STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155323	A. BUILDING 00 B. WING	08/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW VILLAGE SENIOR LIVING	410 TIOGA RD MONTICELLO, IN 47960

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 31, August 1, 2, 3 and 4, 2017 Facility number: 000216 Provider number: 155323 AIM number: 100267580 Census Bed Type: SNF/NF: 33 Total: 33 Census Payor Type: Medicare: 2 Medicaid: 31 Total: 33 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/8/17.	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider or a conclusion set forth in the statement of deficiencies or any violation of regulation. Provider desires that the 2567 plan of correction be considered the letter of credible compliance and respectfully requests paper compliance in lieu of a revisit. Christopher J. Schiavone, HFA Administrator	
F 0225 SS=D Bldg. 00	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS			

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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	483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities 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. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve			

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	abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 ensure allegations of abuse were thoroughly investigated for 2 of 3 abuse allegations reviewed. (Resident 5, 6, 10 and 38) Findings include: 1. An incident investigation, dated 2/6/17, indicated Resident 38 reported LPN 1 would not allow Resident 6 access to her room on 2/5/17. The investigation included a statement from the Social Services Director of an interview with Resident 6, an assessment titled "Possible	F 0225	Resident 38 and Resident 6 had no negative outcomes. All Residents have the potential to be affected; no other Resident was affected or identified by the deficient practice. A thorough investigation was completed by the provider. The Administrator was re-educated on 8-2-17 by the Regional Director on Abuse prohibition policies and procedures, including	08/21/2017

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	or Potential Mental Anguish Assessment," "Allegation of Staff-To-Resident Abuse Investigation," and documentation of 4 residents who may have been affected. The investigation lacked written documentation LPN 1, Resident 38, and Resident 6 were interviewed. An Interview with the Administrator, on 8/2/17 at 3:06 p.m., indicated residents and staff were interviewed but written documentation was not obtained and should have been included in the investigation. 2. An incident investigation, dated 7/13/17, indicated LPN 1 heard Resident 5 yelling at Resident 10 for using a shared computer in the activity room. Resident 10 was assessed and the assessment was documented on a "Possible or Potential Mental Anguish Assessment." The investigation lacked documentation of statements from LPN 1, Resident 5 and Resident 10. An Interview with the Administrator, on 8/2/17 at 3:06 p.m., indicated residents and staff were interviewed but written documentation was not obtained and		the obtaining of written statements and/or interviews when conducting the investigation. The Administrator was re-educated on 8-2-17 by the Regional Director on Abuse prohibition policies and procedures, including the obtaining of written statements and/or interviews when conducting the investigation. The Corporate Regional Director or Corporate Nurse Consultant will review any abuse allegation and corresponding investigation conducted during weekly visits for next month, then monthly thereafter to ensure the policy and procedures are being followed, including but not limited to the inclusion of documented interviews/statements. Should concerns be identified, immediate corrective action shall be taken. All abuse allegations, investigations and findings/resolution will be	

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	should have been included in the investigation. 3.1-28(c) 3.1-28(d)		addressed and reviewed by the Quality Assurance Committee on a quarterly basis ongoing, in an effort to confirm continued compliance with conducting thorough investigation as per facility policy. Date of completion: 08-21-2017	
F 0226 SS=D Bldg. 00	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.			

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	(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. Based on record review and interview, the facility staff failed to follow their policy related to thorough investigations of allegations of abuse for 2 of 3 abuse allegations reviewed. (Resident 5, 6, 10 and 38) Findings include: 1. An incident investigation dated 2/6/17, indicated Resident 38 reported LPN 1 would not allow Resident 6 access to her room on 2/5/17. The investigation included a statement from the Social Services Director of an interview with Resident 6, an assessment titled "Possible or Potential Mental Anguish Assessment," "Allegation of Staff-To-Resident Abuse Investigation" and documentation of 4 residents who may have been affected. The investigation lacked written documentation LPN 1 and Resident 6 were interviewed An Interview with the Administrator, on 8/2/17 at 3:06 p.m., indicated residents and staff were interviewed but written	F 0226	Resident 38 and Resident 6 had no negative outcomes. All Residents have the potential to be affected; no other Resident was affected or identified by the deficient practice. A thorough investigation was completed by the provider. The Administrator was re-educated on 8-2-17 by the Regional Director on Abuse prohibition policies and procedures, including the obtaining of written statements and/or interviews when conducting the investigation. The Administrator was re-educated on 8-2-17 by the Regional Director on Abuse prohibition policies and procedures, including the obtaining of written statements and/or interviews when conducting the investigation. The	08/21/2017

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	documentation was not obtained and should have been. 2. An incident investigation dated 7/13/17, indicated LPN 1 heard Resident 5 yelling at Resident 10 for using a shared computer in the activity room. Resident 10 was assessed and the assessment was documented on a "Possible or Potential Mental Anguish Assessment." The investigation lacked documentation of statements from LPN 1, Resident 5 and Resident 10. An Interview with the Administrator, on 8/2/17 at 3:06 p.m., indicated residents and staff were interviewed but written documentation was not obtained and should have been. A current policy titled "Abuse Prohibition, Reporting and Investigation," provided by the Administrator on 8/2/17 at 2:10 p.m., indicated " ...If Resident Abuse, or Suspicion of Abuse, is Reported: ...10. Residents shall be questioned about the nature of the incident and their statements placed in writing. ... 11. Investigation shall be questioned about the nature of the incident and their statements placed in writing. ...Statements shall be taken		Corporate Regional Director or Corporate Nurse Consultant will review any abuse allegation and corresponding investigation conducted during weekly visits for next month, then monthly thereafter to ensure the policy and procedures are being followed, including but not limited to the inclusion of documented interviews/statements. Should concerns be identified, immediate corrective action shall be taken. All abuse allegations, investigations and findings/resolution will be addressed and reviewed by the Quality Assurance Committee on a quarterly basis ongoing, in an effort to confirm continued compliance with conducting thorough investigation as per facility policy. Date of completion: 08-21-2017	

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	including, but not limited to, facts and observations by involved employee(s) ...facts and observations by witnessing non-employee(s) ...facts and observations by the licensed nurse or individuals to who the initial report was made. ... The Administrator is responsible to coordinate the investigation, assure and accurate and complete written record of the incident and investigation ...." 3.1-28(c) 3.1-28(d)			
F 0323 SS=D Bldg. 00	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to			

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	installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. Based on observation, interview, and record review, the facility failed to ensure a safe environment for a cognitively impaired resident for 1 of 3 resident rooms observed. (Resident 22) Finding includes: On 8/7/17 at 11:08 a.m., Resident 22's bathroom contained the following hazardous chemicals: a bottle of mouthwash and a perineal wash spray bottle. On the bed side table, a spray bottle of perineal wash was observed. On 8/2/17 at 8:43 a.m., in Resident 22's bathroom, the following was observed: a bottle of mouthwash, a spray bottle of perineal wash, lotion and a container of stick deodorant. On the bed side table, 2 bottles of perineal spray wash were observed and accessible to the resident. On 8/2/17 at 10:35 a.m., the same chemicals were observed: a bottle of mouthwash, lotion, a container of stick	F 0323	Resident 22 was not affected by the deficient practice. All items of potential concern were removed from resident access. All Residents have the potential to be affected by the deficient practice. No other Residents were affected by this deficient practice. Facility wide rounds were conducted and any items identified of potential concern were removed from resident access. All staff will be re-educated on 8-23-2017 by the facility Administrator during the monthly all staff in-service as to how to properly store potentially hazardous items. The facility Administrator or	08/23/2017

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	deodorant and a spray bottle of perineal spray. On the bed side table, 2 bottles of perineal spray wash were observed. During the Environmental Tour on 8/2/17 at 11:30 a.m. with the Administrator and the Regional Consultant 2, the following chemicals were observed in Resident 22's room: mouthwash, stick deodorant, lotion and a perineal wash spray bottle in the bathroom. On the bed side table were 2 spray bottles of perineal wash spray. On 8/2/17 at 9:15 a.m., Resident 22 was observed independently ambulating (walked) past the AB Unit Nurse's station. Interview with CNA 8 on 8/2/17 at 9:15 a.m., indicated the resident was independent with ambulation. Interview with QMA/CNA 9 on 8/2/17 at 9:15 a.m., indicated the resident was able to ambulate independently and frequently would change his own clothes. He was able and would go to the bathroom independently at times. Resident 22's record was reviewed on 8/3/17 at 10:23 a.m. Diagnoses included, but were not limited to, moderate intellectual disabilities and Schizophrenia. The Significant		designee will conduct daily room checks for 30-days, then conduct weekly checks indefinitely thereafter. Should potentially hazardous items be observed, the same shall be secured upon discovery and staff re-educated accordingly. Findings from these audits and any corrective actions taken will be submitted to the Quality Assurance Committee for review, and monitoring/education increased or decreased on the basis of finding(s). Date of completion: 08-23-2017	

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	Minimum Data Set assessment dated 7/3/17, indicated the resident was cognitively impaired, no functional limitations to upper and lower extremities (arms and legs) and was able to ambulate and transfer without the assistance of staff. The policy tilted, " Personal care items/medications maintained by the resident," was provided by the Administrator on 8/4/17 at 2:33 p.m. This current policy indicated, "Policy: The facility shall observe the resident's rights to retain and use personal possessions, including persona care item (e.g., lotions, nail polish, etc) and medications (if resident self-administers) unless to do so wound endanger the health and safety of other residents...4. Facility assistance shall be offered to maintain person care items/medications in a manner respectful of resident's rights and in a manner to ensure the health and safety of confused residents of the facility who could have potential access to those items...." 3.1-45(a)(1)(2)			
F 0465 SS=B Bldg. 00	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON			

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	(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. Based on observation and interview, the facility failed to maintain a homelike, clean, and safe environment related to yellow discolored toilet seats, chipped and gouged doors, and worn personal equipment for 4 of 4 hallways. (A, B, C, and D Hallway) Findings include: During the Environmental Tour on 8/2/17 at 11:30 a.m. with the Administrator and the Regional Consultant 2, the following was observed: 1. A Hallway: a. In Room 2, the wall had chipped paint between the photographs and the privacy curtain. There were two residents that resided in this room. b. In Room 3, the bathroom toilet seat had a yellow discoloration. There were two residents who shared this bathroom.	F 0465	No Residents were directly affected by the deficient practice All Residents have the potential to be affected by the deficient practice. All items identified in the 2567 have been repaired, painted, or cleaned. Facility wide rounds were conducted to identify other areas in need of thorough cleaning and/or repair, with repairs scheduled accordingly. Both Maintenance Supervisor and Housekeeping Supervisor have been re-educated by the facility Administrator on 08-23-2017 as adherence with the preventative maintenance program and	08/31/2017

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	2. B Hallway: a. In Room 2, there were small holes on the wall above the bed by the window and white stained areas on the recliner. There was one resident who resided in this room. b. In Room 6, the privacy curtain had multiple brown stains. There was one resident who resided in this room. c. In Room 8, the inside bottom of the bathroom door was gouged, the resident's wheelchair right sided armrest foam pads had come apart and his walker foam handles had missing pieces. There was one resident who resided in this room. 3. C Hallway: a. On Room 3's floor, there were old non-skid strips and paint chipped on the bathroom wall. There was one resident who resided in this room. b. In Room 7, there were non-skid strips peeling from the floor and the bathroom wall was gouged. There was one resident who resided in this room. c. In Room 8, the bathroom wooden door was chipped by the handle and the wall		deep cleaning schedules. The facility Administrator or designee will conduct weekly room inspections for 30 days to ensure the preventative maintenance program is being completed and that deep cleans are being conducted according to the schedule. Should concerns be observed, immediate corrective action and re-education shall be conducted. These inspections will then continue monthly for 3 months thereafter. Findings from these inspections and any corrective actions taken will be submitted to the facility Quality Assurance Committee for review, and monitoring increased or decreased on the basis of finding(s). Completion date: 08-31-2017	

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	behind the mini-refrigerator was gouged. There were two residents who resided in this room. d. In Room 9's bathroom, the floor tiles in front of the toilet were broken. There was one resident who resided in this room. 4. D Hallway: a. In Room 4's bathroom, the toilet seat had a yellow discoloration and a black substance was noted around the base of the toilet. There was one resident who resided in this room. b. In Room 6, there was a hole in the wall above the light fixture by the bed. There was one resident who resided in this room. Interview with the Administrator at the end of the tour on 8/2/17 at 12:00 p.m., indicated all of the above was in need of repair or cleaning. 3.1-19 (f)			