STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/19/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
R 0000 Bldg. 00	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 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency 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.	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 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	01/22/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Meriam Hillis	Executive Director	01/08/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	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		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 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.	

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	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			

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	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.			