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 06/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHICAGOLAND CHRISTIAN VILLAGE	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
F000000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00127606. Complaint IN00127606 - Substantiated. No deficiencies related to the allegation are cited. Survey dates: June 10, 11, 12, 13, and 14, 2013 Facility Number: 001198 Provider Number: 155637 AIM Number: 100471000 Survey Team: Shannon Pietraszewski, RN-TC Regina Sanders, RN Jennifer Redlin, RN Yolanda Love, RN Caitlyn Doyle, RN Census bed type: SNF/NF: 105 SNF: 18 Residential: 42 Total: 165 Census Payor Type: Medicare: 21 Medicaid: 78 Other: 66	F000000	R0000 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 defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Total: 165 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on June 21, 2013, by Janelyn Kulik, RN.			

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F000242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.			
	Based on record review and interview, the facility failed to ensure resident were given a choice, related to bathing preferences and preferred time to get up in the morning, for 2 out of 3 residents reviewed for choices in a sample of 5. (Residents' #5 and #31) Findings include: 1. Resident #5's family member was interviewed on 6/11/13 9:36 a.m. The family member indicated Resident #5 was not bathed according to her past preferences, there was only a shower stall on the floor. The family member indicated Resident #5 took baths at home. Resident #5's clinical record was reviewed on 6/13/13 at 1:25 p.m. Resident #5's diagnosis included, but was not limited to, Alzheimer's dementia with cognitive deficits.	F000242	WE REQUEST DESK COMPLIANCE F242 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a. Nursing supervisors/designee met with Resident # 5's family and Resident #31 to discuss resident choices for the following: Wake time, Type of bath, time of bath and Usual bed time. Attachment #1. 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: a. 100 % audit conducted with interview able resident's present in the facility at the time of the audit, included Resident #5 and Resident #31, to assure choices are being honored by staff. Audits conducted June 17 – June 28 th	07/05/2013

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	An Activity Admission Assessment, dated 1/2/12, indicated the resident liked baths. A 14 day MDS (Minimum Data Set) Assessment, dated 1/14/12, indicated the resident was cognitively impaired, and the family indicated it was very important for the resident to choose a tub bath, shower, bed bath, or sponge bath. An Annual MDS Assessment, dated 12/7/12, indicated it was somewhat important to choose a tub bath, shower, bed bath, or sponge bath. A CNA care card was provided by the DoN on 6/13/13 at 2:45 p.m. The care card did not indicate Resident #5's preference for a bath. The Bathing Report indicated from 4/1/13 to 6/13/13, showers only were given. An interview with the Social Service Director on 6/12/13 at 9:45 a.m., indicated the Unit Manager on the Dementia Unit would address resident/family choices/preferences. An interview with the Unit Manger and LPN #1 on 6/12/13 at 11:15 a.m., indicated they were not aware of the		using above mentioned tool. b. Residents that are unable to be interviewed, nurse managers/designee will discuss resident choices with a family/responsible party. c. Completed forms to be scanned into the record and care planned. 3. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recur: a. Education of managers and nursing staff regarding utilization of new form for choices begun June 18 and will be completed by July 2, 2013. 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 a. New admissions/readmissions audit tools will be completed with each new admission/readmission b. DON/designee staff will audit new admission/readmission to ensure that compliance is maintained with tool..(Attachment #2)	

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	resident's preference for baths. LPN #1 indicated there were no bath tubs on the unit. LPN #1 indicated the resident had refused showers in the past. The Unit Manager indicated the resident could be taken downstairs for a bath. An interview with the DoN on 6/13/13 at 2:10 p.m., indicated the CNA's would ask the residents/family members on admission for their preferences on choices. The CNA's would report it to the nurse on the unit and the nurse would type it in the computer on the care card. The DoN indicated the Unit Manager would update the care card weekly. 2. An interview with Resident #31 on 6/10/13 at 3:18 p.m., indicated she was not able to choose when she wanted to get up in the morning. Resident #31 indicated she would like to get up at 6:30 a.m. and she was up at 5:45 a.m. Resident #31 also indicated she was not able to choose how many times she wanted to take a shower. Resident #31 indicated it was not, "cut and dry" and she would often get showers once a week. Resident #31's clinical record was		c. Audit tools will be submitted to the Quality Assurance Committee and continue to be conducted quarterly to assure continued compliance with staff knowledge and competency of the policy until the compliance is maintained as determined by the Quarterly Assurance Committee review. Compliance by 7/2/13. d. Reports of the audits will be reported to the Quality Assurance meeting quarterly 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.	

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	reviewed on 6/13/13 at 1:15 p.m. Resident #31's diagnoses included but were limited to, status post hip fracture, arthritis, and COPD (lung disease). A 5 day MDS Assessment, dated 7/25/12, indicated Resident #31 was cognitively intact and it was very important for the resident to choose between a tub bath, shower, bed bath or sponge bath. A Nursing Admission Assessment dated 3/15/13 at 12:21 p.m., did not indicate a sleep pattern/preferences in the sleep section. A Readmit 5 day MDS Assessment, dated 3/22/13, indicated the resident was cognitively intact and it was very important for the resident to choose between a tub bath, shower, bed bath or sponge bath. A care card provided by the DoN on 6/13/13 at 2:45 p.m., did not indicate the resident's preference for getting up in the morning or bathing. The Bathing Report indicated the resident had only received 7 showers from April 1, 2013 to 6/13/13. The remainder were bed baths with two "refusals".			

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	An interview with the Social Service Director on 6/12/13 at 9:45 a.m., indicated the Activity Director would address resident/family choices/preferences. An interview with the Activities Director on 6/13/13 at 1:50 p.m., indicated she does not ask the resident their choices/preferences. The Activities Director indicated the nursing staff managed that upon the resident's admission. An interview with the DoN on 6/13/13 at 2:10 p.m., indicated the CNA's would ask the residents/family on admission for their preferences on getting up/shower/baths. The CNA's would report it to the nurse on the unit and the nurse would type it in the computer on the care card. The DoN indicated the Unit Manager would update the care card weekly. 3.1-3(u)(3)			

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F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on observation, record review, and interview, the facility failed to ensure residents were free from unnecessary medications related to psychoactive medications increased without indications for the increase and failed to complete gradual dose reductions for Zoloft (anti-depressant) and Depakote (used for a depressive disorder) for 2 of 10 residents reviewed for unnecessary medications in a total sample of 39. (Residents #39 and #133)	F000329	WE REQUEST DESK COMPLIANCE F 329 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a. Upon receipt of 2567, Resident #39 was re-assessed for factors that contribute to problematic behaviors and need for anti-anxiety medication. b. Resident #133 was re-assessed for factors that contribute to problematic behaviors and need for antidepressant. 2. How other residents having the potential to	07/05/2013

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	Findings include: 1. Resident #39's record was reviewed on 6/12/13 at 8:06 a.m. The resident's diagnoses include, but were not limited to, depression and dementia with behavioral disturbance. During an observation on 6/10/13 at 2:00 p.m., the resident was in bed and asleep. During an observation on 6/11/13 at 9:03 a.m., the resident was awake, sitting in the wheelchair and watching TV in the lounge with other residents. The resident was smiling and exhibited no behaviors. During an observation on 6/12/13 at 8:26 a.m., the resident was in the lounge across from the Nurses' Station, asleep in her wheelchair. There were no behaviors exhibited. A) The Quarterly Minimum Data Set Assessment (MDS), dated 10/26/12, indicated the resident was cognitively impaired, felt down and depressed one day, with a mood severity score of 2 (minimal depression), and had physical behaviors one to three days. A Physician's order, dated 08/23/12,		be affected by the same deficient practice will be identified and what corrective action(s) will be taken: a. Residents currently receiving Psychotropic, Anti-psychotic or anti-anxiety medication have the potential to be affected. b. On 7/3/13 Michiana Psychiatric Group was in the facility and received a list of residents receiving Psychotropic, Anti-psychotic or anti-anxiety medication to evaluate the necessity of the medication. 3. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recur: a. Social Service and unit manager will meet with clinical pharmacist for evaluation of gradual dose reduction for any resident receiving and/or being considered for use anti-psychotic, anti-anxiety and psychotropic medication. The evaluation by social service, unit manager and pharmacist will be based on the gradual dose reduction policy. b. Nursing staff will be re-educated by nursing management/designee on Behavioral Notes by July 5, 2013. The behavior notes are found in Point Click Care. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; a. Social Service/designee will monitor/audit Monday thru Friday records of residents exhibiting	

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	indicated an order for Lexapro (antidepressant), five milligrams (mg) daily for anxiety. A Nurses' Note, dated 11/04/12 at 1:00 p.m., indicated the resident kicked a CNA in the stomach and face and grabbed at the staff arms while CNAs' were providing care and transferring the resident to the wheelchair. The note indicated attempts to redirect were not successful but once the transfer was completed the resident had calmed down. The record lacked documentation of any further behaviors exhibited by the resident. A Nurse Practioner's progress note, dated 11/06/12, indicated, "...Report of recently attempting to grasp peer. Staff attempted to keep her out of reach of peers...episodic anxiety & irritability c/ (with) occas (occasionally) related pt (patient) distress...increase (arrow up) Lexapro 7.5 mg qd (daily) to decrease (arrow down) anxious & dysphorias." A Physician's order, dated 11/06/12, indicated an order to increase the Lexapro to 7.5 mg every morning from 5 mg every morning.		behaviors or on psychotropic, anti-psychotic or anti-anxiety medication to ensure that continued compliance is obtained. b. Monitoring/audit will be done daily Monday thru Friday on each nursing unit by social service personnel. c. The monitoring/audits will be submitted to the Quality Assurance Committee and continue to be conducted quarterly 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 monitoring/audits will be reported to the Quality Assurance meeting quarterly for six months. Any deficiencies will be noted and a plan of action to correct with recommendations will be documented.	

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	During an interview on 06/13/13 at 11:30 a.m., the Social Service Director (SSD) indicated she could not find further supportive documentation in the resident's record, dated 07/20/12 through 01/13/13, to indicate the need to increase the resident's Lexapro. B) Resident #39's Quarterly MDS Assessment, dated 10/26/12, indicated the resident was cognitively impaired, felt down and depressed one day, with a mood severity score of 2 (minimal depression), and had physical behaviors one to three days. The Quarterly MDS Assessment, dated 1/21/13, indicated the resident was cognitively impaired, felt down and depressed for 12-14 days, had a mood severity score of 3 (minimal depression) and had no behaviors. The Quarterly MDS Assessment, dated 4/17/13, indicated the resident was cognitively impaired, had no mood symptoms with a score of 00 and no behaviors. A Physician's Order, dated 08/23/12, indicated an order for Risperidone (anti-psychotic) 0.25 mg every evening for anxiety.			

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	An undated physician's order, indicated a clarification of the Risperidone order for 0.25 mg every evening for organic mental syndrome. A Nurses' Note, dated 11/04/12 at 1:00 p.m., indicated the resident kicked a CNA in the stomach and face and grabbed at staff arms while CNA's were providing care and transferring the resident to the wheelchair. The note indicated attempts to redirect were not successful but once the transfer was completed the resident had calmed down. A Physician's order, dated 11/4/12 at 3:00 p.m., indicated to discontinue the Risperidone 0.25 mg daily and to start Risperidone 0.25 mg twice a day for anxiety. A Psychiatric Consult, dated 02/11/13, indicated, "...Reports of physical aggression with staff...increase Risperdal (Risperidone) to 0.25 mg tid (three times a day)..." A Physician's Order, dated 02/11/3, indicated to increase the Risperidone 0.25 mg to three times a day for organic brain syndrome.			

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	The Social Service Director (SSD) provided a Behavior Occurrence Form, dated 01/24/13, which indicated the resident had behaviors of kicking and hitting. The area to document the cause of the behavior was left blank. The interventions included re-approach, redirection, reposition, which were unsuccessful. There was a lack of documentation in the resident's record of further aggression by the resident, interventions attempted for the aggression and the outcome of the interventions. During an interview on 06/13/13 at 11:30 a.m., SSD indicated she could not find supportive documentation in the resident's record, dated 07/20/12 through 02/11/13, to indicate the need to increase the resident's Risperidone except for the one time on 11/04/12 and the Behavior Occurrence Form, dated 01/24/13. During an interview on 06/13/13 at 1:00 p.m., the Administrator indicated the facility's Behavioral Program was not effective prior to the new SSD coming into the facility. During an interview on 06/13/13 at			

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	1:00 p.m., the SSD indicated the resident had one incident of agitation in November and one incident in January. She indicated there was no supportive documentation about the behaviors. A facility policy, dated 03/31/09, titled, "Psychotropic Medication Use-Management", received from the RN Nurse Consultant as current, indicated, "...psychotropic medications will not be used for the purpose of discipline or staff convenience, or when a resident's symptoms do not require them...Anti-psychotics should not be used if one or more of the following is/are the only indication...uncooperativeness, or agitated behaviors which do not represent danger to the resident or others...Specific behaviors must be quantified (number of episodes), described objectively...and documented...After thorough assessment, the interdisciplinary team will meet to discuss any recommendations for management of targeted behaviors. 3. If the resident's harmful behaviors continue despite attempts to eliminate precipitating factors, and if non-chemical management of behaviors have been implemented and failed, as			

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	documented in the clinical record, notify the physician to receive orders for psychotropic medication...After implementation of psychotropic medication, resident behavior and medication effects should be monitored and documented on a regular basis..." 2. The record for Resident #133 was reviewed on 6/11/13 at 3:15 p.m. The resident's diagnoses included, but were not limited to, depressive disorder, anxiety, and dementia without behavioral disturbance. Review of the Physician's Recapitulation Orders dated 06/2013, indicated an order for Zoloft (an antidepressant medication) 150 milligrams (mg) daily in the morning, originally ordered on 2/22/12. Review of the pharmacy recommendation dated 8/23/12, indicated recommendations to decrease the dose of the Zoloft medication to 125 mg from 150 mg daily. Review of the Physician's response indicated to continue the same order and was signed by Physician on 8/24/12. Review of the Medication Administration Records (MAR) for the months of 05/2013 and 06/2013, indicated the			

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	resident received the Zoloft medication 150 mg daily in the morning. Continued record review indicated documentation of an attempted or refused gradual dose reduction (GDR) was lacking since 8/24/12. Review of the Physician's Recapitulation Orders dated 06/2013, indicated an order for Depakote Sprinkles (a medication that can be used to stabilize mood) 250 mg twice daily, originally ordered on 6/30/12. Review of the pharmacy recommendation dated 5/8/13, indicated a recommendation to decrease the dose of the Depakote Sprinkles medication to 125 mg every morning and 250 mg every evening. Review of the Physician's response indicated to continue the same order and was signed by Physician on 5/11/13. No clinical rationale was provided. Review of the Medication Administration Records (MAR) for the months of 05/2013 and 06/2013 indicated the resident received the Depakote Sprinkles medication 250 mg twice daily. Review of the psychoactive medication quarterly review assessment dated 5/14/13, indicated there were no episodes of behavior per week and no adverse			

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	reactions to medications. Continued record review indicated there were no behavior progress notes or social service notes regarding resident behaviors from 02/2013 through 06/2013. Interview with Social Services Director on 6/13/13 at 9:21 a.m., indicated there have been no dose reductions or reduction attempts on Zoloft since 8/24/12. She indicated the resident received a pharmacy recommendation for Depakote Sprinkles reduction on 5/8/13 and the Physician declined the reduction by checking the box marked "other." The Social Services Director stated, "we don't accept that as an answer." She indicated there was no other documentation regarding clinical rationale for the declined Depakote Sprinkles reduction on 5/11/13. 3.1-48(b)(2)			

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F009999	3.1-14 PERSONNEL In addition to the required inservice hours in subsection (l), 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 facility staff received three hours of dementia specific training annually for 10 of 25 employees who had been employed at the facility for more than six months. (Residential Unit Manager, LPN #2, CNA #3, CNA #4, CNA #5, CNA #6, CNA #7, CNA #8, CNA #9, CNA #10) Findings include:	F009999	F 9999 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a. Residential Unit Manager, LPN #2, CNA #3, CNA #4, CNA #5, CNA # 6, CNA #7, CNA #8, CNA#9, CNA#10 will all have the three hours of dementia specific training completed by July 5, 2013. 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: a. Any new hire will complete their required six hours within the first 60 days of employment, verified by the Human Resource Coordinator. b. Director of Compliance & Education will verify with unit managers of all departments to assure compliance of three hours of dementia specific training for their staff. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:	07/05/2013

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	Ten employees who had been employed by the facility for over four months, records were reviewed on 06/14/13 at 11 a.m. There was a lack of documentation in the facility's dementia training inservices to indicate 10 of the 25 randomly selected employees had received the three hours of dementia training required yearly for the year of 2012. During an interview on 06/14/13 at 1:30 p.m., the Administrator indicated she was not aware the dementia training had not been completed by the staff indicated. 3.1-14(u)		a. Managers will be responsible to assure completion of dementia specific training utilizing the Silverchair program monthly for their assigned employees. Reports to be given to the Director of Compliance & Education monthly. 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. a. Director of Compliance & Education/designee will audit new hire records monthly for compliance and other employees records, quarterly to assure their compliance with dementia specific training. b. Director of Compliance & Education/designee will monitor the reports of completion on the Silverchair access site for six months. c. Monitoring/audits will be submitted to the Quality Assurance Committee for a six months period or until compliance is assured. d. Deficiencies noted, will have a action plan completed and be discussed at the quarterly Quality Assurance Committee meeting	

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R000000	The following State Residential findings cited are in accordance with 410 IAC 16.2.	R000000	e. Compliance of the plan by July 5, 2013. R0000 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.	

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R000214	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to complete Pre-Admission Evaluations for 2 residents (#210 and #223) and failed to complete Semi-Annual Evaluations for 3 residents (#213, #215, and #226) out of 5 resident's reviewed for individual needs assessments in a total sample of 5. Findings include: 1. Resident #210's record was reviewed on 06/13/13 at 3:30 p.m. The resident's diagnosis included, but was not limited to, congestive heart failure. The resident was admitted into the facility on 03/21/13. There was a lack of documentation in the resident's record to indicate a Pre-Admission Evaluation had been completed on the resident prior to being admitted into the facility. 2. Resident #223's record was reviewed on 06/13/13 at 3:45 p.m.	R000214	R Tag 214 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a. Resident #210, 223, 226, 215, 213 will be re-evaluated by 7/5/13 b. Resident listed above, or the family will be offered involvement and it will be documented if they refuse. Signature on the bottom of the re-evaluation form is required by resident and /or family member. (Attachment #3). 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: a. New admission to assisted living will be evaluated prior to admission utilizing a preadmission screening tool. (Attachment #4)	07/05/2013

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	The resident's diagnosis included, but was not limited to, dementia. The resident was admitted into the facility on 01/08/13. There was a lack of documentation in the resident's record to indicate a Pre-Admission Evaluation had been completed on the resident prior to being admitted into the facility. 3. Resident #226's record was reviewed on 06/13/13 at 3:50 p.m. The resident's diagnosis included, but was not limited to, osteoarthritis. The resident was admitted into the facility on 09/06/06. There was a lack of documentation in the resident's record to indicate a Semi-Annual Evaluation had been completed for the resident. 4. Resident #215's record was reviewed on 06/14/13 at 8 a.m. The resident's diagnosis included, but was not limited to, Parkinson's Disease. The resident was admitted into the facility on 10/15/09. There was a lack of documentation in the resident's record to indicate a Semi-Annual Evaluation had been completed for the resident.		b. New residents will be re-evaluated every six months incorporating resident and families utilizing attachment #3. 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. Resident Service Director was inserviced regarding utilization of Attachement #3 and Attachment#4 by Regional Clinical Corporate Nurse on June 18 th . 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. a. Resident Service Director/designee will audit new admission charts for presence of pre-admission assessment tool. b. Resident Service Director will monitor the Evaluation book daily for re-evaluation or updates needed for six months. c. Monitoring/audits will be submitted to the Quality Assurance Committee for a six months period or until compliance is assured. d. Deficiencies are noted a plan of action will be completed and	

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	5. Resident #213's record was reviewed on 06/13/13 at 3:45 p.m. The resident's diagnosis included, but was not limited to, diabetes mellitus. The resident was admitted into the facility on 03/21/11. There was a lack of documentation in the resident's record to indicate a Semi-Annual Evaluation had been completed for the resident. During an interview on 06/14/13 at 10 a.m., the Residential Unit Manager indicated there were no Semi-Annual Evaluations completed on the residents and he could not find the Pre-Admission Evaluations for the residents.		discussed at the quarterly Quality Assurance Committee meeting e. Compliance of the plan by July 5, 2013.	

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R000216	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to obtain an admission weight on a 1 of 2 newly admitted residents reviewed for admission weights in a total sample of 5. (Resident #210) Findings include: Resident #210's record was reviewed on 06/13/13 at 3:30 p.m. The resident's diagnosis included, but was not limited to, congestive heart failure. The resident was admitted into the facility on 03/21/13. There was a lack of documentation in the resident's record to indicate an admission weight had been obtained by the facility.	R000216	R Tag 216 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a. Resident #210 was weighed and recorded 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: a. New admissions to assisted living will be weighed and vital signs taking up admission and bi-annually. 3. What measures will be put into	07/05/2013

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	During an interview on 06/14/13 at 10 a.m., the Residential Unit Manager indicated a weight had not been obtained upon admission for the resident.		place or what systemic changes will be made to ensure that the deficient practice does not recur: a. Resident Service Director was inserviced by Regional Clinical Corporate Nurse on June 18, 2013 regarding regulations of vital signs and weights on admission and bi-annually. 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. a. Resident Service Director/designee will audit new admission charts for presence of vital signs and weights. b. Resident Service Director will monitor the Evaluation book daily for updates needed for six months relating to vital signs and weights. c. Monitoring/audits will be submitted to the Quality Assurance Committee for a six months period or until compliance is assured. d. Deficiencies that are noted, a plan of action will be completed and discussed at the quarterly Quality Assurance Committee meeting	

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			e. Compliance of the plan by July 5, 2013.	

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R000409	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure residents' had an Annual Health Statement, for 3 of 5 residents reviewed for Annual Health Statements in a total sample of 5. (Residents #213, #215, and #223) Findings include: 1. Resident #223's record was reviewed on 06/13/13 at 3:45 p.m. The resident's diagnosis included, but was not limited to, dementia. The resident was admitted into the facility on 01/08/13. There was a lack of documentation in the resident's record to indicate the resident showed no evidence of tuberculosis in an infectious stage and was free from all other communicable disease. 2. Resident #213's record was reviewed on 06/13/13 at 3:45 p.m. The resident's diagnosis included, but	R000409	WE REQUEST DESK COMPLIANCE R Tag 409 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a. Resident #213, #215 and #223 will have statement of no evidence of tuberculosis in an infectious state and free from other communicable disease as evidenced by physician signature by 7/5/13 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: a. New admissions to assisted living will have the physician order sheet, which includes the statement that they have no evidence of tuberculosis in an infectious state and are free from other communicable disease will be signed by the attending	07/05/2013

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	was not limited to, diabetes mellitus. The resident was admitted into the facility on 03/21/11. There was a lack of documentation in the resident's record of an Annual Health Statement, to indicate the resident showed no evidence of tuberculosis in an infectious stage and was free from all other communicable disease. 3. Resident #215's record was reviewed on 06/14/13 at 8:00 a.m. The resident's diagnosis included, but was not limited to, Parkinson's Disease. The resident was admitted into the facility on 10/15/09. There was a lack of documentation in the resident's record of an Annual Health Statement, to indicate the resident showed no evidence of tuberculosis in an infectious stage and was free from all other communicable disease. During an interview on 06/14/13 at 10:00 a.m., the Residential Unit Manager indicated there were no Annual Health Statements or Admission Health Statements completed on the residents.		physician. b. Current residents will have the physician orders signed which includes the communicable disease statement every six months(bi-annually). 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. Resident Service Director was inserviced by Regional Clinical Corporate Nurse on June 18,2013 regarding regulations related to communicable disease statement. 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. a. Resident Service Director/designee will audit new admission charts for presence of signed physician orders. b. Resident Service Director will audit resident records for the presence of physician signature on medication records in July and every six months thereafter. b. Resident Service Director will audit resident records for the presence of physician .	

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			c. Audits will be submitted to the Quality Assurance Committee for a six months period or until compliance is assured. d. Deficiencies that are noted, a plan of action will be completed and discussed at the quarterly Quality Assurance Committee meeting e. Compliance of the plan by July 5, 2013.	

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R000410	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure a two-step mantoux (test for tuberculosis) test had been completed for on admission for 2 of 2 newly admitted residents reviewed for first second step mantouxs in a total sample of 5. (Residents #210 and #223) Findings include: 1. Resident #210's record was reviewed on 06/13/13 at 3:30 p.m. The resident's diagnosis included, but	R000410	WE REQUEST DESK COMPLIANCE R Tag 410 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a. Resident #210, and #223 did receive a chest X-ray prior to admission and have no documented negative outcome from lack of second TB test. 2. How other residents having the potential to be affected by the same deficient practice will be identified	07/05/2013

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 06/14/2013
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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	was not limited to, congestive heart failure. The resident was admitted into the facility on 03/21/13. There was a lack of documentation in the resident's record to indicate the second step of the two step mantoux had been completed on the resident. 2. Resident #223's record was reviewed on 06/13/13 at 3:45 p.m. The resident's diagnosis included, but was not limited to, dementia. The resident was admitted into the facility on 01/08/13. There was a lack of documentation in the resident's record to indicate the second step of the two step mantoux had been completed on the resident. During an interview on 06/14/13 at 10 a.m., the Residential Unit Manager indicated the second step mantoux had not completed on the residents.		and what corrective action (s) will be taken: a. New admissions to assisted living will have second step TB test scheduled within two weeks of their admission. 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. Resident Service Director was inserviced by Regional Clinical Corporate Nurse on a. Resident Service Director was inserviced by Regional Clinical Corporate Nurse on June 18,2013 regarding regulations related to communicable disease statement. 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. a. Resident Service Director/designee will audit new admission charts for presence of schedule for administration of second step TB b. Audits will be submitted to the Quality Assurance Committee for a six months period or until compliance is assured. c. Deficiencies that are	

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			noted a plan of action will be completed and discussed at the quarterly Quality Assurance Committee meeting	