STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA MERRILLVILLE	7900 RHODE ISLAND STREET, MERRILLVILLE, , 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00449432. Complaint IN00449432 - State deficiency related to the allegations is cited at R0090. Survey date: December 19, 2024 Facility number: 013733 Residential Census: 57 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 12/26/24.	R 0000	This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies. This plan of correction is being submitted as required by the regulation. The Administrator will ensure all corrective action in the following Plan of Correction has been completed.	
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the	R 0090	**A** The incident regarding residents B and C was reported to the IDOH while the state survey complaint # IN00449432 was in process. Resident B no longer	01/22/2025

	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:		resides in the community. Resident C still resides at the facility and has had no adverse effects related to the deficient practice. **B** To determine if other residents may have been affected by the same deficient practice all nursing notes of the residents on the 24-hour log over the last 6 months will be reviewed by the Director of Nursing or her designee. Immediate action will be taken if a nursing note is deemed needing further investigation. Action to include additional investigating by the Administrator or her designee and reporting of the incident to the proper authorities. The residents responsible party and physician will be notified of any additional findings regarding the review of the nursing notes. APS and IDOH will also be notified. **C** To ensure that the deficient practice does not recur, the Executive Director or her designee will in-service all staff members on reporting	

(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 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 an unusual occurrence of sexual nature was reported and investigated in a timely manner for 2 of 2 residents reviewed for abuse. (Residents B and C)

Finding includes:

During an interview on 12/19/24 at 10:25 a.m., the Executive Director indicated she had been made aware on 12/18/24 of an event that occurred on 12/14/24. Resident C had been found by a CNA in Resident B's room. His pants were down around his ankles, Resident B was fully clothed and seated on her bed. The CNA had reported

allegations of abuse and neglect per AVIVA Senior Living Policy and Procedures
(Protocol Title: 9017- Abuse, Suspected or Reported) and IDOH regulations.

D
To monitor the corrective action all nursing notes of residents on the
24-hour log will be reviewed by the Director of Nursing or her designee to
assure any report of alleged abuse or neglect is thoroughly investigated and
reported to all parties per AVIVA Senior Living Policy and Procedures and IDOH regulations. This will be reported quarterly to the quality assurance committee
on the ongoing results of this review for 6 months or until a pattern of
compliance is obtained.

E
All training will be completed by 01/17/2025.

it to LPN 1.

a. Resident B's record was reviewed on 12/19/24 at 10:30 a.m. The resident was admitted to the locked memory care facility on 12/6/24. Diagnoses included, but were not limited to, dementia, depression and hypertension.

There were no Progress Notes between 12/9 and 12/16/24.

A Progress Noted, dated 12/16/24, indicated Resident B had left the facility over the weekend with family. The resident remained out of the facility as of 12/19/24.

A Progress Note, dated 12/18/24 and designated as a late entry note from 12/14/24, indicated the midnight shift had reported Resident C had been found in Resident B's room with his pants around his ankles. No physical touch was witnessed. Resident C was redirected out of Resident B's room.

b. Resident C's record was reviewed on 12/19/24 at 11:50 a.m. The resident was admitted on 11/1/24. Diagnoses included, but were were not limited to, dementia unspecified severity delusional disorder, bipolar current depressed with psychotic features and major depression.

Progress Notes, dated 12/15,

12/16 and 12/17/24, indicated the resident was being monitored for behaviors; there were no specific behaviors documented anywhere in the record.

A Progress Note, dated 12/18/24, indicated on 12/14/24 the resident had been found in Resident C's room with his pants around his ankle, Resident C was seated on the bed fully dressed. No physical touch was witnessed. The resident was redirected out of the room and his representative and Physician were notified.

A local Police Department Report, dated 12/14/24, indicated Resident B's family representative had taken her to the hospital on 12/14/24. The resident was normally non-verbal due to severe dementia. The family had visited her for lunch that day, and after their meal, returned to her room. The resident began crying and saying, "rape" and "that man hurt me". The family took the resident to the hospital emergency room where a sexual assault exam was completed and the police were notified.

During a telephone interview on 12/19/24 at 10:39 a.m., the family member of Resident B indicated he had visited his mother on 12/14/24. His mother

was normally non-verbal due to severe dementia. She was crying, and said, "hurt" and "rape". He did not report this to the facility. He had taken his mother to the hospital for examination that day and she had not returned to the facility.

During an interview on 12/19/24 at 10:51 a.m., the Executive Director was made aware of the sexual assault allegation. She indicated they had not been notified of any unusual events until 12/18/24. She indicated the incident should have been reported to her immediately to be investigated.

During an interview on 12/19/24 at 11:31 a.m., LPN 1 indicated she came into work on 12/14/24 at 7:00 a.m. The midnight CNA reported to her that Resident C had been found with his pants down in Resident B's room around 5:00 a.m. The CNA had been unable to tell her if Resident C had his underwear on or off. The residents were immediately separated. The LPN notified Resident C's wife and Physician of the behavior. She indicated she did not contact Resident B's family or Physician, or notify management of the incident.

The current policy, "Abuse, Suspected or Reported", indicated, "...Sexual abuse: includes physical force, threats

or coercion to facilitate non-consensual touching, fondling, intercourse or other sexual activities. This is particularly true with vulnerable adults who are unable to give consent or comprehend the nature of these actions...." and "...Executive Director will be responsible to understand and maintain compliance with Abuse Reporting requirements. Each Executive Director will ensure training is provided to all staff on how to recognize and reports alleged or suspected signs of abuse...."

The police and facility's investigations were ongoing at the time of exit from the facility.

This citation relates to Complaint IN00449432.

Based on record review and interview, the facility failed to ensure an unusual occurrence of sexual nature was reported and investigated in a timely manner for 2 of 2 residents reviewed for abuse. (Residents B and C)

Finding includes:

During an interview on 12/19/24 at 10:25 a.m., the Executive Director indicated she had been made aware on 12/18/24 of an event that occurred on 12/14/24. Resident C had been found by a CNA in Resident B's room. His pants were down

around his ankles, Resident B was fully clothed and seated on her bed. The CNA had reported it to LPN 1.

a. Resident B's record was reviewed on 12/19/24 at 10:30 a.m. The resident was admitted to the locked memory care facility on 12/6/24. Diagnoses included, but were not limited to, dementia, depression and hypertension.

There were no Progress Notes between 12/9 and 12/16/24.

A Progress Noted, dated 12/16/24, indicated Resident B had left the facility over the weekend with family. The resident remained out of the facility as of 12/19/24.

A Progress Note, dated 12/18/24 and designated as a late entry note from 12/14/24, indicated the midnight shift had reported Resident C had been found in Resident B's room with his pants around his ankles. No physical touch was witnessed. Resident C was redirected out of Resident B's room.

b. Resident C's record was reviewed on 12/19/24 at 11:50 a.m. The resident was admitted on 11/1/24. Diagnoses included, but were were not limited to, dementia unspecified severity delusional disorder, bipolar current depressed with psychotic features and major

depression.

Progress Notes, dated 12/15, 12/16 and 12/17/24, indicated the resident was being monitored for behaviors; there were no specific behaviors documented anywhere in the record.

A Progress Note, dated 12/18/24, indicated on 12/14/24 the resident had been found in Resident C's room with his pants around his ankle, Resident C was seated on the bed fully dressed. No physical touch was witnessed. The resident was redirected out of the room and his representative and Physician were notified.

A local Police Department Report, dated 12/14/24, indicated Resident B's family representative had taken her to the hospital on 12/14/24. The resident was normally non-verbal due to severe dementia. The family had visited her for lunch that day, and after their meal, returned to her room. The resident began crying and saying, "rape" and "that man hurt me". The family took the resident to the hospital emergency room where a sexual assault exam was completed and the police were notified.

During a telephone interview on 12/19/24 at 10:39 a.m., the

family member of Resident B indicated he had visited his mother on 12/14/24. His mother was normally non-verbal due to severe dementia. She was crying, and said, "hurt" and "rape". He did not report this to the facility. He had taken his mother to the hospital for examination that day and she had not returned to the facility.

During an interview on 12/19/24 at 10:51 a.m., the Executive Director was made aware of the sexual assault allegation. She indicated they had not been notified of any unusual events until 12/18/24. She indicated the incident should have been reported to her immediately to be investigated.

During an interview on 12/19/24 at 11:31 a.m., LPN 1 indicated she came into work on 12/14/24 at 7:00 a.m. The midnight CNA reported to her that Resident C had been found with his pants down in Resident B's room around 5:00 a.m. The CNA had been unable to tell her if Resident C had his underwear on or off. The residents were immediately separated. The LPN notified Resident C's wife and Physician of the behavior. She indicated she did not contact Resident B's family or Physician, or notify management of the incident.

The current policy, "Abuse,

	Suspected or Reported", indicated, "...Sexual abuse: includes physical force, threats or coercion to facilitate non-consensual touching, fondling, intercourse or other sexual activities. This is particularly true with vulnerable adults who are unable to give consent or comprehend the nature of these actions...." and "...Executive Director will be responsible to understand and maintain compliance with Abuse Reporting requirements. Each Executive Director will ensure training is provided to all staff on how to recognize and reports alleged or suspected signs of abuse....." The police and facility's investigations were ongoing at the time of exit from the facility. This citation relates to Complaint IN00449432.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE