STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY CHARM VILLAGE	7212 US HWY 31 S INDIANAPOLIS, IN 46227

(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
R000000	This visit was for the Investigation of Complaints IN00148135, IN00148428 and IN00148894. Complaint IN00148135 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00148428 - Unsubstantiated due to lack of evidence. Complaint IN00148894 - Substantiated. No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: May 13, 14, 15 and 19, 2014 Facility number: 003283 Provider number: 003283 AIM number: N/A Survey team: Diana Zgonc, RN-TC Susan Worsham, RN (May 15, 2014) Census bed type: Residential: 60 Total: 60 Census payor type:	R000000		

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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	Medicaid: 40 Other: 20 Total: 60 Residential sample: 8 These state residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 23, 2014; by Kimberly Perigo, RN.			
R000052	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review and interview, the facility failed to ensure residents were not subjected to mental and physical abuse for 2 of 8 residents reviewed for abuse in a sample of 8 (Resident #G and #J).	R000052	**CountryCharm Village Facility#3283 Plan ofCorrection – June 7, 2014 Event IDZ8XN11** "This plan of correction is submitted as required under either or both State and Federal law. The submission of this Plan of Correction on June 7, 2014,	06/07/2014

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	Findings include: 1. The clinical record for Resident #G was reviewed on 5/15/14 at 1:00 P.M. Diagnoses for Resident #G included, but were not limited to, legal blindness, hard of hearing, congestive heart failure, hypothyroidism, atrial fibrillation, hyperlipidemia and benign prostatic hypertrophy. A nurses note for Resident #G, dated 3/27/14 at 12:30 P.M., indicated there had been a physical altercation with another resident (Resident #J) that resulted in 2 skin tears to the right elbow and complaints of pain to right side of his upper torso and pain to the outer aspect of his right hand. The Executive Director (ED/Administrator) had been contacted according to the facility policy. A "Community/Physician Communication" document for Resident #G, dated 3/27/14, indicated the resident was involved in a resident to resident altercation. The facility requested an x-ray for complaints of right side pain to the upper torso and hand and noted 2 skin tears to the right elbow (no further injuries reported). 2. The clinical record for Resident #J		does not constitute an admission of fault or liability to the government entity or any third party, on the part of Country Charm Village, as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis and the Community reserves its right to object to the admission of this Statement of Deficiency or the Plan of Correction under any other theory of law. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies." The initial report of this incident was verbally provided to Administrator on March 27, 2014, the same date of the incident. At the time of this verbal report, there was no	

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	was reviewed on 5/19/14 at 9:00 A.M. Diagnoses for Resident #J included, but were not limited to, congestive heart failure, diabetes, hypertension, coronary artery disease, hyperlipidemia, gastroesophageal reflux disease, hypothyroidism and depression. A nurses note dated 3/27/14 at 12:30 P.M., indicated there had been a physical altercation with another resident (Resident #G) that resulted in a skin tear to the right elbow and a scrape/abrasion to the right knee with redness. A "Community/Physician Communication" document for Resident #J indicated the resident was involved in a resident to resident physical altercation and sustained a skin tear to the right elbow and and a scrap/abrasion to the right knee (no further injuries noted). During the entrance conference with the Administrator on 5/13/14 at 12:10 P.M., an interviewable list was requested and received. Resident #G and Resident #J were listed as interviewable residents. During a confidential interview on 5/13/14 at 5:20 P.M., information was provided regarding concerns in the facility. On 5/14/14 at 3:00 P.M., during a 2nd interview, information was		verbal or written indication or allegation of abuse provided to the Administrator. Never the less, upon return to the facility, Administrator reviewed charts, physician communication, camera footage and interviewed appropriate parties. Following these measures, and based upon thefindings, or lack of findings, it was concluded that this incident was an accidental collision of resident walkers. On May 15, 2014, additional information, in written form, was provided to Administrator regarding this incident. The additional information contained an allegation of abuse. The Administrator immediately opened an investigation and filed an incident report with the Indiana State Department of Health on May 16, 2014, following all requirements as set forth by both the ISDH and the Elder Justice Act. Investigation included review of resident charts, physician communication, camera footage and interview of appropriate parties. Again, it was concluded that this incident was accidental in nature and that there was no evidence tosubstantiate resident to resident abuse. The facility has taken and shall take the following corrective actions toward a plan of correction in this incident: Education: The facility began initiating the plan of correction on May 16, 2014, when an in-service was held for staff personnel. This	

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	provided regarding an allegation of abuse and fear that nothing would be done related to a resident to resident altercation that occurred on March 27, 2014. During an interview with Resident #J on 5/15/14 at 11:00 A.M., he indicated he did not remember the incident with Resident #G. (Resident #J answered other questions appropriately). During an interview with Concierge #2 on 5/15/14 at 11:15 A.M., she indicated she received a call from a resident that 2 men were yelling and cussing in the hallway outside her door. Statements taken at the time of the incident by Concierge #2 indicated, ... "heard walkers rattling" ... "Resident #G pushed me down" ... Resident #J has been verbally abusive to Resident #G in the past ... "the first time he rammed me, my fingers jammed against the door (Resident #G)" ... Resident #J refused to give Concierge #2 a statement at the later time. During an interview on 5/15/14 at 11:50 A.M., Resident #G indicated he felt afraid to walk on the other side of the building because he could not see who the resident was due to he is legally blind. He also indicated this was not the first time he's had an incident with this		in-service included the following topics: Types of Abuse – Handouts and educational discussion The Elder Justice Act – Handouts and educational discussion Reporting Requirements –Explanation of authorized designee, as well as how to report abuse in absence of Administrator and Director of Nursing Chain of Command – For reporting abuse or allegations of abuse Investigation – Discussion of how investigations are conducted and who is responsible for launching investigation in absence of Administrator and Director of Nursing, as well as the time frame for reporting Ombudsman and ISDH – Discussion on role of Ombudsman and ISDH as it relates to incident reporting and allegations of abuse Internal Controls – Discussion of corporate structure and how incidents and concerns may be reported In addition to the above staff-wide education, nurses were provided additional training on how to conduct an investigation, and report an incident of alleged abuse, in the absence of the Administrator and Director of Nursing. The above action was immediate in nature and will continue to be ongoing in nature, as all new employees are trained on these topics, and the facility does provide quarterly in-service on these topics. This cycle of education will continue. All	

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	resident and the other resident cusses at him. It has happened 2 other times before, but Resident #G did not report it to the facility. The resident started walking in 2003 when his wife died for therapy and feels he cannot walk to the other side of the building now for fear of another altercation with Resident #J. The resident also indicated he talked to the Administrator in April, but nothing had been done about the other resident. During an interview with the ED on 5/15/14 at 12:30 P.M., she indicated nothing had been done, because she was not aware of abuse. When staff informed her of the altercation they did not indicate it was abuse.		residents have the potential to be affected by the deficient practice and the above cited corrective action will continue to be in place as measures to ensure further compliance. This corrective action will be monitored by both the Director of Nursing and the Executive Director of the community. In the absence of the Executive Director, the Director of Nursing will have the responsibility of monitoring this plan, while the Executive Director has the ultimate responsibility of ensuring compliance to this plan. This concludes the Plan of Correction for Country Charm Village, Event ID Z8XN11. This plan of correction was prepared by Kamala M. West, RCA.	
R000053	410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse. Based on record review and interview,	R000053	**CountryCharm Village**	06/07/2014

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	the facility failed to ensure residents were free of verbal abuse/cursing for 2 of 8 residents reviewed for verbal abuse in a sample of 8 (Resident #G and #J). Findings include: 1. The clinical record for Resident #G was reviewed on 5/15/14 at 1:00 P.M. Diagnoses for Resident #G included, but were not limited to, legal blindness, hard of hearing, congestive heart failure, hypothyroidism, atrial fibrillation, hyperlipidemia and benign prostatic hypertrophy. A nurses note for Resident #G, dated 3/27/14 at 12:30 P.M., indicated there had been a physical altercation with another resident (Resident # J) that resulted in 2 skin tears to the right elbow and complaints of pain to right side of his upper torso and pain to the outer aspect of his right hand. The ED had been contacted according to the facility policy. A "Community/Physician Communication" document for Resident #G, dated 3/27/14, indicated the resident was involved in a resident to resident altercation. The facility requested an x-ray for complaints of right side pain to the upper torso and hand and noted 2 skin tears to the right elbow (no further		**Facility#3283 Plan ofCorrection – June 7, 2014 Event IDZ8XN11** "This plan of correction is submitted as required under either or both State and Federal law. The submission of this Plan of Correction on June 7, 2014, does not constitute an admission of fault or liability to the government entity or any third party, on the part of Country Charm Village, as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis and the Community reserves its right to object to the admission of this Statement of Deficiency or the Plan of Correction under any other theory of law. TheCommunity submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney,	

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	injuries reported). 2. The clinical record for Resident #J was reviewed on 5/19/14 at 9:00 A.M. Diagnoses for Resident #J included, but were not limited to, congestive heart failure, diabetes, hypertension, coronary artery disease, hyperlipidemia, gastroesophageal reflux disease, hypothyroidism and depression. A nurses note dated 3/27/14 at 12:30 P.M., indicated there had been a physical altercation with another resident (Resident #G) that resulted in a skin tear to the right elbow and a scrape/abrasion to the right knee with redness. A "Community/Physician Communication" document for Resident #J indicated the resident was involved in a resident to resident physical altercation and sustained a skin tear to the right elbow and and a scrap/abrasion to the right knee (no further injuries noted). During the entrance conference with the Administrator on 5/13/14 at 12:10 P.M., an interviewable list was requested and received. Resident #G and Resident #J were listed as interviewable residents. During a confidential interview on 5/13/14 at 5:20 P.M., information was		or shareholder of the Community or affiliated companies." The initial report of this incident was verbally provided to Administrator on March 27, 2014, the same date of the incident. At the time of this verbal report, there was no verbal or written indication or allegation of abuse provided to the Administrator. Never the less, upon return to the facility, Administrator reviewed charts, physician communication, camera footage and interviewed appropriate parties. Following these measures, and based upon the findings, or lack of findings, it was concluded that this incident was an accidental collision of resident walkers. On May 15, 2014, additional information, in written form, was provided to Administrator regarding thisincident. The additional information contained an allegation of abuse. The Administrator immediately opened an investigation and filed an incident report with the Indiana State Department of Health on May 16, 2014, following all requirements as set forth by both the ISDH and the Elder Justice Act. Investigation included review of resident charts, physician communication, camera footage and interview of appropriate parties. Again, it was concluded that this incident was accidental in nature and that there was no evidence to substantiate resident to resident abuse. The facility has	

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	provided regarding concerns in the facility. On 5/14/14 at 3:00 P.M., during a 2nd interview, information was provided regarding an allegation of abuse and a fear of nothing being done related to a resident to resident altercation that occurred on March 27, 2014. During an interview with Resident #J on 5/15/14 at 11:00 A.M., he indicated he did not remember the incident with Resident #G. (Resident #J answered other questions appropriately). During an interview with Concierge #2 on 5/15/14 at 11:15 A.M., she indicated she received a call from a resident that 2 men were yelling and cussing in the hallway outside her door. Statements taken at the time of the incident by Concierge #2 indicated, ... "heard walkers rattling" ... "Resident #G pushed me down" ... Resident # J has been verbally abusive to Resident #G in the past ... "the first time he rammed me, my fingers jammed against the door (Resident # G)" ... Resident #J refused to give Concierge #2 a statement at the later time. During an interview on 5/15/14 at 11:50 A.M., Resident #G indicated he felt afraid to walk on the other side of the building because he could not see who		taken and shall take the following corrective actions toward a plan of correction in this incident: Education: The facility began initiating the plan of correction on May 16, 2014, when an in-service was held for staff personnel. This in-service included thefollowing topics: Types of Abuse – Handouts and educational discussion The Elder Justice Act – Handouts and educational discussion Reporting Requirements –Explanation of authorized designee, as well as how to report abuse in absence of Administrator and Director of Nursing Chain of Command – For reporting abuse or allegations of abuse Investigation – Discussion of how investigations are conducted and who is responsible for launching investigationin absence of Administrator and Director of Nursing, as well as the time framefor reporting Ombudsman and ISDH – Discussionon role of Ombudsman and ISDH as it relates to incident reporting and allegations of abuse Internal Controls – Discussion of corporate structure and how incidents and concerns may be reported In addition to the above staff-wide education, nurses were provided additional training on how to conduct an investigation, and report an incident of alleged abuse, in the absence of the Administrator and Director of Nursing. The above action was immediate in nature and will	

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	the resident was due to he is legally blind. He also indicated this was not the first time he's had an incident with this resident and the other resident cusses at him. It has happened 2 other times before, but Resident #G did not report it to the facility. The resident started walking in 2003 when his wife died for therapy and feels he cannot walk to the other side of the building now for fear of another altercation with Resident #J. The resident also indicated he talked to the Administrator in April, but nothing had been done about the other resident. During an interview with the ED on 5/15/14 at 12:30 P.M., she indicated nothing had been done, because she was not aware of abuse. When staff informed her of the altercation they did not indicate it was abuse.		continue to be ongoing in nature, as all new employees are trained on these topics, and the facility does provide quarterly in-service on these topics. This cycle of education will continue. All residents have the potential to be affected by the deficient practice and the above cited corrective action will continue to be in place as measures to ensure further compliance. This corrective action will be monitored by both the Director of Nursing and the Executive Director of the community. In the absence of the Executive Director, the Director of Nursing will have the responsibility of monitoring this plan, while the Executive Director has the ultimate responsibility of ensuring compliance to this plan. This concludes the Plan of Correction for Country Charm Village, Event ID Z8XN11. This plan of correction was prepared by Kamala M. West, RCA.	
R000090	410 IAC 16.2-5-1.3(g)(1-6)			

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	Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be			

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	available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on record review and interview, the facility failed to ensure a resident to resident abuse allegation was reported according to the facility policy for 2 of 8 residents reviewed for resident abuse in a sample of 8 (Resident #G and #J). 1. The clinical record for Resident #G was reviewed on 5/15/14 at 1:00 P.M. Diagnoses for Resident #G included, but were not limited to, legal blindness, hard of hearing, congestive heart failure, hypothyroidism, atrial fibrillation, hyperlipidemia and benign prostatic hypertrophy. A nurses note for Resident #G, dated 3/27/14 at 12:30 P.M., indicated there had been a physical altercation with another resident (Resident #J) that resulted in 2 skin tears to the right elbow and complaints of pain to right side of his upper torso and pain to the outer aspect of his right hand. The ED had been contacted according to the facility policy. A "Community/Physician	R000090	**CountryCharm Village Facility#3283 Plan ofCorrection – June 7, 2014 Event IDZ8XN11** "This plan of correction is submitted as required under either or both State and Federal law. The submission of this Plan of Correction on June 7, 2014, does not constitute an admission of fault or liability to the government entity or any third party, on the part of Country Charm Village, as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis and the Community reserves its right to object to the admission of this Statement of	06/07/2014

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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
	Communication" document for Resident #G, dated 3/27/14, indicated the resident was involved in a resident to resident altercation. The facility requested an x-ray for complaints of right side pain to the upper torso and hand and noted 2 skin tears to the right elbow. (No further injuries reported). 2. The clinical record for Resident #J was reviewed on 5/19/14 at 9:00 A.M. Diagnoses for Resident #J included, but were not limited to, congestive heart failure, diabetes, hypertension, coronary artery disease, hyperlipidemia, gastroesophageal reflux disease, hypothyroidism and depression. A nurses note dated 3/27/14 at 12:30 P.M., indicated there had been a physical altercation with another resident (Resident #G) that resulted in a skin tear to the right elbow and a scrape/abrasion to the right knee with redness. A "Community/Physician Communication" document for Resident #J indicated the resident was involved in a resident to resident physical altercation and sustained a skin tear to the right elbow and and a scrap/abrasion to the right knee (no further injuries noted). During the entrance conference with the		Deficiency or the Plan of Correction under any other theory of law. TheCommunity submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies." The initial report of this incident was verbally provided to Administrator on March 27, 2014, the same date of the incident. At the time of this verbal report, there was no verbal or written indication or allegation of abuse provided to the Administrator. Never the less, upon return to the facility, Administrator reviewed charts, physician communication, camera footage and interviewed appropriate parties. Following these measures, and based upon the findings, or lack of findings, it was concluded that this incident was an accidental collision of resident walkers. On May 15, 2014, additional information, in written form, was provided to Administrator regarding this incident. The additional information contained an allegation of abuse. The Administrator immediately opened an investigation and filed an incident report with the Indiana State Department of Health on May 16, 2014, following all requirements as set forth by both the ISDH and the Elder Justice	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/19/2014

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	Administrator on 5/13/14 at 12:10 P.M., an interviewable list was requested and received. Resident #G and Resident #J were listed as interviewable residents. During a confidential interview on 5/13/14 at 5:20 P.M., information was provided regarding concerns in the facility. On 5/14/14 at 3:00 P.M., during a 2nd interview, information was provided regarding an allegation of abuse related to a resident to resident altercation that occurred on March 27, 2014. During an interview with the Administrator on 5/14/14 at 4:00 P.M., the resident to resident reportable incident investigation was requested. During an interview with the Administrator on 5/15/14 at 10:00 A.M., she indicated the resident to resident altercation had not been reported the Indiana State Department of Health. During an interview on 5/15/14 at 11:15 A.M., with Concierge #2 she indicated she received a call at the receptionist desk from another resident that she could hear 2 men arguing in the hallway. She also indicated she took statements from the resident's and provided the information to the ED (Administrator).		Act. Investigation included review of resident charts, physician communication, camera footage and interview of appropriate parties. Again, it was concluded that this incident was accidental in nature and that there was no evidence to substantiate resident to resident abuse. The facility has taken and shall take the following corrective actions toward a plan of correction in this incident: Education: The facility began initiating the plan of correction on May 16, 2014, when an in-service was held for staff personnel. This in-service included the following topics: Types of Abuse – Handouts and educational discussion The Elder Justice Act – Handouts and educational discussion Reporting Requirements –Explanation of authorized designee, as well as how to report abuse in absence of Administrator and Director of Nursing Chain of Command – For reporting abuse or allegations of abuse Investigation – Discussion of how investigations are conducted and who is responsible for launching investigation in absence of Administrator and Director of Nursing, as well as the time frame for reporting Ombudsman and ISDH – Discussion on role of Ombudsman and ISDH as it relates to incident reporting and allegations of abuse Internal Controls – Discussion ofcorporate structure and how incidents and	

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	During an interview on 5/15/14 at 12:30 P.M., with the Administrator and Director of Nursing (DON), she indicated we did not realize there was resident abuse, because neither the Administrator or the DON were in the building at the time. She also indicated she did not remember staff providing the statements taken at the time of the altercation or the nurses reporting it as abuse. During an interview on 5/15/14 at 1:35 P.M., the statements taken by staff were found in another staff members desk drawer and provided to the Administrator. A current facility policy dated 10/1/07 and titled "Abuse of Residents" and provided by the Administrator on 5/15/14 at 12:30 P.M. indicated, "The Company will not tolerate any abuse ... The Company may also report such actions to the appropriate state or local regulatory authority. Abuse is defined as the following: any act, ... done willfully, knowingly or recklessly through words or physical action which causes or could cause mental or physical injury ..."		concerns may be reported In addition to the above staff-wide education, nurses were provided additional training on how to conduct an investigation, and report an incident of alleged abuse, in the absence of the Administrator and Director of Nursing. The above action was immediate in nature and will continue to be ongoing in nature, as all new employees are trained on these topics, and the facility does provide quarterly in-service on these topics. This cycle of education will continue. All residents have the potential to be affected by the deficient practice and the above cited corrective action will continue to be in place as measures to ensure further compliance. This corrective action will bemonitored by both the Director of Nursing and the Executive Director of the community. In the absence of the Executive Director, the Director of Nursing will have the responsibility of monitoring this plan, while the Executive Director has the ultimate responsibility of ensuring compliance to this plan. This concludes the Plan of Correction for Country Charm Village, Event ID Z8XN11. This plan of correction was prepared by Kamala M. West, RCA.	

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