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	<p>and the bed, the inside of the bottom of the bathroom door had gouges and the inside of the bottom of the bathroom door frame had paint chipped off in Room 273. Two residents resided in this room.</p> <p>d. The inside of the bathroom door had gouges, and inside of the bottom of the bathroom door frame had paint chipped off in Room 277. Two residents resided in this room.</p> <p>e. The inside bottom of the bathroom door had gouges, the bottom of the outside bathroom door frame had paint chipped off, and the carpet between the bathroom and bed was ripped in Room 269. Two residents resided in this room.</p> <p>f. In Room 255, there was a rusty toilet paper holder, towel rack and ceiling vent. Two residents resided in this room.</p> <p>g. Gouges were observed at the bottom of the inside of the bathroom wall and the door frame had paint chipped off in Room 273. Two residents resided in this room.</p> <p>h. The closet door in Room 275 had a hole at the bottom of the door, the inside bottom of the bathroom door was marred, the inside bottom of the bathroom door frame had paint chipped off, the vent and</p>		<p>replaced room 139, 147.</p> <p>l. Wall repaired 107, 108, 109, 137, 142.</p> <p>m. Electrical outlet repaired in room 113.</p> <p>2. 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:</p> <p>a. No residents were adversely affected by the deficits.</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.</p> <p>a. Staff re-educated related to completion of work orders for any new area of concerns like those listed above</p> <p>b. Housekeeping staff re-educated on 6/10/14 to complete work orders and turn them into their supervisor if any deficits are identified while they clean their designated areas each day.</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.</p>	

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	<p>the raised commode in the bathroom was rusted. Two residents resided in this room.</p> <p>I. The bathroom door had wood chipped off of the outside corner and the inside of the bottom of the door had gouges, the outside bottom of the bathroom door frame had paint chipped off and the wall between the dresser and closet had gouges in Room 257. Two residents resided in this room.</p> <p>2. Haven Unit</p> <p>a. The bathroom in Room C, had cracked caulking on wall above the sink, torn non-skid adhesives in the shower, rusty toilet paper holder and towel rack, the inside of bathroom door was marred, marred walls and torn wall paper near bed 1. Two residents resided in this room.</p> <p>b. In Room G, the lights above the sink and on the ceiling in the bathroom were not functioning, there were yellow stains under the wall soap dispenser. The walls were marred and there were holes in the walls. Two residents resided in this room.</p> <p>c. In the bathroom in Room O, there were rust stains on the shower floor, a</p>		<p>a. Housekeeping /maintenance staff will audit the identified rooms two times a week for two weeks, then 10% of the rooms on each nursing unit once a week for two months, then every other week for two months and then every three weeks for two months.</p> <p>b. Deficits identified will be submitted to the maintenance supervisor for repair when identified.</p> <p>c. Audits will be submitted to the Quality Assurance Committee and continue to be conducted for six months to assure continued compliance. Compliance by June 25, 2014.</p>	

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	<p>rusted ceiling vent and a rusted wall vent. One resident resides in this room.</p> <p>d. In Room B, the inside of the bathroom door was marred at the bottom of the door and there was a hole in the wall near the light switch in the bedroom. Two residents resided in this room.</p> <p>e. In the bathroom in Room E, the light over the mirror was not functioning, there were multiple holes in the walls on 3 separate walls, rust stains in the shower under the grab bars, rusty toilet paper holder and the wall paper near bed 2 was separating from the wall. Two residents resided in this room.</p> <p>f. Observed in Room M's bathroom was a rusty toilet paper holder. One resident resided in this room.</p> <p>g. In Room H's bathroom the following was observed, multiple holes in the wall, a rusty toilet paper holder and towel bars.</p> <p>h. The wall paper was separating from the wall near the call light, multiple holes were observed in the wall around the thermostat and in the wall near the window. There was a strong urine odor in the bathroom, rust stains on the shower floor, and a rusty toilet paper holder in Room J. One resident resided in this</p>			

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	<p>room.</p> <p>3. Eden Unit</p> <p>a. The walls in the bathroom were marred, there was rust on the raised commode, no pull cord for the call light and paint chipped off on the outside of the door frame in Room 145. Two resident resided in this room.</p> <p>b. The wall outside the bathroom was marred and the door frame had paint chipped off in Room 142. Two residents resided in this room.</p> <p>c. In Room 135's bathroom, the wall vent was rusted. Two residents resided in this room.</p> <p>e. Observed in Room 109, multiple mars and gouges on the wall behind the bed. One person resided in this room.</p> <p>f. In the bathroom in Room 140, the raised commode had rust on the seat and the pull cord had a brown substance on it. Two residents resided in this room.</p> <p>g. Green discoloration on the faucet handles on the bathroom sink in Room 147 was observed. Two residents resided in this room.</p>			

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	<p>h. The wall on the inside and the outside of the bathroom was marred, the outside of the bathroom door frame had paint chipped off and the raised commode had rust on the leg. Two residents resided in this room.</p> <p>I. The bathroom faucet handles on the sink had a green discoloration, a rusted vent cover, a hole around a pipe behind the toilet, and the wall behind bed 2 had paint chipped off in Room 139. Two residents resided in this room.</p> <p>J. In Room 107, unpainted plaster was observed behind the toilet in the bathroom. One resident resided in this room.</p> <p>K. In Room 108, behind the toilet near the floor was a circular opening. Two residents resided in this room.</p> <p>L. In the bathroom of Room 137, the molding above the bathroom sink was cracked and multiple drill holes were in the bathroom walls. One resident resided in this room.</p> <p>M. In Room 143, a brown substance was observed on the call light cord. Two residents resided in this room.</p> <p>N. In Room 113, the electrical outlet</p>			

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F009999	<p>near the bedside was cracked and part of the outlet was exposed. One resident resided in this room.</p> <p>Interview with the DoN, Housekeeper/Laundry Supervisor and the Maintenance Supervisor at the time of the tour, indicated all of the areas were in need of repair or cleaning.</p> <p>3.1-19(f)</p> <p>3.1-14 PERSONNEL In addition to the required inservice hours in subsection (1), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This State rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure staff received six and three hours of dementia specific</p>	F009999	<p>F9999 Request Desk Review</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. C.N.A's #3 through C.N.A #38 inclusive, Sitter #1 and #2, RN #2 and #3, LPN# 6 thorough #16 inclusive, Cook #1 , #2, #3 dietary aide #1, #2, #3, #4, Maintenance #1, Receptionist #1, Housekeeper/Laundry #1, #2, #3, Transportation #1 , #2 Wound Nurse, Director of Compliance, Lifestyle Coordinator, Office Manager, Payroll, Office Assistant, HR coordinator and Chaplain will all have the three hours of dementia specific training complete by June 25, 2014.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and</p>	06/25/2014

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	<p>training annually for 78 of 188 employees who had been employed at the facilities for more than six months. (CNA #3, CNA #4, CNA #5, CNA #6, CNA #7, CNA #8, CNA #9, CNA #10, CNA #11, CNA #12, CNA #13, CNA #14, CNA #15, CNA #16, CNA #17, CNA #18, CNA #19, CNA #20, CNA #21, CNA #22, CNA#23, CNA #24, CNA #25, CNA #26, CNA #27, CNA #28, CNA #29, CNA #30, CNA #31, CNA #32, CNA #33, CNA#34, CNA #35, CNA #36, CNA #37, CNA #38, Sitter #1, Sitter #2, RN #2, RN #3, LPN #3, LPN #4, LPN #5, LPN #6, LPN #7, LPN #8, LPN #9, LPN #10, LPN #11, LPN #12, LPN #13, LPN #14, LPN #15, LPN #16, Cook #1, Cook #2, Cook #3, Dietary Aide #1, Dietary Aide #2, Dietary Aide #3, Dietary Aide #4, Maintenance #1, Activity Aide #1, Receptionist #1, Housekeeper/Laundry #1, Housekeeper/Laundry #2, Housekeeper/Laundry #3, Social Service #1, Transportation #1, Transportation #2, Wound Nurse, Director of Clinical Compliance, Lifestyle Coordinator, Office Manager, Payroll, Office Assistant, HR Coordinator and Chaplin)</p> <p>Findings include:</p> <p>Seventy-eight employees who had been employed by the facility for over four</p>		<p>what corrective action (s) will be taken:</p> <p>a. New hire will complete their required dementia hours within four months of hire, verified by the HR coordinator.</p> <p>b. HR coordinator will verify which associates have not completed their requirements regarding dementia and notify appropriate manager.</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:</p> <p>a. Managers will be responsible to assure completion of dementia specific training utilizing the Relias program monthly for their assigned employees. Reports to be given to the Administrator.</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.</p> <p>a. HR coordinator will audit new hire records monthly for compliance and other employees records, quarterly to assure their compliance with dementia specific training.</p> <p>b. HR coordinator will monitor the reports of completion on the Relias access site for six months.</p> <p>c. Monitoring/audits will be submitted to the Quality Assurance</p>	

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R000000	<p>months, records were reviewed on 06/04/14 at 9:00 a.m. There was a lack of documentation in the facility's dementia training inservices to indicate 78 of the 188 employees had received the initial six hours of dementia training or the three hours of dementia training required yearly for the year of 2013.</p> <p>During an interview on 06/04/14 at 3:00 p.m., the RN consultant indicated the HR Coordinator was in charge of keeping track of the dementia training and hours completed.</p> <p>During an interview on 6/4/14 at 3:04 p.m., the HR Coordinator indicated the hours for dementia training for the staff in question had not been completed.</p> <p>3.1-14(u)</p>	R000000	<p>Committee for a six month period or until compliance is assured.</p> <p>d. Deficiencies noted, will have an action plan completed and associate counseling and be discussed at the monthly Quality Assurance Committee meeting.</p> <p>e. Compliance by June 25, 2014.</p>	
R000241	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.</p>			

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	<p>(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on record review and interview, the facility failed to ensure Physician's orders were followed related to weekly weights for a resident who had been prescribed a new medication for 1 of 5 residents reviewed for Physician's orders in a total sample of 7. (Resident #3)</p> <p>Findings include:</p> <p>The record for Resident #3 was reviewed on 6/3/14 at 10:20 a.m. The resident was admitted to the facility on 1/28/06. Her diagnoses included, but were not limited to, diabetes, diabetic neuropathy, and vascular dementia.</p> <p>Review of the Physician's orders dated 4/23/14 indicated, "Aricept (a dementia medication) 5 milligrams (mg) by mouth daily. Weekly weights times 4 weeks once medication started."</p> <p>Review of the Weight Tracking log indicated no evidence of documentation related to weekly weights.</p>	R000241	<p>R 241 Request Desk Review</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>a. The physician was notified of the lack of weekly weights on Resident #3.</p> <p>2. 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:</p> <p>a. No residents were adversely affected by the deficits.</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.</p> <p>a. Nursing - staff re-educated related to completion of physician orders upon admission/readmission and to be re-checked by assisted living coordinator. .</p>	06/25/2014

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 06/04/2014
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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R000298	<p>Interview with the Assisted Living Coordinator on 6/4/14 at 9:47 a.m. indicated, the resident had not been weighed weekly as prescribed by the physician.</p> <p>410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident</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.</p> <p>a. Assistant Living Coordinator will audit new admission/readmission charts for presence of orders to ensure they are completed accurately.</p> <p>b. Assistant Living Coordinator will monitor for six months.</p> <p>c. Reports will be submitted to the Quality Assurance Committee and continue to be conducted for six months to assure continued compliance. Compliance by June 25, 2014.</p>		

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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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	<p>receiving these services at least once every sixty (60) days.</p> <p>Based on record review and interview, the facility failed to ensure a pharmacy drug regimen review was completed every sixty days for 1 of 7 residents reviewed for pharmaceutical services in a total sample of 7. (Resident #7)</p> <p>Findings include:</p> <p>Resident #7's closed record was reviewed on 6/3/14 at 3:00 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and renal failure.</p> <p>Review of the Pharmacy Services Monthly Pharmacist Consulting Log indicated there were pharmacy drug regimen reviews completed 7/20/13 and 1/17/14. There was not a pharmacy drug regimen review completed in September 2013. The resident was not in the Assisted Living facility during November 2013.</p> <p>Review of the Progress Notes, indicated the resident went to the hospital on 10/12/13 and returned to her Assisted Living apartment on 11/15/13.</p> <p>An interview with the Assisted Living Coordinator 6/4/14 at 11:40 a.m., indicated he spoke to the pharmacist and</p>	R000298	<p>R 298 Request Desk Review</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>a. Resident #7 is no longer in our assisted living</p> <p>2. 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:</p> <p>a. No residents were adversely affected by the deficits.</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.</p> <p>a. Assisted Living Coordinator inserviced by Compliance nurse on June 17, 2014 regarding regulation of reviewing drug regimen of each resident receiving service at least once every six(60) days..</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.</p>	06/25/2014

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	the September 2013 drug regimen review had been missed.		<p>a. Assistant Living Coordinator will audit resident charts monthly for presence of review of drug regimen..</p> <p>b. Assistant Living Coordinator will monitor for six months.</p> <p>c. Reports will be submitted to the Quality Assurance Committee and continue to be conducted for six months to assure continued compliance. Compliance by June 25, 2014.</p>		