

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155100	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2016
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NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BEDFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN 47421
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00209174 and IN00210229.</p> <p>Complaint IN00209174 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00210229 - Unsubstantiated due to lack of evidence.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: September 26 and 27, 2016</p> <p>Facility number: 000040 Provider number: 155100 AIM number: 100274460</p> <p>Census bed type: SNF/NF: 130 SNF: 3 Total: 133</p> <p>Census payor type: Medicare: 7 Medicaid: 111 Other: 15 Total: 133</p> <p>Sample: 04</p>	F 0000	Preparation and submission of this plan of correction does not constitute an admission or agreement by Garden Villa of the conclusions of this survey. We respectfully submit this plan of correction as proof of our compliance with the State and Federal regulations, and per the laws that mandate the submission of this plan of correction. Please review the attached documents with this plan of correction, as evidence of completion of this plan and evidence of compliance.	

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

TITLE

(X6) DATE

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

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F 0225 SS=D Bldg. 00	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Q.R. completed by 14466 on October 03, 2016.</p> <p>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</p>			

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	<p>any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to ensure an allegation of mistreatment was immediately reported to the administrator of the facility and to other officials in accordance with State law as indicated by the the facility's abuse prevention policy and procedure for 1 of 1 resident reviewed for an allegation of</p>	F 0225	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident D was assessed for injury and Resident D's family and physician were notified of the incident with no change in plan of care.</p> <p>How other residents having the potential to be affected by the same</p>	10/27/2016

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	<p>mistreatment. (Resident #D)</p> <p>Findings include:</p> <p>Review of Resident D's clinical record on 9/27/2016 at 1:00 p.m., indicated diagnoses which included, but were not limited to: atrial fibrillation, idiopathic orafacil dystonia, general muscle weakness, and cognitive communication deficit.</p> <p>Resident #D's BIMS (Brief Interview Mental Status) dated 8/26/2016, indicated a score of 4 out of 15, severe cognitive impairment.</p> <p>Resident #D's MDS (Minimum Data Set) assessment dated 8/26/2016, indicated Resident #D was totally dependent of care, needing extensive assistance with ADL's (activities of daily living).</p> <p>On 9/27/2016 at 2:50 p.m., interview with CNA #3, indicated on a date CNA #3 could not remember, CNA #2 came to CNA #3 and informed CNA#3 that CNA #1 restrained Resident #D's arm down and verbally talked down to Resident #D, during ADL care. CNA #3 indicated CNA #3 told CNA #2 and CNA #2 said they needed to go immediately to the unit manager (UM) and the administration. CNA #3 indicated CNA #3 and CNA #2</p>		<p>deficient practice will be identified and what corrective action will be taken?</p> <p>All residents have the potential to be affected by this deficient practice. All staff have been re-educated on the facility abuse policies and procedures.</p> <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Employees will be provided education upon hire and at least annually concerning the reporting of allegations of potential mistreatment, neglect or abuse immediately to the Administrator. Progressive written counseling, discipline or termination will result if staff fail to follow policies and procedures.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur?</p> <p>All allegations of mistreatment, neglect or abuse will be reviewed to ensure the allegation was reported immediately to the Administrator. Education will be provided as necessary. The allegations will be reviewed monthly during the QAPI meeting.</p>				

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	<p>went to the UM (unit manager) who instructed CNA #3 and CNA #2 to make sure the resident (Resident #D) was safe and go report the allegation of restraining Resident #3 immediately to the administration. CNA #2 indicated to the administration on 9/14/2016 (several days after the the date of occurrence), CNA #1 held down Resident #D's arm during care and spoke demeaning to Resident #D.</p> <p>On 9/27/2016 at 3:10 p.m., interview with the UM indicated immediately after the UM was told of the concern; approximately 10 days after; the alleged restraining of Resident #D by CNA#1 allegedly took place. The UM then advised CNA #2 and #3, voicing the concern, to make sure the resident was safe and go to advise administration.</p> <p>Review on 9/27/2016 at 3:30 p.m., of the facility's incident reporting to the State Survey and Certification Agency indicated Resident #D's mistreatment had not been reported until 10 days after the incident according to the statement written by CNA #2 to administration..</p> <p>Interview with the ADM (Administrator) on 9/27/2016 at 2:05 p.m., indicated the allegation of mistreatment was not reported to the State due to the facility</p>			

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	<p>not being advised of the incident until 10 days later, from CNA # 2.. The Administrator indicated he had spoken with CNA #1, CNA #2, CNA #3, and the UM from the 600 hall. All the staff advised administration of the incident, and CNA #1 was immediately terminated and the State was notified.</p> <p>Review of CNA #1's time sheet on 9/29/2016, at 2:05 p.m., indicated CNA #1 worked 2 shifts (Saturday 09/10/2016 and Sunday 09/11/2016), after the alleged mistreatment of Resident #D occurred.</p> <p>On 9/27/2016, at 2:05 p.m., the administrator provided the facility's current policy "ABUSE POLICY" revised 7/13/15. Review of the policy's standard #6 indicated, "... any staff member who has knowledge of the abuse of a resident, has reasonable cause to believe that a resident is being or has been abused, or who has knowledge that a resident has sustained physical injury which is not reasonably explained by the history of injuries provided in the resident's medical record, shall make an immediate oral report to the Administrator, Director of Nursing or their immediate supervisor."</p> <p>3.1-28(c)</p>			

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F 0226 SS=D Bldg. 00	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure implementation of their policy to report an allegation of mistreatment immediately to Administrator and the State survey and certification agency in accordance to state law and the facility's policy and procedure for 1 of 1 resident reviewed for allegation of mistreatment. (Resident #D)</p> <p>Findings include:</p> <p>Review of Resident D's clinical record on 9/27/2016 at 1:00 p.m., indicated diagnoses which included, but were not limited to: atrial fibrillation, idiopathic orafacil dystonia, general muscle weakness, and cognitive communication deficit.</p> <p>Resident #D's BIMS (Brief Interview Mental Status) dated 8/26/2016, indicated</p>	F 0226	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident D was assessed for injury and Resident D's family and physician was notified of the incident with no change in plan of care.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>All residents have the potential to be affected by this deficient practice. All staff have been re-educated on the facility abuse policies and procedures.</p> <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Employees will be provided education upon hire and at least annually concerning the reporting of allegations of potential</p>	10/27/2016

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	<p>a score of 4 out of 15, severe cognitive impairment.</p> <p>Resident #D's MDS (Minimum Data Set) assessment dated 8/26/2016, indicated Resident #D was totally dependent of care, needing extensive assistance with ADL's (activities of daily living).</p> <p>On 9/27/2016 at 2:50 p.m., interview with CNA #3, indicated on a date CNA #3 could not remember, CNA #2 came to CNA #3 and informed CNA#3 that CNA #1 restrained Resident #D's arm down and verbally talked down to Resident #D, during ADL care. CNA #3 indicated CNA #3 told CNA #2 and CNA #2 said they needed to go immediately to the unit manager (UM) and the administration. CNA #3 indicated CNA #3 and CNA #2 went to the UM (unit manager) who instructed CNA #3 and CNA #2 to make sure the resident (Resident #D) was safe and go report the allegation of restraining Resident #3 immediately to the administration. CNA #2 indicated to the administration on 9/14/2016 (several days after the the date of occurrence), CNA #1 held down Resident #D's arm during care and spoke demeaning to Resident #D.</p> <p>On 9/2720/16 at 3:10 p.m., interview with the UM indicated immediately after</p>		<p>mistreatment, neglect or abuse immediately to the Administrator. Progressive written counseling, discipline or termination will result if staff fail to follow policies and procedures. How the corrective action will be monitored to ensure the deficient practice will not recur? All allegations of mistreatment, neglect or abuse will be reviewed to ensure the allegation was reported immediately to the Administrator. Education will be provided as necessary. The allegations will be reviewed monthly during the QAPI meeting.</p>		

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	<p>the UM was told of the concern; approximately 10 days after; the alleged restraining of Resident #D by CNA#1 allegedly took place. The UM then advised CNA #2 and #3, voicing the concern, to make sure the resident was safe and go to advise administration.</p> <p>Review on 9/27/2016 at 3:30 p.m., of the facility's incident reporting to the State Survey and Certification Agency indicated Resident #D's mistreatment had not been reported until 10 days after the incident according to the statement written by CNA #2 to administration..</p> <p>Interview with the ADM (Administrator) on 9/27/2016 at 2:05 p.m., indicated the allegation of mistreatment was not reported to the State due to the facility not being advised of the incident until 10 days later, from CNA # 2.. The Administrator indicated he had spoken with CNA #1, CNA #2, CNA #3, and the UM from the 600 hall. All the staff advised administration of the incident, and CNA #1 was immediately terminated and the State was notified.</p> <p>Review of CNA #1's time sheet on 9/29/2016, at 2:05 p.m., indicated CNA #1 worked 2 shifts (Saturday 09/10/2016 and Sunday 09/11/2016), after the alleged mistreatment of Resident #D occurred.</p>			

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	<p>On 9/27/2016, at 2:05 p.m., the administrator provided the facility's current policy "ABUSE POLICY" revised 7/13/15. Review of the policy's standard #6 indicated, "... any staff member who has knowledge of the abuse of a resident, has reasonable cause to believe that a resident is being or has been abused, or who has knowledge that a resident has sustained physical injury which is not reasonably explained by the history of injuries provided in the resident's medical record, shall make an immediate oral report to the Administrator, Director of Nursing or their immediate supervisor."</p> <p>3.1-28(a)</p>			