STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155611	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOOSIER CHRISTIAN VILLAGE	621 S SUGAR ST BROWNSTOWN, IN 47220

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F0000	This visit was for a Recertification and State Licensure Survey. This visit is in conjunction with the investigation of Complaint IN00118578. .Survey dates: October 15-19, 22 & 23, 2012 Facility number : 000277 Provider number 155611 AIM number: 100290530 Survey Team: Susan Worsham, RN- TC Marla Potts, RN Sharon Whiteman, RN Census bed type: SNF: 8 SNF/NF: 86 Total: 94 Census payor type: Medicare: 8 Medicaid: 67 Other: 19 Total: 94 These deficiencies reflect state	F0000	Please consider this plan of correction as Hoosier Christian Village's credible plan of correction. This plan of correction constitutes a written allegation of substantial compliance under Federal Medicare requirements. Submission of this plan of correction is not an admission that a deficiency exists or that the community agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our residents solely as a requirement of the provisions of Federal and State law. Please accept this evidence in lieu of an onsite follow up visit for Recertification and State Licensure Survey Event ID UOSV11 on October 23, 2012.	

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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	findings cited in accordance with 410 IAC 16.2. Quality review completed on October 25, 2012 by Bev Faulkner, RN			

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F0159 SS=C	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that			

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	receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.			
	Based on interview and observation, the facility failed to ensure resident funds were available to residents on the weekends. This had the potential to affect 55 of 58 residents who had personal funds accounts. Findings Include: During interview of the Resident Council President on 10/18/12 at 10:00 a.m., she indicated residents could not get money on the weekends. The Resident Council President indicated if residents wanted money for the weekend, they had to ask for the money during the week. During interview of the Business Office Manager on 10/19/12 at 11:02 a.m., she indicated residents could only get money from their funds account during the week days and they would have to request money during the week to have for the weekend.	F0159	Hoosier Christian Village does ensure resident funds are available to residents according to 410 IAC 16.2-3.1-6 Protection of Resident Funds (f)(1) The facility must provide reasonable access during normal business hours to the funds in the account. On October 22, 2012, resident funds were made available for weekends. Funds were placed in locked boxes, in locked rooms on both units, with access by professional staff for residents needing funds on the weekends. During the week of October 22, 2012 all residents were notified of accessibility of funds on weekends by unit managers. On November 5, 2012, the Social Service Designee re-informed resident council of accessibility of funds on weekends. On Fridays of each week, the Business Office Manager will audit locked boxes on both units for sufficient funds and replenish as necessary. All residents who have funds in the facility have the potential to be affected by this practice. The Social Service Designee will interview random residents weekly for one month to	11/06/2012

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	During interview of LPN #1 on 10/22/12 at 1:50 p.m., he indicated money for a few residents who frequently asked for money on weekends was kept in a lock box. LPN #1 indicated he once called the Director of Nursing (DON) when a resident who did not have money in the lock box requested money and she came in and got the resident some money. With LPN #1 present the lock box was checked and there was an envelope with money in it for one resident. During interview LPN #2 on 10/222/12 at 1:40 p.m., indicated the facility kept money in a lock box for a couple of residents who frequently requested money on the weekends. LPN #2 indicated the facility had explained to other residents that they have to request money earlier in the week if they want money on the weekends. LPN #2 checked the lock box and there was money in it for two residents. Interview of the DON on 10/22/12 at 3:40 p.m., indicated there were 58 residents who had personal funds accounts. . 3.1-6(f)(1)		ensure compliance of available funds on weekends. Any concerns will be brought to the CQI committee for further review and recommendations as needed. The CQI committee has reviewed the Social Service Deisgnee's weekly interviews for compliance of availability of funds. Once all residents who were interviewed acknowledged the availability of funds and denied any further concerns, the audits may cease. In view of the fact of resident's satisfaction with fund availability on the weekend, the CQI committee has deferred further auditing. On November 26, 2012, the CQI committee recommend that fund availability on weekends be added to the orientation to new residents by the Social Service Designee. On November 26, 2012, the Social Service Designee updated the resident orientation program.	

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F0170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. Based on interview, the facility failed to ensure that residents received mail on Saturday. This would affect 94 of 94 residents who had the potential to receive mail. Findings Include: During interview of the Resident Council President on 10/18/12 at 11:00 a.m., she indicated that she did not receive mail on Saturdays. During interview of the Business Office manager on 10/19/12 at 11:02 a.m., she indicated business hours were only Monday through Friday from 8 a.m. to 4 p.m. The Business Office Manager indicated residents did not get mail on Saturday due to the post office had changed their hours and there was no one available to pick up the mail during the time the post office was open. The Business Office Manager indicated she was not sure how long residents had not received mail on Saturday, but she thought it had been quite awhile.	F0170	On October 22, 2012, the Activity Director and Activity Staff were re-inserviced on obtaining and delivering mail to residents on Saturdays. All residents who receive mail have the potential to be affected by this practice. The Activity Aide will pick up mail from the post office every Saturday and deliver to residents as necessary. The Activity Aide will sign off on a log once mail has been delivered to residents. The Social Service Designee will interview residents from each unit weekly for one month to ensure mail has been properly delivered on Saturdays. Any concerns will be brought to the CQI committee for review and further recommendations as needed.On November 26, 2012, the CQI committee reviewed the Social Service Designee's interviews of residents for compliance of receiving mail on Saturdays. All residents acknowledged mail being delivered on Saturdays and voiced no further concerns with mail delivery. The CQI committee recommended that the Social Service Designee make an ongoing audit of the Acitivity Aide's log that mail is being delivered on Saturdays. The	11/06/2012

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	3.1-3(s)(1)		Social Service Designee has agreed and has updated Social Service audits to include the monthly check of the Activity Aide log for Saturday mail delivery. The Social Service Designee will follow up on any further concerns with mail delivery on Saturday.	

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F0224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure 1 of 3 residents reviewed for narcotic medication was free from misappropriation of narcotics. (Resident A) Findings Include: During interview of the DON [Director of Nursing]on 10/23/12 at 11:00 a.m., the DON indicated she had an issue with a new RN and a missing narcotic sheet. The DON indicated during morning count of the narcotics, the count was correct but the day shift nurse who had counted the day before indicated she thought there should have been narcotics (MS Contin- Morphine Sulfate) remaining on the old sheet instead of 2 new sheets. The DON indicated she attempted to call the RN, but she would not return the phone call. The DON indicated the missing narcotic	F0224	On October 3, 2012, RN #1 was suspended from duty and terminated from employment on October 8, 2012 due to noncompliance with investigation of misappropriation of resident medications. On October 24, 2012, an inservice was presented to nurses that included reporting misappropriation to Administration immediately and expectation of of participation with the investigation process. The Director of Nursing, the dayshift RN Supervisor, and the evening shift RN Supervisor will complete weeklly audits of shift to shift narcotic counts for one month, then every month for three months with any findings brought to the CQI committee for further review and/or recommendations.On November 26, 2012, the CQI committee reviewed the DON and RN Supervisors weekly audits of shift to shift narcotic count. The narcotic count sheets were updated to include the number of cards for each narcotic. An inservice was given on November 14, 2012, by the Director of Nursing to all nurses on	11/06/2012

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	sheet was found folded up in [name of RN #1's] report sheet. The DON indicated the nurse had taken three (3) MS Contin (narcotic pain medication) tablets from Resident A's medications. The DON indicated an investigation was done, but the occurrence was not reported to ISDH (Indiana State Department of Health). The DON indicated the RN had finished orientation and had worked on the floor for about a week. An investigation sheet was provided by the DON on 10/23/12 at 12:30 p.m. The investigation sheet indicated, "On the morning of 10/03/12 1 South charge nurse [name of LPN #1] reported after morning narcotic count that there was a missing sheet of narcotics then she found a narcotic sign out/count sheet for resident (A) folded between a report sheet belonging to [name of RN #1], RN charge nurse. It was noted on the count sheet that 3 MS Contin 30 mg tabs were left out of 30 tabs received and 27 tabs administered as ordered. The 3 remaining MS Contin 30mg tabs were not located in the locked narcotic box in the locked med [medication] cart. [name of RN #1] had already left the building and was unable to be reached by phone to clarify what		instruction of the new narcotic count sheets that included counting and documenting the number of cards. The CQI committee recommended that the DON or a designee continue with monthly audits of the narcotic count sheets ongoing. Any future issues with compliance with the narcotic count sheets are to be addressed by the DON with the plan of correction for compliance brought to the CQI committee for any further recommendations.	

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	happened to the three missing narcotic pills and why the narcotic count sheet was not in the book to be check (sic) at shift to shift report as per policy. A message was left on [name of RN #1's] boyfriend per phone by [name of the DON] to return her call a.s.a.p. [as soon as possible] 'to discuss an incident that had happened that morning.' [name of RN #1] did not return the call on 10/03/12. [Name of the DON] left another message on 10/03/2012 evening on [name of RN #1's] cell phone stating that her scheduled shift on 10/03/12 10 pm-6am had been covered by another nurse and that she needed to call [name of DON] to discuss an incident before her next scheduled shift on 10/04/2012. Again, [name of RN #1] did not return the call or report to work as scheduled on 10/04/12. [Name of RN #1's] next scheduled shifts were 10/06/12 and 10/07/12 -10pm to 6am shift. Another message was left on [name of RN #1's] phone by [name of DON] on 10/05/2012 informing her that she needed to contact [name of DON] prior to returning work (sic) the next night. [Name of RN #1] did not report to work or return the phone calls. On 10/08/2012 [name of DON] left a message on [name of RN #1's] phone stating that since [name of RN			

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	#1] had not returned the phone call and did not report to work on her scheduled shifts of duty that it is considered abandonment of her job and that she has terminated her employment at HCV [Hoosier Christian Village.]" Review of a policy titled "Prevention of Abuse" provided by the facility on 10/16/12. The policy had a "Revision Date" of 10/29/10. The policy indicated, "It is the policy of Christian Homes, Inc. that each resident has the right to be free from abuse by anyone, including, but not limited to: staff members, other residents, consultants, volunteers, staff of other agencies serving the resident....The Administrator serves as the Abuse Prevention Coordinator and is responsible for the coordination of investigations into allegations of abuse or neglect.... It is everyone's responsibility to report suspicions of neglect or abuse to the Abuse Prevention Coordinator immediately....Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent...."			

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F0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F0225	On October 23, 2012,	11/06/2012

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	Based on interview and record review, the facility failed to ensure a misappropriation of narcotic medication was reported to state agencies for 1 of 3 residents reviewed for narcotic medication. (Resident A) Findings Include: During interview of the DON [Director of Nursing] on 10/23/12 at 11:00 a.m., the DON indicated she had an issue with a new RN and a missing narcotic sheet. The DON indicated during morning count of the narcotics the count was correct but the day shift nurse who had counted the day before indicated she thought there should have been narcotics (MS Contin-Morphine Sulfate) remaining on the old sheet instead of 2 new sheets. The DON indicated she attempted to call the RN, but she would not return the phone call. The DON indicated the missing narcotic sheet was found folded up in [name of RN #1's] report sheet. The DON indicated the nurse had taken 3 MS Contin (narcotic pain medication) tablets from Resident A's medications. The DON indicated an investigation was done, but the occurrence was not reported to ISDH (Indiana State Department of Health).		Administration reported misappropriation to Indiana State Department of Health. On October 23, 2012, surveyors investigated the occurrence and the Office of Attorney General was notified. On October 29, 2012, the Office of Attorney General visited Hoosier Christian Village and investigated the occurrence. The Administrator will report to Indiana State Department of Health as per Hoosier Christian Village policy misappropriation of resident property and complete a thorough investigation. 1. Resident A's three missing MS Contin tabs were replaced by the facility. No other residents were found to be effected. 2. All residents had the potential to be effected by RN #1's deficient practice. RN #1 is no longer employed by the facility. The narcotic count policy was reviewed by the Director of Nursing with nurses at the 11/14/2012 nurses meeting and will be included in the nurse orientation program to ensure newly employeed nurses understand narcotics are monitored closely and nurses are held accountable for accurate count at the end of their shift of duty. The Administrator will report any misappropriation of narcotic medication to other officials in accordance with state law (including to the state survey and certification agency) within 5 working days of the incident, and	

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	The DON indicated the RN had finished orientation and had worked on the floor for about a week. The DON indicated she did not report this to the police department. An investigation sheet was provided by the DON on 10/23/12 at 12:30 p.m. The investigation sheet indicated, "On the morning of 10/03/12 1 South charge nurse [name of LPN #1] reported after morning narcotic count that there was a missing sheet of narcotics then she found a narcotic sign out/count sheet for resident (A) folded between a report sheet belonging to [name of RN #1], RN charge nurse. It was noted on the count sheet that 3 MS Contin 30 mg tabs were left out of 30 tabs received and 27 tabs administered as ordered. The 3 remaining MS Contin 30mg tabs were not located in the locked narcotic box in the locked med [medication] cart. [name of RN #1] had already left the building and was unable to be reached by phone to clarify what happened to the three missing narcotic pills and why the narcotic count sheet was not in the book to be check (sic) at shift to shift report as per policy. A message was left on [name of RN #1's] boyfriend per phone by [name of the DON] to return		if the alleged violation is verified appropriate corrective action will be taken. 3. On November 14, 2012, the DON reinserviced nurses on completion of the shift to shift narcotic count and reporting any concerns immediately to the DON and/or Administrator. The Administrator will report any misappropriation of narcotic medication to other officials in accordance to state law (including to the state survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action will be taken. 4. The Administrator will review all incidents at the morning clinical meeting with the DON, Dietary Manager, SSD, MDS Coordinator, Rehab Manager,. Any incident with misappropriation of narcotics will be reported by the administrator to other officials in accordance to state law (including state survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action will be taken.	

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	her call a.s.a.p. [as soon as possible] 'to discuss an incident that had happened that morning.' [name of RN #1] did not return the call on 10/03/12. [Name of the DON] left another message on 10/03/2012 evening on [name of RN #1's] cell phone stating that her scheduled shift on 10/03/12 10pm-6am had been covered by another nurse and that she needed to call [name of DON] to discuss an incident before her next scheduled shift on 10/04/2012. Again, [name of RN #1] did not return the call or report to work as scheduled on 10/04/12. [Name of RN #1's] next scheduled shifts were 10/06/12 and 10/07/12 10pm to 6am shift. Another message was left on [name of RN #1's] phone by [name of DON] on 10/05/2012 informing her that she needed to contact [name of DON] prior to returning work (sic) the next night. [Name of RN #1] did not report to work or return the phone calls. On 10/08/2012 [name of DON] left a message on [name of RN #1's] phone stating that since [name of RN #1] had not returned the phone call and did not report to work on her scheduled shifts of duty that it is considered abandonment of her job and that she has terminated her employment at HCV [Hoosier Christian Village.]"			

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	Review of a policy titled "Prevention of Abuse" provided by the facility on 10/16/12. The policy had a "Revision Date" of 10/29/10. The policy indicated, "It is the policy of Christian Homes, Inc. that each resident has the right to be free from abuse by anyone, including, but not limited to: staff members, other residents, consultants, volunteers, staff of other agencies serving the resident....The Administrator serves as the Abuse Prevention Coordinator and is responsible for the coordination of investigations into allegations of abuse or neglect.... It is everyone's responsibility to report suspicions of neglect or abuse to the Abuse Prevention Coordinator immediately....Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent... Reporting - When staff are aware of any type of abuse, such as witnessing or hearing any action that could constitute abuse, as defined in the 'definitions' section of this policy, they are to immediately report it to the Abuse Coordinator. As soon as possible without delay an initial report will be made to the appropriate state			

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	department...." 3.1-28(c)			

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F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to follow facility policy and procedures for reporting misappropriation of narcotic medication for 1 of 3 residents reviewed for narcotic medication. (Resident A) Findings Include: During interview of the DON [Director of Nursing] on 10/23/12 at 11:00 a.m., the DON indicated she had an issue with a new RN and a missing narcotic sheet. The DON indicated during morning count of the narcotics the count was correct, but the day shift nurse who had counted the day before indicated she thought there should have been narcotics (MS Contin- Morphine Sulfate) remaining on the old sheet instead of 2 new sheets. The DON indicated she attempted to call the RN, but she would not return the phone call. The DON indicated the missing narcotic	F0226	On October 23, 2012, Administration reported misappropriation to Indiana State Department of Health. On October 23, 2012, surveyors investigated the occurrence and the Office of Attorney General was notified. On October 29, 2012, the Office of Attorney General visited Hoosier Christian Village and investigated the occurrence. The Administrator will report to Indiana State Department of Health as per Hoosier Christian Village policy misappropriation of resident property and complete a thorough investigation.1. Resident A's three missing MS Contin tabs were replaced by the facility. No other residents were found to be effected.2. All residents had the potential to be effected by this practice. The Administrator will review all incidents every morning at the clinical meeting. Any incidents with misappropriation of narcotic medication will be reported within 5 working days by the Administrator to other officials in accordance with state law (including state survey and certification survey) and if the alleged violation is verified	11/06/2012

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	sheet was found folded up in [name of RN #1's] report sheet. The DON indicated the nurse had taken 3 MS Contin (narcotic pain medication) tablets from Resident A's medications. The DON indicated an investigation was done, but the occurrence was not reported to ISDH (Indiana State Department of Health). The DON indicated the RN had finished orientation and had worked on the floor for about a week. The DON indicated she did not report this to the police department. An investigation sheet was provided by the DON on 10/23/12 at 12:30 p.m. The investigation sheet indicated, "On the morning of 10/03/12 1 South charge nurse [name of LPN #1] reported after morning narcotic count that there was a missing sheet of narcotics then she found a narcotic sign out/count sheet for resident (A) folded between a report sheet belonging to [name of RN #1], RN charge nurse. It was noted on the count sheet that 3 MS Contin 30 mg tabs were left out of 30 tabs received and 27 tabs administered as ordered. The 3 remaining MS Contin 30mg tabs were not located in the locked narcotic box in the locked med [medication] cart. [name of RN #1] had already left the		appropriate corrective action will be taken.3. The systemic change that has been implemented is the review of incidents by the Administrator at the morning clinical meetings as stated in statement 2.4. The CQI committee will review monthly, ongoing, all incidents to ensure compliance with reporting to other state officials (including state survey and certification agency) has been completed per policy.	

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	building and was unable to be reached by phone to clarify what happened to the three missing narcotic pills and why the narcotic count sheet was not in the book to be check (sic) at shift to shift report as per policy. A message was left on [name of RN #1's] boyfriend per phone by [name of the DON] to return her call a.s.a.p. [as soon as possible] 'to discuss an incident that had happened that morning.' [name of RN #1] did not return the call on 10/03/12. [Name of the DON] left another message on 10/03/2012 evening on [name of RN #1's] cell phone stating that her scheduled shift on 10/03/12 10pm-6am had been covered by another nurse and that she needed to call [name of DON] to discuss an incident before her next scheduled shift on 10/04/2012. Again, [name of RN #1] did not return the call or report to work as scheduled on 10/04/12. [Name of RN #1's] next scheduled shifts were 10/06/12 and 10/07/12 10pm to 6am shift. Another message was left on [name of RN #1's] phone by [name of DON] on 10/05/2012 informing her that she needed to contact [name of DON] prior to returning work (sic) the next night. [Name of RN #1] did not report to work or return the phone calls. On 10/08/2012 [name of DON]			

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	left a message on [name of RN #1's] phone stating that since [name of RN #1] had not returned the phone call and did not report to work on her scheduled shifts of duty that it is considered abandonment of her job and that she has terminated her employment at HCV [Hoosier Christian Village.]" Review of a policy titled "Prevention of Abuse" provided by the facility on 10/16/12. The policy had a "Revision Date" of 10/29/10. The policy indicated, "It is the policy of Christian Homes, Inc. that each resident has the right to be free from abuse by anyone, including, but not limited to: staff members, other residents, consultants, volunteers, staff of other agencies serving the resident....The Administrator serves as the Abuse Prevention Coordinator and is responsible for the coordination of investigations into allegations of abuse or neglect.... It is everyone's responsibility to report suspicions of neglect or abuse to the Abuse Prevention Coordinator immediately....Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's			

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	consent... Reporting - When staff are aware of any type of abuse, such as witnessing or hearing any action that could constitute abuse, as defined in the 'definitions' section of this policy, they are to immediately report it to the Abuse Coordinator. As soon as possible without delay an initial report will be made to the appropriate state department...." 3.1-28(a)			

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F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions			
	Based on observation, interview and record review, the facility failed to ensure food was served and trays set up in a sanitary manner. This had the potential to affect 93 residents who had food prepared and served by the facility staff in the census of 95 residents. Findings include: 1. During observation of the serving line on 10/16/12 at 11:45 a.m., Cook #1, was observed at the serving line located in the main dining room. The cook was observed to have on gloves and to use scoops to dip up each resident's food as a nursing staff member brought the tray down and indicated which resident they wished to serve. Cook #1 would locate the paper with the resident's name, place it on the tray, get a plate and then use scoops to place the food upon the tray. The substitute for the meal was observed to have been a ham	F0371	Hoosier Christian Village has established and does maintain an Infection Control Program designed to help prevent the development and transmission of disease and infection. On October 22, 2012, Cook #1 was re-inserviced on the policy of Food Handling that included procedure to ensure not to wipe gloved hands on her apron while serving food. During the week of October 29, 2012, nursing staff were re-inserviced on proper handling of clean utensils in dining room while serving trays to residents, which included cleaning hands prior to wrapping silverware in napkins. All residents have the potential to be affected by this practice. The Administrator, DON, and Dietary Manager will complete weekly audits in the dining room with serving trays and meals to ensure compliance of proper food handling as well as proper handling of clean utensils. These audits will continue for three months with any findings brought to the CQI committee for further review and/or any recommendations.On November	11/06/2012

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	sandwich. The cook was observed to obtain cartons of milk and desserts and also place them upon the trays. Twice during the observation of serving the residents, the cook was observed to wipe her gloved hands on the front of her apron and then proceed to fix plates for the residents. For three residents the cook was observed to use her gloved hands to pick up the ham sandwich and place it on the plate. The cook was not observed to change her gloves at any time while serving the meal. During interview with the Dietary Manager on 10/22/12 at 1:30 P.M., she indicated the kitchen prepared and serviced food for 93 of the 95 residents residing within the facility. The policy and procedure for "Food Handling," dated June 2010, obtained from the Director of Nursing on 10/22/12 at 10:00 A.M., indicated "This facility recognizes that the critical factor implicated in food borne illness are: poor personal hygiene of food service employees." 2. During observation of the dining room on 10/19/12 at 11:14 A.M., a metal cart was observed sitting in the dining room with trays, napkins and silverware on it. The cart was open.		26, 2012, the CQI committee reviewed the audits completed by the Administrator, Dietary Manager, and DON for compliance with proper food handling as well as proper handling of clean utensils. The Dietary Manager assigned two servers in the serving line instead of one to ensure proper handling of food with serving. The CQI committee recommended that the Dietary Manager continue monthly audits in the dining room to ensure proper handling of food and clean utensils. The Dietary Manager will address any further issues if identified and bring the plan of correction to the CQI committee for any further recommendations.	

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	CNA #1 was observed to walk up to the cart and was observed to put on a hairnet, then rolled eating utensils up in napkin, placing them on the tray and then taking the tray to the kitchen serving line to take to a resident on the hallways. The CNA was not observed to wash her hands after placing the hair net on her hair and touching the silverware to roll it in the napkin for meal service. CNA #2 was then observed to follow CNA #1, and put on a hair net, then obtain silverware and place it on a napkin, rolling the utensils up in the napkin and taking the tray to the kitchen where a plate of food was given to the CNA for delivery. CNA #3 was then observed to place a hairnet on, roll silverware in a napkin and take the tray to the serving line and obtain a plate of food for delivery to a resident on the hallways. In interview, the Dietary Manager indicated on 10/19/12 at 11:20 A.M., a volunteer normally rolled the silverware up in the napkins and had it ready for the CNA's, but there had been no volunteers that day. 3.1-21(i)(3)			

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F0441 SS=E	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. (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. (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 disease. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to	F0441	Hoosier Christian Village has established and does maintain an	11/06/2012

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	ensure adult protective garments were maintained and delivered in a manner to prevent cross contamination, and failed to ensure soiled linens were handled in a manner to prevent cross contamination, and failed to ensure nursing removed gloves worn to provide personal care before handling a door knob to a resident's bathroom, for 2 of 5 observations of personal care. This had the potential to affect all residents who used either adult protective garments or received incontinence care from staff. Findings include: 1. CNA #1 on 10/15/12 at 11:15 a.m., was observed to go table to table in the main dining room, offering clothing protectors to the residents. She was observed to have the stack of clean clothing protectors placed under her arm touching her uniform, then would place the stack on the table, help the residents apply the clothing protector, put the remaining protectors back under her arm and go to the next table. Resident #13 was observed on 10/19/12 at 11:16 a.m., getting clothing protectors out of the cabinet for herself and the other residents.		Infection Control Program designed to help prevent the development and transmission of disease and infection. All residents that require assist with toileting have the potential to be effected by this alleged practice. During the week of October 29, 2012, CNAs were reinserviced on the policy of handling soiled linens that included considering all soiled linens to be potentially infectious and placing soiled linen directly into covered laundry hamper. Also during the week of October 29, 2012, audits were completed by the DON, RN Supervisor, Restorative RN, and the Wound Care Nurse on all three shifts to ensure compliance of handling soiled linens per policy. These audits will continue weekly for a month, then for three months, with findings brought to the CQI committee for further review and recommendations. During the week of October 29, 2012, CNAs were reinserviced on the policy Personal Protective Equipment-Gloves that included gloves being used only once and discarded into the appropriate receptacle located in the room in which the procedure is being performed and washing hands after removing gloves. Audits were completed during the week of October 29, 2012, by the DON, RN Supervisor, RN Restorative Nurse and Wound Care Nurse that included removal of gloves and handwashing. These audits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155611	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/23/2012
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(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
	The clothing protectors were observed to be kept in two cabinets in the main dining room. These cabinets were closed with doors, but had no locks. At 11:20 A.M., this same day, two visitors were observed to enter the dining room, open the cabinets and obtain clothing protectors and provide them to residents. The policy and procedure for "Laundry and Linen," dated 11/2011, provided by the Director of Nursing on 10/22/12 at 11:00 A.M., indicated "do not allow linen, clean or soiled to touch clothing or uniform" and "wash hands before contact with clean linen."		will continue weekly for one month, then ever month for three months, findings will be brought to the CQI committee for further review and recommendations.On October 19, 2012, clothing protectors were removed from the unlocked cabinets in the dining room. Clothing protectors will be distributed by a designated CNA in the dining room, using proper linen handling. During the week of October 29, 2012, CNAs were re-inserviced on proper handling of clean and dirty linen per Hoosier Christian Village policy. Any resident who chooses to wear a clothing protector during meal time has the potential to be affected by this practice. Audits will be completed weekly or one month and every month for three months by DON, Dietary Manager, and Administrator to ensure proper handling of clothing protectors. Any findings will be brought to CQI committee for further review and/or any recommendations. The audits for handling soiled linens, removal of gloves and handwahsing were reviewed by the CQI committee on November 26, 2012. The CQI committee recommended that monthly audits be completed by the DON or designee ongoing. The DON assigned the Infection Control nurse to complete a monthly audit of handling soiled linens, removal of gloves and handwashing properly and address any identified concerns.	

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			The Infection Control Nurse will bring a plan of correction of any identified concerns to the CQI committee for any further review. The audits for proper handling of the clothing protectors were also reviewed on November 26, 2012, by the CQI committee. The CQI committee will review the audits again after the three month completion. If clothing protectors are handled by the designated CNA, as per Plan of Correction, using proper linen handling, no further auditing will be recommended. Any concerns with the handling of clothing protectors in the dining room in the next three months will be addressed and corrected by the DON and the plan of correction brought to the CQI committee for any further recommendations.	
	2. On 10/19/12 at 9:40 a.m., CNA #5 and CNA #6 were observed to toilet Resident #63 in the common handicapped restroom. The resident urinated in the commode. CNA #5 was observed to wear gloves, remove a wet brief, and cleanse the resident's bottom with Peri Rinse No-rinse Cleanser. CNA #5 was observed to place the linens used to cleanse the resident's bottom on the arm rests of the commode prior to bagging. An MDS (Minimum Data Set) assessment, dated 09/13/12, indicated Resident #63 required			

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	extensive assistance of staff for toileting and hygiene. A policy provided by the facility titled "Departmental (Environmental Services) - Laundry and Linen with a revised date of November 2011, indicated, "...Consider all soiled linen to be potentially infectious....All soiled linen must be placed directly into a covered laundry hamper which can contain moisture....Handle soiled linen as little as possible...." 3. On 10/22/12 at 11:40 a.m., CNA #2 was observed to provide personal care for Resident #11 after the resident had a bowel movement in her bedside commode. CNA #2 was observed to wear gloves and cleanse the resident's bottom with cleansing wipes. Wearing the same gloves which had been used to cleanse the resident's bottom, the CNA was observed to handle the door knob to the resident's bathroom while opening the door. An MDS (minimum data set) assessment, dated 08/23/12, indicated the resident required assistance of 1 staff for toileting and hygiene. A policy titled "Personal Protective			

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	Equipment - Gloves" was provided by LPN #3 on 10/22/12 at 3:40 p.m. The policy had a revision date of August 2009. The policy indicated, "Gloves must be worn when handling blood, body fluids, secretions....Gloves shall be used only once and discarded into the appropriate receptacle located in the room in which the procedure is being performed....Wash your hands after removing gloves..." 3.1-18(l) 3.1-19(g)			