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	07/10/2023

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

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00404744 and IN00410968. Complaint IN00404744 - State deficiency related to the allegations are cited at R0052. Complaint IN00410968 - State deficiency related to the allegations are cited at R0052. Survey date: July 10, 2023 Facility number: 013733 Residential Census: 40 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 7/13/23.	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 regulations. The Administrator will ensure all corrective action in the following Plan of Correction has been completed.	
R 0052 Bldg. 00	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 observation, interview and record review, the facility failed to prevent resident to resident sexual abuse for 2 of 4 residents reviewed for abuse. (Residents C & E). Using the reasonable person concept, it is likely this deficient practice would lead to chronic anxiety, depressive episodes, or fear.	R 0052	A. A. Resident E no longer resides in the community. Resident E was put on 15-minute checks until transport arrived. Resident E left the facility within hours of the incident. Resident C was sent to the emergency room for further evaluation and	08/10/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Meriam Hillis	Executive Director	08/07/2023

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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	Finding includes: The record for Resident C was reviewed on 7/10/23 at 9:19 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, major depressive disorder, alcohol abuse, cognitive communication deficit, and hemiplegia (one sided weakness) following a stroke affecting the right dominant side. The Mini-Mental State Examination (MMSE), dated 1/22/23, indicated the resident was moderately cognitively impaired. The Service Plan, dated 4/22/23, indicated the resident had moderate impairment for orientation, short term memory, and long term memory. The resident had depression or a mood disorder. She needed assistance with awareness as she had an inability to discern and avoid harmful situations. She had exhibited occasional poor judgment. She required moderate assistance for mobility/ambulation. A Progress Note, dated 6/15/23 at 4:00 p.m., indicated the writer was called to Resident E's room where Resident C was observed lying on the bed undressed from the waist down. A male resident was noted in the room to be undressed completely sitting on the bed. The resident's were separated immediately. Resident C stated, "he didn't ask he just did it." The resident was taken to her room for an evaluation. The family and the physician were notified and she was sent to the hospital. A Progress Note, dated 6/16/23 at 11:00 a.m., indicated the resident had returned from the hospital and she had seemed depressed. She barely ate her breakfast.		treatment. B. B. To determine if other residents may have been affected the Executive Director and Wellness Director interviewed staff and residents/family to see if any other residents have been affected by the same deficient practice. Immediate action and reporting will take place if the same deficient practice is noted. A. C. All staff has been in-serviced on AVIVAs Abuse, Suspected or Reported Policy, Event Reporting Policy and How to recognize and intervene with potentially escalating behaviors. Additional HIPAA and Resident Rights training had been completed prior to IDOH visit and a copy was provided at that time. Nurses have been in-serviced on documentation. B. D. The Director or Nursing or his/her designee will audit the 24-hour log daily for sexual behaviors. The staff and residents/family will be interviewed weekly to ensure all behaviors have been included in the 24-hour log. The audit tools will be reviewed at our morning manager meeting to ensure compliance. The audits will be reviewed quarterly at the Quality Assurance meetings to ensure continued compliance. C. E. All training and review will be completed by August 10, 2023	

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	On 7/10/23 at 2:36 p.m., Resident C was observed in day clothes in the common area with other residents watching television. The record for Resident E was reviewed on 7/10/23 at 11:28 a.m. Diagnoses included, but were not limited to, affective disorder, dementia with behavioral disturbance, confusion, and memory loss. The Mini-Mental State Examination (MMSE), dated 3/8/23, indicated the resident was moderately cognitively impaired. A Semi-Annual Service Plan, dated 5/16/23, indicated the resident had a current or history of occasional disruptive, aggressive, or socially inappropriate behavior, either verbally or physically improper. He had poor judgment, moderate impairment with long term memory, and mild impairment with short term memory. He had a history of depression or a mood disorder. The Quarterly Resident Assessment Form, dated 12/23/22, indicated the resident had exhibited unwanted sexual type behaviors and would become sexual with other residents. A Late Entry Progress Note, dated 6/7/23 at 9 p.m., indicated the resident was observed making sexually inappropriate hand gestures in the hallway and he became upset when an attempt was made to redirect. A Progress Note, dated 6/8/23 at 1:30 p.m., indicated the physician was notified of increased behaviors and a new order for prophylactic macrobid (an antibiotic) 100 milligrams by mouth twice daily for 7 days was placed.		A	

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	A Progress Note, dated 6/10/23 at 10:45 a.m., indicated the CNA had entered the resident's room to assist with his shower. The resident was in bathroom wearing only his underwear. The resident stated to the CNA, "I want you in my bed, all I want from you is this and this," while pointing to both cheeks. The CNA went to the nurses' station and requested cares in pairs for the resident. A Progress Note, dated 6/10/23 at 11:40 a.m., indicated the resident was observed pushing a female resident in her wheelchair in the hallway. The resident stated that he was taking her back to her room because she had asked him to. He was redirected. A Progress Note, dated 6/10/23 at 1:30 p.m., indicated the resident was requiring close one on one supervision due to repeated attempts to take another resident to her room. The resident was difficult to redirect. A Progress Note, dated 6/11/23 at 1:45 p.m., indicated the resident was observed pushing another resident from wheelchair to room. When the writer attempted to redirect, the resident became agitated and verbally aggressive towards staff. A Progress Note, dated 6/15/23 at 4:00 p.m., indicated the resident was sitting on his bed completely nude with a female resident next to him completely undressed from the waist down. He became agitated yelling at staff to leave and kept repeating, "she is not married." The female was assessed immediately and both residents were separated. At dinner, he kept trying to approach the female resident and yelled at staff when they			

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	tried to redirect. The resident was sent to the hospital for treatment. The family, Director of Nursing, Administrator, and Physician were notified. An Incident Report and Investigation, provided by the Administrator, included the Investigation Timeline, the investigation, camera review, and interviews from the employees and residents. The Incident Report indicated the incident occurred on 6/15/23 at 4:01 p.m. Residents C and E were found in Resident E's apartment in the nude on the bed. Per the hospital paperwork, Resident C reported it was consensual, however she informed the nurse at the facility, "he didn't ask he just did it." The resident denied penile penetration and there were no injuries noted at the time. Resident C was sent to the hospital for further evaluation and treatment. Resident E was sent out to psych services and would not be returning to the facility. Facility investigative interview with Resident C was conducted on 6/16/23 at 11:00 a.m. Resident C indicated Resident E had touched her and she pointed to her vagina. She indicated it was not consensual and she did not want him to touch her. She indicated there was no penile penetration, but he put his fingers in her vagina and he hurt her. She could not remember how she got to his room and indicated Resident E had undressed her. Facility investigative interview with Employee 1 on 6/16/23, indicated the she had taken Resident C to bingo around 1:30 p.m. on 6/15/23 and she observed Resident E pacing in the hallway. Around dinner time, the nurse was passing medications and she was getting residents seated for dinner and they had noticed Resident C was			

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	not in the dining room. The nurse had asked Employee 1 to look for her and check Resident E's room. She went to the room and observed both residents in the bed. Resident E was naked and had his fingers in Resident C's vagina. When Resident E saw Employee 1, he stopped and began yelling to get out of the room. Employee 1 called on the walkie for the nurses to come to the room immediately. The nurses arrived and immediately took Resident C out of the room and Resident E started hitting towards them. Facility investigative interview with Employee 2 on 6/16/23, indicated she was in the hall passing medications. When she got to Resident C's medications she wasn't around so she asked if anyone had seen her. She sent Employee 1 to go check in Resident E's room. When Employee 1 entered, she immediately called out on the walkie for the nurses to come to his room. She was already in route to his room. Employee 2 observed Resident C on the bed with a shirt on and nothing below the waist with her legs open. Resident E was naked and yelling to get out of the room. Employee 2 went to Resident C to make sure she was ok. She told Resident E that the situation was inappropriate and he started going back and forth. She was able to remove Resident C from the bed and Resident E was swinging at her. Interview with Employee 3 on 7/10/23 at 2:36 p.m., indicated she was passing medications around 3:45 p.m. and noticed Resident C was not in her room so she went to go check for her. The Activity Director arrived to the room first and entered. When Employee 3 entered the room, she observed Resident C on Resident E's bed and he was sitting next to her. The Director of Nursing was called immediately and she had completed an assessment of the resident for any injuries.			

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	Resident C indicated to her that the situation that occurred was not consensual. Employee 3 indicated Resident E had a history of sexual behaviors such as trying to kiss other residents in the facility. Interview with the Administrator on 7/10/23 at 2:48 p.m., indicated Resident C went willingly with Resident E to his room. She wasn't screaming out or asking for help when watching the video recording from the hallway. The resident said it was consensual to the hospital staff and when she returned and was questioned the next day she just indicated that she did not say no. She did indicate Resident E had hurt her. Resident E had always been able to be redirected in the past with his behaviors, but recently had become more physical with staff but it was nothing sexual. Interview with Employee 4 on 7/10/23 at 3:04 p.m., indicated she was at lunch when she received the call over the walkie for staff to assist in Resident E's room. When she arrived, Resident E was laying on the bed naked with his hand over Resident C's mouth. Resident C was only wearing a shirt and socks. She immediately covered Resident C with a blanket and helped to remove her from the room. She indicated the resident was always trying to take her or talk to her. After the incident occurred, the resident was just not herself for a while. She wasn't very talkative. A follow-up interview with the Administrator on 7/10/23 at 4:04 p.m., indicated she had no further information to provide. This state residential finding relates to Complaints IN00404744 and IN00410968.			