STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WITTENBERG LUTHERAN VILLAGE	1200 E LUTHER DR 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 the Investigation of Complaint IN00150211. Complaint IN00150211-Substantiated. Federal/State deficiencies related to the allegations are cited at F225, F226, and F323 Survey Dates: June 11, 2014 Facility number: 000515 Provider number: 155608 AIM number: 100290820 Survey team: Regina Sanders, RN Census bed type: SNF: 15 SNF/NF: 111 Total: 126 Census payor type: Medicare: 25 Medicaid: 70 Other: 31 Total: 126 Sample: 3 Supplemental sample: 1 These deficiencies reflect State findings	F000000		

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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	cited in accordance with 410 IAC 16.2. Quality review completed on June 16, 2014, by Janelyn Kulik, RN.			
F000225 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			

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	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. Based on record review and interview, the facility failed to thoroughly investigate an injury of an unknown source, related to a laceration to the left forehead for 1 of 3 residents reviewed for injuries of an unknown source in a total sample of 3. (Resident #B) Findings include: Resident #B's record was reviewed on 06/11/14 at 9:10 a.m. The resident's diagnoses included, but were not limited to, hypertension and stroke. A Significant Change Minimum Data Set Assessment (MDS), dated 04/20/14, indicated the resident was an extensive assistance of two or more staff for bed mobility and transfers. A Siderail assessment, dated 04/11/14, indicated the resident had difficulty with bed mobility, used the side rails for positioning, was visually challenged, and	F000225	**1. What corrective actions(s) will be accomplished for those residentsfound to have been affected by the deficient practice.** Resident #Bwas on Hospice and expired on 6/14/14 **2. How you will identify other residents having the potential to beaffected by the same deficient practice and what corrective action will betaken.** An audit of allother reports of injuries of unknown source indentified in the last 6 monthswas conducted. No other issues withthese reports were identified. **3. What measures will be put into place or what systemic changes you willmake to ensure that the deficient practice does not recur.** All nurseleaders and Abuse Prevention Coordinator were re-educated related toinvestigating and following through on an injury of unknown source on6/27/14. Internal Investigation Form washighlighted in this re-education and implemented	07/07/2014

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	used half side rails as an enabler. A Nurses' Note, dated 05/21/14 at 12 p.m., indicated the resident was alert and pleasantly confused. A Nurses' Note, dated 05/29/14 at 4:15 a.m. indicated, "Resident found in room in bed with injury to head. Large amount of blood. Skin tear to (L) (left) side of head...awaiting ambulance..." A "Skin Condition Identification Form", dated 05/29/14, indicated there was a laceration to the left forehead 2.1 centimeters (cm) by 0.5 cm with 0.3 depth and a large amount of blood. The form indicated the resident had five steri-strips on the laceration. The Emergency Room notes, dated 05/29/14, indicated the resident had a skin tear and instructions were provided for care of the area upon return to the facility. A Nurses' Note, dated 05/29/14 at 8:20 a.m., indicated there was bruising noted on the head, which covered the circumference of the head and extended to the left ear and the resident indicated she had pain in the bruised area. A "Report of Incident" form, dated		6/27/14. **4. How the corrective action(s) will be monitored to ensure the deficientpractice will not recur.** Administratoror Designee to randomly audit 5 abuse allegations per month to ensure allcomponents were followed through on correctly. Audit will be done monthly for 6 months or until 100% compliance is achieved.	

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	05/29/14, indicated a Lab Technician entered the resident's room and observed the resident bleeding from the head area and the Technician had contacted facility staff for assistance. A typed investigation, which was not dated, indicated the facility had interviewed the resident's alert and oriented roommate (Resident #E), who had reported Resident #B had woke up about 1:30 a.m. and she could hear Resident #B hitting something and moaning out, "Dear God help me, help me" and "Lord be with me". Resident #E then indicated she had activated the call light and then fell back to sleep. Resident #E then indicated she was awake when Resident #B was transferred to the hospital and she had not heard anyone else in the room the morning of the occurrence. An undated, hand-written investigation, received from LPN #1 on 06/11/14 at 11:40 a.m., indicated, "Felt like she made rounds...I did not answer call light..." During an interview at this time, LPN #1 indicated this was an interview with the Nurse on duty at the time of the incident. Another hand-written note,undated, on the investigation indicated an interview with CNA #2 (CNA working the night of			

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	the occurrence), which indicated, "state she answered call light". There was a lack of documentation to indicate the resident had been questioned about the injury. During an interview on 06/11/14 at 11 a.m., Resident #B indicated she did not remember how she hurt her forehead. She indicated she was not in too much pain and denied the injury was from anyone in the facility. A further interview, on 06/11/14 at 11:40 a.m., with MDS LPN present, LPN #1, indicated she was the one who had completed the investigation on the occurrence. She indicated she had spoke with CNA #2 and CNA #2 informed her she had answered the call light. LPN #1 indicated she had interviewed CNA #3, who had also been working the night of the occurrence and CNA #3 had informed her she had thought CNA #2 had gone into Resident #B's room. She indicated she had not documented the interview with CNA #3. LPN #1 was unable to acknowledge what time the call light, which Resident #E had said she activated at 1:30a.m., was answered by the staff. She indicated she did not know what was done by the staff when they answered the call light at 1:30 a.m. She indicated the			

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	Lab Technition who had found the injured resident had not been interviewed. During an interview on 06/11/14 at 11:40 a.m., The MDS LPN indicated the investigation had not been done as thorough as it should have been. During an interview on 06/11/14 at 1:45 p.m., LPN #1 indicated she had summarized the resident had hit her head on the side rail because this was the "only thing it could have been". She indicated there was no investigation or assessment of the position the resident was laying in the bed when the injury occurred. This Federal Tag relates to complaint IN00150211. 3.1-28(c)			
F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit			

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	mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to follow their Abuse Policy related to the investigation of a suspicious injury of an unknown source, related to a head laceration, for 1 of 3 residents reviewed for injuries of an unknown source in a total sample of 3. (Resident #B) Findings include: Resident #B's record was reviewed on 06/11/14 at 9:10 a.m. The resident's diagnoses included, but were not limited to, hypertension and stroke. A Significant Change Minimum Data Set Assessment (MDS), dated 04/20/14, indicated the resident was an extensive assistance of two or more staff for bed mobility and transfers. A Siderail assessment, dated 04/11/14, indicated the resident had difficulty with bed mobility, used the side rails for positioning, was visually challenged, and used half side rails as an enabler. A Nurses' Note, dated 05/21/14 at 12 p.m., indicated the resident was alert and pleasantly confused.	F000226	**1. What corrective actions(s) will be accomplished for those residentsfound to have been affected by the deficient practice.** Resident #Bwas on Hospice and expired on 6/14/14 **2. How you will identify other residents having the potential to beaffected by the same deficient practice and what corrective action will betaken.** An audit of allother reports of injuries of unknown source indentified in the last 6 monthswas conducted. No other issues withthese reports were identified. **3. What measures will be put into place or what systemic changes you willmake to ensure that the deficient practice does not recur.** All nurseleaders and Abuse Prevention Coordinator were re-educated related toinvestigating and following through on an injury of unknown source on6/27/14. Internal Investigation Form washighlighted in this re-education and implemented 6/27/14.	07/07/2014

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	A Nurses' Note, dated 05/29/14 at 4:15 a.m. indicated, "Resident found in room in bed with injury to head. Large amount of blood. Skin tear to (L) (left) side of head...awaiting ambulance..." A "Skin Condition Identification Form", dated 05/29/14, indicated there was a laceration to the left forehead 2.1 centimeters (cm) by 0.5 cm with 0.3 depth and a large amount of blood. The form indicated the resident had five steri-strips on the laceration. The Emergency Room notes, dated 05/29/14, indicated the resident had a skin tear and instructions were provided for care of the area upon return to the facility. A Nurses' Note, dated 05/29/14 at 8:20 a.m., indicated there was bruising noted on the head, which covered the circumference of the head and extended to the left ear and the resident indicated she had pain in the bruised area. A "Report of Incident" form, dated 05/29/14, indicated a Lab Technician entered the resident's room and observed the resident bleeding from the head area and the Technician had contacted facility staff for assistance.		**4. How the corrective action(s) will be monitored to ensure the deficientpractice will not recur.** Administratoror Designee to randomly audit 5 abuse allegations per month to ensure allcomponents were followed through on correctly. Audit will be done monthly for 6 months or until 100% compliance is achieved.	

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	A typed investigation, which was not dated, indicated the facility had interviewed the resident's alert and oriented roommate (Resident #E), who had reported Resident #B had woke up about 1:30 a.m. and she could hear Resident #B hitting something and moaning out, "Dear God help me, help me" and "Lord be with me". Resident #E then indicated she had activated the call light and then fell back to sleep. Resident #E then indicated she was awake when Resident #B was transferred to the hospital and she had not heard anyone else in the room the morning of the occurrence. An undated, hand-written investigation, received from LPN #1 on 06/11/14 at 11:40 a.m., indicated, "Felt like she made rounds...I did not answer call light..." During an interview at this time, LPN #1 indicated this was an interview with the Nurse on duty at the time of the incident. Another hand-written note,undated, on the investigation indicated an interview with CNA #2 (CNA working the night of the occurrence), which indicated, "state she answered call light". There was a lack of documentation to indicate the resident had been questioned			

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	about the injury. A facility policy, dated 05/15/14, titled, "Abuse and Neglect of a Resident", and received from the Administrator as current, indicated, "...INJURIES OF UNKNOWN SOURCE...Bruising of unknown origin...interview the resident...interview of any witnesses....Investigations for potential 'injuries of unknown source' will include interviews with staff, resident and families..." A further interview, on 06/11/14 at 11:40 a.m., with MDS LPN present, LPN #1, indicated she was the one who had completed the investigation on the occurrence. She indicated she had spoke with CNA #2 and CNA #2 informed her she had answered the call light. LPN #1 indicated she had interviewed CNA #3, who had also been working the night of the occurrence and CNA #3 had informed her she had thought CNA #2 had gone into Resident #B's room. She indicated she had not documented the interview with CNA #3. LPN #1 was unable to acknowledge what time the call light, which Resident #E had said she activated at 1:30a.m., was answered by the staff. She indicated she did not know what was done by the staff when they answered the call light at 1:30 a.m. She indicated the			

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	Lab Technition who had found the injured resident had not been interviewed. During an interview on 06/11/14 at 11:40 a.m., The MDS LPN indicated the investigation had not been done as thorough as it should have been. During an interview on 06/11/14 at 1:45 p.m., LPN #1 indicated she had summarized the resident had hit her head on the side rail because this was the "only thing it could have been". She indicated there was no investigation or assessment of the position the resident was laying in the bed when the injury occurred. This Federal Tag relates to complaint IN00150211. 3.1-28(c)			
F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident			

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	hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to provide adequate supervision and assistance to prevent accidents, related to assisting a resident calling out for help and the resident received a head laceration for 1 of 3 residents reviewed for injuries of an unknown source, in a total sample of 3. (Resident #B, CNA #2, and CNA #3) Findings include: During an observation on 06/11/14 at 8:20 a.m., Resident #B was laying in bed with her eyes closed. There was a dressing on the resident's left forehead area and a fading purple bruise, which covered the resident's frontal and upper scalp. During an interview on 06/11/14 at 8:20 a.m., Resident #E (Resident #B's roommate), who was deemed interviewable by the facility, indicated she had activated the call light because Resident #B was thrashing around the bed, the night she had injured her head. Resident #B's record was reviewed on 06/11/14 at 9:10 a.m. The resident's diagnoses included, but were not limited	F000323	**1. What corrective actions(s) will be accomplished for those residentsfound to have been affected by the deficient practice.** Resident #Bwas on Hospice and expired on 6/14/14. **2. How you will identify other residents having the potential to beaffected by the same deficient practice and what corrective action will betaken.** An audit ofall other reports of injuries of unknown source identified in the last 6 monthswas conducted. No other issues withthese reports were identified. There hasbeen no further concerns brought to our attention related to timliness of assistinga resident. **3. What measures will be put into place or what systemic changes you willmake to ensure that the deficient practice does not recur.** The part ofthe call light system that allows the call light to be answered and clearedfrom the nurse’s station was disabled on 6/24/14. Nursingdepartment was re-educated about the need to	07/07/2014

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	to, hypertension and stroke. A Significant Change Minimum Data Set Assessment (MDS), dated 04/20/14, indicated the resident was an extensive assistance of two or more staff for bed mobility and transfers. A Siderail assessment, dated 04/11/14, indicated the resident had difficulty with bed mobility, used the side rails for positioning, was visually challenged, and used half side rails as an enabler. The Physician's Recapitulation Orders, dated 05/14, indicated on 4/24/14 the resident had an order for Coumadin (blood thinner) 1.5 mg (milligrams) daily and an order dated 04/11/14 for aspirin 81 mg daily. A PT/INR (blood clotting time laboratory test), dated 05/29/14 at 6:06 a.m., indicated the PT was 47.6 (high) (normal 10-12) and the INR was 4.2 (normal 2-3). A Nurses' Note, dated 05/21/14 at 12 p.m., indicated the resident was alert and pleasantly confused. A Nurses' Note, dated 05/29/14 at 4:15 a.m. indicated, "Resident found in room in bed with injury to head. Large amount of blood. Skin tear to (L) (left) side of		ensure timely rounds and visualchecks on all residents throughout shift on 6/24/14 & 6/26/14. They were also informed that when a calllight is activated, it is expected to be responded to as soon as possible. The staffinvolved in the incident has received corrective action related to theincident. **4. How the corrective action(s) will be monitored to ensure the deficientpractice will not recur.** Administratoror Designee to randomly audit 4 call light reports per week to ensure timelyresponse. Also, 4 residents per weekwill be randomly asked if their needs are being met in a timely matter. Audit will be done monthly for 6 months oruntil 100% compliance is achieved.	

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	head...awaiting ambulance..." A "Skin Condition Identification Form", dated 05/29/14, indicated there was a laceration to the left forehead 2.1 centimeters (cm) by 0.5 cm with 0.3 depth and a large amount of blood. The form indicated the resident had five steri-strips on the laceration. The Emergency Room notes, dated 05/29/14, indicated the resident had a skin tear and instructions were provided for care of the area upon return to the facility. A Nurses' Note, dated 05/29/14 at 8:20 a.m., indicated there was bruising noted on the head, which covered the circumference of the head and extended to the left ear and the resident indicated she had pain in the bruised area. During an interview on 06/11/14 at 11 a.m., Resident #B indicated she did not remember how she hurt her forehead. She indicated she was not in too much pain and denied the injury was from anyone in the facility. Review of the facilities investigation on 06/11/14 at 11:30 a.m. indicated: A "Report of Incident" form, dated			

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	05/29/14, indicated a Lab Technician entered the resident's room and observed the resident bleeding from the head area and the Technician had contacted facility staff for assistance. A typed investigation, which was not dated, indicated the facility had interviewed the resident's alert and oriented roommate (Resident #E), who had reported Resident #B had woke up about 1:30 a.m. and she could hear Resident #B hitting something and moaning out, "Dear God help me, help me" and "Lord be with me". Resident #E then indicated she had activated the call light and then fell back to sleep. Resident #E then indicated she was awake when Resident #B was transferred to the hospital. An undated, hand-written investigation, received from LPN #1 on 06/11/14 at 11:40 a.m., indicated, "Felt like she made rounds...I did not answer call light..." During an interview at this time, LPN #1 indicated this was an interview with the Nurse on duty at the time of the incident. Another hand-written note,undated, on the investigation indicated an interview with CNA #2 (CNA working the night of the occurrence), which indicated, "state			

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	she answered call light". A further interview, on 06/11/14 at 11:40 a.m., with MDS LPN present, LPN #1, indicated she was the one who had completed the investigation on the occurrence. She indicated she had spoke with CNA #2 and CNA #2 informed her she had answered the call light. LPN #1 indicated she had interviewed CNA #3, who had also been working the night of the occurrence and CNA #3 had informed her she had thought CNA #2 had gone into Resident #B's room. She indicated she had not documented the interview with CNA #3. LPN #1 was unable to acknowledge what time the call light, which Resident #E had said she activated at 1:30a.m., was answered by the staff. She indicated she did not know what was done by the staff when they answered the call light at 1:30 a.m. She indicated the Lab Technition who had found the injured resident had not been interviewed. During an interview on 06/11/14 at 11:50 a.m., LPN #1 indicated she had ran a call light report and indicated the call light for Resident #B and #E's room was activated at 1:03 a.m. and was answered at the Nurses' Station within 19 seconds. She indicated CNA #2 had said she was not Resident #B and E's CNA and had told			

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	their CNA (CNA #3) the call light was on. LPN #1 indicated she did not know why the call light was activated. She indicated CNA #3 had said she was not told to go down to the residents' room. LPN #1 further indicated the call light was activated at 3:36 a.m. and someone had turned the call light off in the residents' room. She indicated she did not know who canceled the call light and was not aware what the resident needed at that time. During a telephone interview on 06/11/14 at 12:05 p.m., CNA #3 indicated she had not answered the call light activation for Resident #B and #E's room. She indicated no one had informed her to go into the residents' room nor was told the residents' had requested help. She indicated the room was on her assignment sheet and she had not been in the room often because it had been a busy night. She indicated she could not remember what time she had last been in the resident's room prior to the resident being transferred to the Emergency Room. The facility was unable to reach CNA #2 on the telephone. During a telephone interview with Lab			

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	Tech (Laboratory Technition) #4 on 06/11/14 at 1:40 p.m., Lab Tech #4 indicated she had entered Resident #B's room around 4:15 to 4:30 a.m. to draw blood for blood tests. She indicated when she walked in the room, the resident's head was leaning on the side rail and there was blood on the floor and the rail and the blood had appeared to be clotted on the resident's head (Resident #B's blood clotting time was high). She indicated the bruising had already spread across the resident's head (balding). She indicated the resident was laying still but answered when spoken to. She indicated she yelled for help from the facility. During an interview on 1:45 p.m., LPN #1 indicated by reviewing the call light report for the 05/29/14, the report indicated: The call light was activated at 12:59 a.m. and was answered and canceled at the Nurses' Station in four minutes and 53 seconds. LPN #1 indicated no one canceled the call light from the room and she was unsure of what the residents' of the room needed at this time. The call light was then re-activated at 1:03 a.m. and was answered and canceled at the Nurses' Station in 19 seconds. (Call where Resident #E had reported Resident			

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	#B was hitting something and moaning out). LPN #1 indicated CNA #2 had informed her she had told CNA #3 to go down to the room because the CNA #2 was not assigned to Resident #B and #E. LPN #1 indicated all staff were to answer the call lights. The call light was then activated at 3:36 a.m. and canceled in 25 seconds from the room. LPN #1 indicated she was unsure who had canceled the call light or what the residents may have needed. LPN #1 then presented pictures from a camera on the hallway. LPN #1 indicated the camera was activated by motion. She indicated the Resident #B's Nurse was in the room on 05/28/14 at 10:14 p.m. and the next picture the facility had of someone entering the room was on 05/29/14 at 4:14 a.m. when the Lab Tech had entered the room. LPN #1 indicated the staff were to make rounds every two hours. This Federal Tag relates to complaint IN00150211. 3.1-45(a)(2)			