

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 09/28/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	<p>This visit was for the investigation of Complaint Number 00096027.</p> <p>Complaint 00096027, Substantiated with Federal/State Deficiencies related to the allegation cited at F323.</p> <p>Dates of Survey: September 27 & 28, 2011</p> <p>Facility Number: 001198 Provider Number: 155637 AIM Number: 100471000</p> <p>Survey Team: Heather Tuttle, R.N.- T.C. Janet Adams, R.N.</p> <p>Census Bed Type: 25 SNF 107 SNF/NF 38 Residential 170 Total</p> <p>Census Payor Type: 26 Medicare 73 Medicaid 71 other 170 Total</p> <p>Sample: 7</p>	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/28/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307
---	---

(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
F0323 SS=G	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 30, 2011 by Bev Faulkner, R.N.</p> <p>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.</p> <p>Based on record review and interviews, the facility failed to ensure Physical Therapy's recommendation/evaluation for the use of a Hoyer lift was utilized for resident transfers to and from the wheelchair and failed to ensure the leg brace was in place, which resulted in a fracture of the left hip for 1 of 4 fractures reviewed in the sample of 7. (Resident #B)</p> <p>Findings include:</p> <p>The closed record for Resident #B was reviewed on 9/27/11 at 1:55 p.m. The resident was admitted to the facility on 8/24/11 from the hospital. The resident's diagnoses included, but were not limited to, healing of left femur fracture, osteoporosis, muscle weakness, history of falls, dementia, Alzheimer's disease, and difficulty walking.</p>	F0323	<p>It is the policy of Chicagoland Christian Village to ensure that the resident environment remains as free of accident hazards as it is possible; and each resident receives adequate supervision and assistance to prevent accidents. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Identified resident is no longer within the building 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. 1. All residents chart's and C.N.A. care cards were audited 9-29-11 to assure no discrepancies between current physician orders and the therapy evaluation, as it related to transfer orders and special devices. All residents have the potential to be affected by the alleged deficient practice. What measues will be put into place or</p>	10/13/2011

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 09/28/2011
NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307		
(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>Review of Physician Orders dated 8/24/11, indicated "Strict toe touch only for physical therapy times two weeks." Further review of Physician Orders, dated 8/24/11, indicated brace to left leg on in the morning and off at night.</p> <p>Physician orders dated 8/25/11, indicated Physical Therapy five times a week times 90 days for therapeutic exercises, neuromotor need, gait training, group therapy and patient and caregiver education.</p> <p>Review of the Initial Plan of Care, dated 8/24/11, indicated Surgical wound left leg, pain related to left femur fracture. The nursing approach was to ensure the resident wore a brace to the left leg at all times.</p> <p>Review of the Physical Therapy Evaluation, dated 8/25/11, completed by a Physical Therapist, indicated the resident was completely dependent on staff for transfers related to her impairments of weakness, pain, balance, cognition, range of motion and weight bear restriction of the left lower extremity. The assistive device to be used for transfer was to be a Hoyer lift.</p> <p>Review of the Weekly Physical Therapy Progress Note by the Physical Therapy</p>		<p>what systemic changes will be made to ensure that the deficient practice does not recur.1. All completed resident therapy evaluations and physician transfer orders have been reviewed and nursing care plans updated.2. A process established between nursing and therapy department to communicate resident therapy evaluation findings by giving copy of the completed therapy evaluation to the nurse in charge to ensure that it is reviewed and proper changes are in place if necessary.3. Nursing staff will receive education regarding following resident transfer orders and ensuring the C.N.A. follow care card instructions regarding special devices. 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.1. Nurse Management will monitor compliceance through clinical review of new therapy evaluations and CNA care records, 5 days per week and report any discrepcrepancies to the Quality Assurance Committee for 6 months.2. Licensed staff will directly observe 10% of transfers on each unit and on each shift three times a week following an established schedule for the next 3 months, then three times monthly for 3 months and then monthly for 3 months to assure</p>		

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 09/28/2011
NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307		
(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>Assistant, dated the week of 8/26/11-9/1/11, indicated the resident required the use of the Hoyer lift for transfers and was completely dependent on staff for transfer. The resident had impairments with cognition, left lower extremity pain, poor activity tolerance, and decrease balance. The resident's precautions were weight bear restriction of left lower extremity of toe touch weight bear, brace for left lower extremity to be worn during the day time, confusion and macular degeneration. The resident was educated on her weight bearing status when working with parallel bars in which the resident needed maximum visual cues and assistance to be compliant. Physical Therapy was on hold as of 8/31/11 due to a new fracture.</p> <p>Review of Nursing Progress Notes, dated 8/29/11, indicated the resident was verbally alert with confusion. Nursing Progress Notes dated 8/30/11, at 4:30 p.m., indicated "Resident complaints of increased pain to left leg and pelvic area, after being transferred to bed. PRN (as needed) medication given, no relief after hour, new orders received, daughter made aware.</p> <p>Review of Physician Orders dated 8/29/11, indicated X-ray left leg/pelvis.</p>		<p>ongoing compliance beginning 10/21/11. The results of the observations will be forwarded to the Quality Assurance COmmittee for 9 months.3. Director of compliance/education, DON and Administrator will conduct an audit weekly beginning 10/10/11 including therapy evaluation and care record reviews completed by nursing management, and observation of transfers for 6 months and report findings to the QA committee to assure compliance is maintained.Date completed 12/21/11</p>		

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 09/28/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307
---	---

(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>Review of the Radiology Report, dated 8/30/11, indicated there was a displaced periprosthetic fracture involving the margin of the femoral stem on the left. The conclusion was left hip periprosthetic fracture.</p> <p>Review of Nursing Progress Notes, dated 8/30/11, at 7:00 p.m., indicated mobile X-ray were at the facility to obtain the X-rays. At 9:00 p.m., the results were received and the resident's physician was notified. The resident's orthopedic physician was notified and indicated the resident's leg brace was to be worn at all times. The Orthopedic Physician indicated he wanted a copy of the disc with the X-rays sent to his office so he could compare them to older ones.</p> <p>Review of Physician Orders, dated 8/31/11, indicated bed rest, turn and reposition every two hours, and full leg brace.</p> <p>Review of Nursing Progress Notes, dated 9/1/11, indicated the resident was febrile with complaints of pain. The resident's Physician was notified and the resident was directly admitted to the hospital with a fracture of the left hip.</p> <p>Review of the Investigation of the fracture of the left hip, dated 8/31/11, indicated</p>			

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 09/28/2011
NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307		
(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>CNA #2 indicated Resident #B wanted to go to bed. At that time, CNA #3 placed the gait belt around her waist and they both assisted her to bed. She indicated the resident turned and pivoted and sat on the bed. CNA #3 picked up her legs and placed them into the bed. After sitting down, the resident screamed, "You broke my leg." The resident did not have on her leg brace at the time of the transfer. CNA #2 indicated CNA #3 told the resident not to bear weight on her leg. CNA #3 indicated she had seen the resident's leg brace in the chair by the wall after the transfer. The CNA indicated she did not realize it was not on until after the transfer. The resident's roommate indicated to staff that Resident #B took her leg brace off by herself.</p> <p>Review of the Rehab Addendum Note by the Physical Therapy Assistant, dated 8/31/11, indicated "patient continued to complain of pain in left lower extremity just above the knee with standing in the parallel bars. Patient needs constant reminders of left lower weight bearing status of toe touch weight bear."</p> <p>Interview with the Physical Therapist on 9/28/11, at 11:00 a.m., who completed the initial evaluation indicated she had recommended the Hoyer lift for transfers on the day the resident was evaluated.</p>				

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 09/28/2011
NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307		
(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>She indicated at the time of evaluations they would instruct the staff working with the resident what should be used to transfer for each resident. She indicated she recalled the resident was very confused and was only toe touch weight bear. She further indicated the therapists only worked with her for five days and with maximum assist were working with her on the parallel bars with only toe touch weight bear.</p> <p>Interview with LPN #1 on 9/28/11, at 11:05 a.m., indicated she recalled the resident and had taken care of her. She indicated the resident was a two person transfer with a gait belt. She indicated she was not aware of the recommendation from the therapy department for the Hoyer lift to be used for transfers.</p> <p>Interview with CNA #1 on 9/28/11, at 11:15 a.m., indicated she had worked with the resident while she was there at the facility. She indicated the resident was a two person transfer with a gait belt. She indicated she was unaware the resident was supposed to be transferred with the Hoyer lift.</p> <p>Interview with the Physical Therapist and the Therapy Manager on 9/28/11, at 12:10 p.m., indicated she had recommended the Hoyer lift at the time of the evaluation and</p>				

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 09/28/2011
NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307		
(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>only for that day 8/25/11. She further indicated the case was passed onto a physical therapy assistant.</p> <p>Further review of the Physical Therapy weekly progress notes, dated 8/26/11-9/1/11, indicated there was no documentation indicating the Hoyer lift was only recommended on the first day of the evaluation. There was no further documentation or other assessments for the resident's transfer status and the use of the Hoyer lift.</p> <p>Interview with the Director of Nursing on 9/28/11, at 11:25 a.m., indicated she was completely unaware the Physical Therapist had indicated during her evaluation the assistive device for transfers was to be a Hoyer lift. She indicated the therapists were to inform the nursing staff of their recommendations.</p> <p>This Federal Tag related to Complaint Number IN00096027.</p> <p>3.1-45(a)(2)</p>				