CENTERS FOR	MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-0391
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155486	B. WIN	IG		11/05/	2021
MIDDLE	PROVIDER OR SUPPLIEF	ND REHABILITATION CENTER		131 S 1 MIDDLE	ADDRESS, CITY, STATE, ZIP CODE 0TH ST ETOWN, IN 47356		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ſΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00	IN00365590. Complaint IN00365 Federal/state deficite allegations are cited survey dates: Nove Facility number: 00 Provider number: 1002 Census Bed Type: SNF/NF: 15 Total: 15 Census Payor Type Medicare: 4 Medicaid: 5 Other: 6 Total: 15 These deficiencies is accordance with 41	d at F607, F609 and F610. In the factor of	F 000	00	This plan of correction is submitted to serve as a credible allegation of compliance in association with stated compled dates. Preparation and/or execution of this plan of correction does not constitute admission or agreement, the provider of conclusion set facts the statement of deficiencies. In plan of correction is prepared and/or executed solely because is required by state and federal law.	etion an s on The	
F 0607 SS=D Bldg. 00	§483.12(b) The fa implement written that:	nt Abuse/Neglect Policies cility must develop and policies and procedures hibit and prevent abuse,					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

neglect, and exploitation of residents and

TITLE

(X6) DATE

Any defiency statement 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.

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	LETED
		155486	B. W	NG		11/05	/2021
				CTDEET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2			10TH ST		
MIDDI E.	TOWN NUIDOING A	ND REHABILITATION CENTER					
MIDDLE	TOWN NURSING A	IND REHABILITATION CENTER		MIDDL	ETOWN, IN 47356		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
	misappropriation of	of resident property,					
	§483.12(b)(2) Establish policies and						
	procedures to inve	estigate any such					
	allegations, and						
	§483.12(b)(3) Incl	ude training as required at					
	paragraph §483.9						
		and record review, the	F 06	507	WHAT CORRECTIVE ACTION		11/19/2021
		plement their policies and			WILL BE ACCOMPLISHED F		
	^	to not immediately reporting			THOSE RESIDENTS FOUND	то	
	I -	ff to resident abuse to the			HAVE BEEN AFFECTED BY		
	· ·	reporting an allegation of			THE DEFICIENT PRACTICE:		
		se to the Indiana Department			All allegations of abuse, of an	У	
		Long-Term Care (LTC)			type, be substantiated or		
		residents reviewed for abuse			unsubstantiated by other sour		
		2 of 4 staff members			will be reported immediately to		
		prohibition and prevention			Administrator, DON, resident's		
		education in the last 12			physician/medical director, an		
	months. (Resident	B, Administrator, CNA 4)			an investigation will commend		
					immediately. All alert and orie		
	Findings include:				residents will be interviewed a		
					well as all visitors and staff pro		
		11-4-21 at 1:43 p.m., with the			at the time of the incident. Als	0	
		Nursing (DON) indicated			the responsible party/family		
		work on 10-21-21 at			member of the resident will be		
	approximately 8:00				interviewed. This process will		
		n a plastic caddy, located on			completed by members of the		
		N's door, along with a variety			administrative team; i.e.,	400	
		She estimated she found the			Administrator, DON, ADON, N		1
		ely 8:15 a.m., from CNA 4, a			coordinator, and social service	∌S.	
		rding Resident B. The note			The Administrator will be		
	· ·	ot limited to, "[Name of			responsible for monitoring.		
	_	the aide that got her out of bed			HOW OTHER RESIDENTS	`	
		n'." The DON indicated she			HAVING THE POTENTIAL TO		
	1	to look for the aide to find			BE AFFECTED BY THE SAM		
	"	onShe told me that [name of			DEFICIENT PRACTICE WILL	DE	
		d her when she went to get her			IDENTIFIED AND WHAT		
	_	t woke her up that morning			CORRECTIVE ACTIONS WIL	L	
	was rough and rude	e." She immediately sought the	1		BE TAKEN:		

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155486	B. W	NG		11/05/	/2021
		1.00.100				, ,	
NAME OF I	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP CODE		
					OTH ST		
MIDDLE	IOWN NURSING A	ND REHABILITATION CENTER		MIDDLE	ETOWN, IN 47356		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	assistance of the SS	D to go with her to speak to			All staff were re-educated on		
		dicated in interview with			investigating and reporting		
	-	arned Resident B was shaken			allegation of abuse (Physical,		
	"real hard to wake her up, but did not understand				Mental, Verbal and Sexual) ar	nd/or	
		wake up [name of Resident			financial exploitation and		
		e honest, at the time, I did not			involuntary seclusion and		
		natsoever of her alleging any			reviewed the Elder Justice Ac		
	concerns about post	sible abuse.			The training specifies reportin	~	
					any allegation of abuse to the		
		n CNA 4 on 11-5-21 at 11:29			Administrator or DON		
		on 10-21-21 around 6:45			immediately, in order for the	_	
		esident B's room to get her			responsible party to report such		
		routine and asked how she			allegation to IDOH within 2 ho		
	_	nt B told her "that girl" had			Please see attachment #1 and	d #3.	
		and yanked her up out of bed.			WHAT MEASURES WILL BE		
		esident B told her it had			PUT INTO PLACE OR WHAT		
		hour before this "and it hurt			SYSTEMIC CHANGES WILL		
		NA 4 indicated she reported			MADE TO ENSURE THAT TH		
		soon as she saw her in the			DEFICIENT PRACTICE DOES	S	
		or 8:30 a.m. She indicated she			NOT RECUR:		
		und 7:00 a.m., or 7:30 a.m.,			All allegations of abuse, of an	У	
	_	ON's box previously, but did			type, be substantiated or		
	_	N when she saw her in the			unsubstantiated by other sour		
	building.				will be reported immediately to		
	In an intermious!41	1 the Administrator on			Administrator, DON, resident's physician/medical director, an		
		m., he indicated an incident			an investigation will commend		
		curred on 10-21-21.			immediately. All alert and orie		
		as woken up and confused."			residents will be interviewed a		
		s out of state when he was			well as all visitors and staff pro		
		he investigation was			at the time of the incident. Als		
		ed by the time he was			the responsible party/family	•	
		Il anyone to report it.			member of the resident will be	2	
	nominea. I didn't te	anyone to report it.			interviewed. This process will		
	In an interview on 1	11-4-21 at 11:25 a.m. with			completed by members of the		
	In an interview on 11-4-21 at 11:25 a.m., with the SSD, she indicated the DON told her				administrative team; i.e.,		
	Resident B had told an aide she had been treated				Administrator, DON, ADON, N	/DS	
	rough by a staff member. She indicated she and				coordinator, and social service		
		he Administrator of the			The Administrator will be		
		ot aware if the incident was or			responsible for monitoring.		
			1				

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155486	B. WI	NG		11/05/	2021
		100 100				1 17 0 07	2021
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
				131 S 1	0TH ST		
MIDDLE		ND REHABILITATION CENTER		MIDDLE	ETOWN, IN 47356		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	was not reported to	the state as an allegation of			HOW THE CORRECTIVE		
	abuse. "It was prett	ty evident at the time that she			ACTIONS WILL BE		
	was somewhat confused. I did a BIMS [Brief Interview of Mental Status] on her that day and it				MONITORED TO ENSURE TH	E	
					DEFICIENT PRACTICE WILL		
	was an 8 [indicating	g moderate cognitive			NOT RECUR, I.E., WHAT		
	impairment]. I noti	ced her BIMS scores have			QUALITY ASSURANCE		
	fluctuated since she	has been herehas had some			PROGRAM WILL BE PUT INT	o	
	problems with being	g delusional and confused."			PLACE:		
	She indicated she w	vas not aware of the timing of			The corrective actions will be		
	the actual alleged e	vent or the persons involved			monitored by the Administrato	r	
	with the allegation.				and DON.		
					BY WHAT DATE THE		
	On 11-4-21 at 10:50	0 a.m., the Administrator			SYSTEMIC CHANGES WILL I	3E	
	provided a copy of	a "Resident			COMPLETED:		
	Grievance/Complai	nt Form." It indicated on			All staff will be in-serviced by		
	10-21-21, Resident	B "believed staff was 'mean			Friday, November 19, 2021 or	1	
	to her." It indicated	l a staff member had shaken			investigating and reporting		
	her awake, estimate	ed time of occurrence was			allegation of abuse (physical,		
	6:00 a.m., on the sa	me date.			mental, verbal and sexual) and	d/or	
					financial exploitation and		
	In an interview on 1	11-5-21 at 1:10 p.m., with			involuntary seclusion. Please s	see	
	Resident B's spouse	e, he indicated he was aware			attachment #2.		
	of the the allegation	ns of abuse towards staff by			We respectfully request paper		
	his spouse. He indi	cated, "I wanted you to know			compliance for tag F 607.		
		d trouble telling what's real					
		e had told me about somebody					
	shaking her and I ha	ave found no evidence to					
		s been treated anything other					
	than wonderful here	e. He added since her stroke,					
	Resident B has had	similar statements that have					
	no basis in truth, "S	the just comes up with these					
	things and it seeme	d to happen overnight since					
	her stroke."						
		of Resident B was reviewed					
		a.m. Her diagnoses					
		ot limited to cerebral					
		rillation, hypertension, need					
		personal care. Her most					
	recent Minimum Da	ata Assessment, dated					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. Bl	UILDING	00	COMPL	LETED	
		155486	B. W	ING		11/05	/2021
NAME OF F	PROVIDER OR SUPPLIEF	₹	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
MIDDLE	TOWN NURSING A	ND REHABILITATION CENTER			ETOWN, IN 47356		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		L LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		she was moderately					
		reported she was depressed, requires extensive					
	1	mobility, transfers, and					
		a walker or wheelchair for					
	_	n and in the facility.					
	,	•					
	In review of abuse	prohibition and prevention					
		inistrator provided a copy of					
	· ·	ecent training, dated 3-19-21.					
		s unable to find a signature for					
		and indicated it has been over					
		acility has documented					
	training for himself	of CNA 4.					
	CNA 4 indicated he	er last abuse prohibition and					
		on was upon hire in March,					
	1 ~	er such education since.					
	CNA 4 indicated sh	ne was aware of the need to					
	report any abuse all	legations as soon as possible,					
	at least within 2 ho	urs.					
l		5 a.m., the Administrator					
	provided a copy of						
		Reporting Allegation of Abuse					
		Verbal and Sexual) And/Or ion and Involuntary					
	_	olicy has a revision date of					
	1	identified as the current					
		ne facility. This policy					
		policy of Middletown					
		ilitation Center to ensure					
	1	be free from verbal, sexual,					
	1 * *	abuse, corporal punishment					
	-	elusionthe facility will					
	thoroughly investigate all allegations of						
		ment the results of such					
	_	ng the investigation, the					
		t further potential abuse while					
	me investigation is	in progress by suspension of					

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STATEMEN	T OF DEFICIENCIES	F DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE :	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155486	B. W	NG		11/05/	2021
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
MIDDLET		ND DELIABII ITATION CENTED		131 S 1	ETOWN, IN 47356		
MIDDLE	IOWN NURSING A	ND REHABILITATION CENTER		MIDDLE	=1 OVVIN, IN 47356		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
	the alleged perpetra	tor while the investigation is					
	completed [sic]Ph	ysical Abuse. Includes, but					
	is not limited to hitt	ing, slapping, kicking,					
	pinching, etc. It all	includes controlling behavior					
	through corporal pu	nishment. Report. Any					
	allegations of physi	cal abuse should be reported					
	to the charge nurse,	Administrator, Designee and					
	Director of Nursing	IMMEDIATELYNotify.					
	A. The State licensi	ng/certification agency					
	responsible for surv	eying/licensing the facility					
	immediately, but no	later than two (2) hours. B.					
	The Resident's Repr	resentative. C. The Resident's					
	Attending Physician	n. D. The Facility Medical					
	Director. Incident I	Report. An incident report is					
	completed and as in	ternal investigation is					
	initiated immediate	y; the investigation will					
	include interview w	ith residents, staff and family					
	members, observati	ons and record reviews as					
	appropriate to ensur	re a complete, accurate and					
	thorough investigat	ionFollow-Up. A thorough					
	investigation will be	e completed within 5 days and					
	the results of their is	nvestigation will be					
	submitted electronic	cally or faxed to the Indiana					
	State Department of	f Health by or on the 5th					
	dayTraining. All	employees will be in-serviced					
	upon hire and yearl	y thereafter on interventions					
	dealing withprope	r procedures on reporting any					
	suspected abusive s						
	occurReporting.	Names and telephone					
	numbers of agencie	s to contact for reasonable					
	-	including abuse with be					
	posted in conspicuo	us areas throughout the					
	building as covered	in the elder justice act. All					
		antiated incidents will be					
	_	ly to the proper licensing					
	Board by the Admir	nistrator or D.O.N"					
	This Federal tag rel	ates to Complaint					
	IN00365590.						
			1				

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION		B. WING	00	
		155486			11/05/2021
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
MIDDLET		ND DELIABILITATION OFNITED		IOTH ST	
MIDDLE	OWN NURSING A	ND REHABILITATION CENTER	MIDDL	ETOWN, IN 47356	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	3.1-28(a)				
	3.1-28(c)				
	3.1-28(e)				
F 0609	483.12(c)(1)(4)				
SS=D	Reporting of Alleg	ed Violations			
Bldg. 00	§483.12(c) In resp	onse to allegations of			
	abuse, neglect, ex	ploitation, or mistreatment,			
	the facility must:				
	- ',','	ure that all alleged			
	violations involving	g abuse, neglect, treatment, including injuries			
	•	e and misappropriation of			
		are reported immediately,			
		2 hours after the allegation			
	is made, if the eve	_			
	allegation involve	abuse or result in serious			
	bodily injury, or no	t later than 24 hours if the			
		the allegation do not involve			
		result in serious bodily			
		nistrator of the facility and			
	· ·	ncluding to the State ad adult protective services			
		rovides for jurisdiction in			
	·	ilities) in accordance with			
	-	established procedures.			
	J	·			
		ort the results of all			
	-	ne administrator or his or			
		presentative and to other			
		ance with State law,			
	_	ate Survey Agency, within			
		the incident, and if the sverified appropriate			
	corrective action n				
		and record review, the	F 0609	WHAT CORRECTIVE ACTION	11/19/2021
		ure an allegation of abuse		WILL BE ACCOMPLISHED FO	11/1//2021
	_	ported to the Administrator		THOSE RESIDENTS FOUND	то
	and then failed to re	port the allegation of abuse		HAVE BEEN AFFECTED BY	
			I	1	

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Event ID:

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		155486	B. WI			11/05/	
		100 100		_		1 17007	2021
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					0TH ST		
MIDDLE	TOWN NURSING A	ND REHABILITATION CENTER		MIDDLE	ETOWN, IN 47356		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	VIE.	DATE
	to the Indiana Depa	rtment of Health within two			THE DEFICIENT PRACTICE:		
	hours of the allegat	ion being made for 1 of 3			All allegations of abuse, of an	y	
	residents reviewed for allegations of abuse.				type, be substantiated or		
	(Resident B)				unsubstantiated by other sour	ces,	
					will be reported immediately to	o the	
	Findings include:				Administrator, DON, resident's	S	
					physician/medical director, an	d	
	In an interview on 1	11-4-21 at 1:43 p.m., with the			an investigation will commend	е	
	interim Director of	Nursing (DON) she indicated			immediately. All allegations of	:	
	when she arrived to	work on 10-21-21 at			abuse will be reported to IDOI	Н	
	approximately 8:00	a.m., she found a			within 2 hours. The Administra	ator	
	hand-written note in	n a plastic caddy, located on			will be responsible for monitor	ing.	
	the door of the DON's door, along with a variety				HOW OTHER RESIDENTS		
	of other paperwork	. She estimated she found the			HAVING THE POTENTIAL TO)	
	note at approximate	ely 8:15 a.m., from CNA 4, a			BE AFFECTED BY THE SAM	E	
	day shift aide, regar	rding Resident B. The note			DEFICIENT PRACTICE WILL	BE	
	included, but was n	ot limited to, "[Name of			IDENTIFIED AND WHAT		
	Resident B] stated t	the aide that got her out of bed			CORRECTIVE ACTIONS WIL	L	
	was 'rude and rough	1'."			BE TAKEN:		
					All staff were re-educated on		
	In an interview with	n CNA 4 on 11-5-21 at 11:29			investigating and reporting		
	a.m. On 10-21-21 a	round 6:45 a.m., she entered			allegation of abuse (Physical,		
	Resident B's room t	to get her up, as per her usual			Mental, Verbal and Sexual) ar	nd/or	
	routine and asked h	ow she was doing. She			financial exploitation and		
	indicated Resident	B told her "that girl" had			involuntary seclusion and		
	shook her real hard	and yanked her up out of bed.			reviewed the Elder Justice Ac	t.	
		esident B told her it had			The training specifies reportin	•	
	happened about an	hour before this "and it hurt			any allegation of abuse to the		
	and scared her" C	NA 4 indicated she reported			Administrator or DON		
	this to the DON as	soon as she saw her in the			immediately, in order for the		
	building, around 8	or 8:30 a.m. She indicated			responsible party to report su	ch	
	she did write a note	around 7:00 a.m., or 7:30			allegation to IDOH within 2 ho	urs.	
	a.m., and put it in t	he DON's box previously, but			Please see attachment #1.		
	_	DON when she saw her in the			WHAT MEASURES WILL BE		
	building. CNA 4 indicated she was aware of the				PUT INTO PLACE OR WHAT		
	need to report any abuse allegations as soon as				SYSTEMIC CHANGES WILL	BE	
	possible, at least within 2 hours.				MADE TO ENSURE THAT TH	IE	
					DEFICIENT PRACTICE DOES	3	
	In an interview with	n the Administrator on			NOT RECUR:		
	11-4-21 at 10:35 a.i	m., he indicated an incident	1		All allegations of abuse, of an	y	

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Event ID:

4FNB11 Facility ID: 000343

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLI	ETED
		155486	B. WI	ING		11/05/	2021
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹			0TH ST		
MIDDLE	TOWN NURSING A	ND REHABILITATION CENTER			ETOWN, IN 47356		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		curred on 10-21-21.			type, be substantiated or		
		as woken up and confused."			unsubstantiated by other sour		
	He indicated he was out of state when he was				will be reported immediately to		
		the investigation was			Administrator, DON, resident's		
		ed by the time he was			physician/medical director, an		
	notified. I didn't te	ll anyone to report it.			an investigation will commenc		
	0 11 121 122				immediately. All allegations of		
		0 a.m., the Administrator			abuse will be reported to IDO		
	provided a copy of				within 2 hours. The Administra		
	•	int Form." It indicated on			will be responsible for monitor	ing.	
	·	B "believed staff was 'mean			HOW THE CORRECTIVE		
		d a staff member had shaken			ACTIONS WILL BE		
	her awake, estimated time of occurrence was				MONITORED TO ENSURE TH	'E	
	6:00 a.m., on the sa	ime date.			DEFICIENT PRACTICE WILL		
	TE 1' ' 1 1	CD '1 (D ' 1			NOT RECUR, I.E., WHAT		
		of Resident B was reviewed			QUALITY ASSURANCE		
		a.m. Her diagnoses			PROGRAM WILL BE PUT INT	١	
	· ·	ot limited to cerebral			PLACE:		
		orillation, hypertension, need			The corrective actions will be	_	
		personal care. Her most			monitored by the Administrato and DON.	r	
		ata Assessment, dated			BY WHAT DATE THE		
	10-6-21, indicated					DE	
		reported she was depressed, reping, requires extensive			SYSTEMIC CHANGES WILL I	DC	
	-				All staff will be in-serviced by		
		mobility, transfers, and a walker or wheelchair for			Friday, November 19, 2021 or	,	
	_	m and in the facility.			investigating and reporting	'	
	moomity in her roof	m and m the facility.			allegation of abuse (physical,		
	On 11-4-21 at 10-2	5 a.m., the Administrator			mental, verbal and sexual) and	_{d/or}	
	provided a copy of				financial exploitation and	u, 01	
		Reporting Allegation of Abuse			involuntary seclusion. Please	see	
		Verbal and Sexual) And/Or			attachment #2.		
		ion and Involuntary			We respectfully request paper		
	_	olicy has a revision date of			compliance for tag F 609.		
	_	identified as the current					
	·						
	policy utilized by the facility. This policy indicated, "It is the policy of Middletown						
	Nursing and Rehabilitation Center to ensure						
	resident's rights to be free from verbal, sexual,						
	_	abuse, corporal punishment					
	Physical of incital	aoase, corporar panisinnent	1				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		155486	B. WI	NG		11/05/	2021
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L					
MIDDLE		ND DELIABILITATION CENTED			OTH ST		
MIDDLE	IOWN NURSING A	ND REHABILITATION CENTER		MIDDLE	ETOWN, IN 47356		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	F	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	_	DATE
	and involuntary sec	lusionthe facility will					
	thoroughly investig	ate all allegations of					
	violations and docu	ment the results of such					
	investigation. Duri	ng the investigation, the					
	facility will prevent	further potential abuse while					
	the investigation is	in progress by suspension of					
	the alleged perpetra	tor while the investigation is					
	completed [sic]Ph	ysical Abuse. Includes, but					
		ing, slapping, kicking,					
	pinching, etc. It all	includes controlling behavior					
		nishment. Report. Any					
	allegations of physi	cal abuse should be reported					
	to the charge nurse,	Administrator, Designee and					
	Director of Nursing	IMMEDIATELYNotify.					
	-	ng/certification agency					
		reying/licensing the facility					
	-	o later than two (2) hours. B.					
	-	resentative. C. The Resident's					
	-	n. D. The Facility Medical					
		Report. An incident report is					
		iternal investigation is					
	-	ly; the investigation will					
		rith residents, staff and family					
		ons and record reviews as					
	· · · · · · · · · · · · · · · · · · ·	re a complete, accurate and					
	* * *	ionFollow-Up. A thorough					
		e completed within 5 days and					
	_	nvestigation will be					
		cally or faxed to the Indiana					
		f Health by or on the 5th					
	-	employees will be in-serviced					
		y thereafter on interventions					
		er procedures on reporting any					
	suspected abusive s						
	•	Names and telephone					
		s to contact for reasonable					
	_	including abuse with be					
	-	ous areas throughout the					
		in the elder justice act. All					
		antiated incidents will be					
	Totations and saust	minuted incidents will be					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155486		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 11/05/2021				
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 131 S 10TH ST MIDDLETOWN, IN 47356					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	•	ly to the proper licensing nistrator or D.O.N"						
	This Federal tag rel IN00365590.	ates to Complaint						
	3.1-28(a) 3.1-28(c) 3.1-28(e)							
F 0610 SS=D Bldg. 00	§483.12(c) In resp	nt/Correct Alleged Violation conse to allegations of eploitation, or mistreatment,						
	- ' ' ' '	re evidence that all alleged oughly investigated.						
	abuse, neglect, ex	vent further potential ploitation, or mistreatment ation is in progress.						
	investigations to the her designated reposition officials in accordation including to the St working days of	oort the results of all ne administrator or his or oresentative and to other ance with State law, ate Survey Agency, within the incident, and if the severified appropriate nust be taken.						
	facility failed to ens was completely inv	and record review, the sure an allegation of abuse estigated for 1 of 3 residents tions of abuse. (Resident B)	F 0610	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:	OR IIIIII			
		1-4-21 at 1:43 p.m., with the Nursing (DON) she indicated		All allegations of abuse, of any type, be substantiated or unsubstantiated by other sour will be reported immediately to	ces,			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155486		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/05/2021		
	F PROVIDER OR SUPPLIEI ETOWN NURSING A	ND REHABILITATION CENTER		131 S 1	ADDRESS, CITY, STATE, ZIP CODE 0TH ST ETOWN, IN 47356		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	when she arrived to approximately 8:00 hand-written note in the door of the DOI of other paperwork note at approximated day shift aide, regal included, but was in Resident B] stated was 'rude and rough "immediately went out what was going Resident B] had toll up that the aide that was rough and rude immediately sough go with her to speal indicated in interviol learned Resident B her up. The DON in Resident B what has shaken awake and I smacked the aide's she felt safe her and The DON indicated assessment with the concerns. She india B's daughter of the she did speak with the DON when she B, she "very gentle upper arms, definition soon as Resident B she stopped and go with [name of LPN and got her and told at her and would she LPN 5] said that with the DOI said that with the DOI said that with the DOI said that with [name of LPN] and got her and told at her and would she LPN 5] said that with the DOI said that with the DOI said that with [name of LPN] and got her and told at her and would she LPN 5] said that with the DOI said that with the DOI said that with [name of LPN] and got her and told at her and would she LPN 5] said that with the DOI said that with [name of LPN] and got her and told at her and would she LPN 5] said that with the DOI said that with [name of LPN] and got her and told at her and would she LPN 5] said that with the DOI said that with [name of LPN] and got her and told at her and would she LPN 5] said that with the DOI said the said the said the DOI said the said the DOI said the sa	work on 10-21-21 at		TAG	Administrator, DON, resident's physician/medical director, and an investigation will commence immediately. All allegations of abuse will be reported to IDON within 2 hours. Nursing will be sure to complete all charting of allegations reported to them be residents. The Administrator at DON will be responsible for monitoring. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAMIDEFICIENT PRACTICE WILL IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN: All nursing staff have been re-educated on proper charting. In the event that a resident presents an allegation to the nurse, the nurse will immediate notify and DON and/or Administrator, and then write at thorough progress note. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL IMADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: All allegations of abuse, of any type, be substantiated or unsubstantiated by other sour will be reported immediately to Administrator, DON, resident's physician/medical director, and an investigation will commence immediately. All allegations of immediately.	deed nythe need not be seen no	DATE

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STATEMENT OF DEFICIENCIES >		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		00	COMPL	ETED
155486		155486	B. WING		11/05/2021		
				CED DEET 1	A DDD FOR CUTY OT A TE TIN CODE		-
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
					OTH ST		
MIDDLETOWN NURSING AND REHABILITATION CENTER				MIDDLE	ETOWN, IN 47356		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	and there was no fu	orther issuesthere was no			abuse will be reported to IDOF	1	
	mention of the aide	being rough with her at all. I		within 2 hours. Nursing will be			
	will tell you, a lot o	of this, I did not document, but			sure to complete all charting o	re to complete all charting on	
	will add it as a late	entry to her chart."			allegations reported to them by	y the	
					residents. The Administrator a	nd	
	In an interview with	h CNA 4 on 11-5-21 at 11:29			DON will be responsible for		
	a.m. She indicated	on 10-21-21 around 6:45			monitoring.		
	a.m., she entered R	esident B's room to get her			HOW THE CORRECTIVE		
	up, as per her usual	routine and asked how she			ACTIONS WILL BE		
	was doing. She inc	licated Resident B told her			MONITORED TO ENSURE TH	IE	
	"that girl" had shoo	k her real hard and yanked her			DEFICIENT PRACTICE WILL		
	up out of bed. CNA	A 4 indicated Resident B told			NOT RECUR, I.E., WHAT		
	her it had happened	l about an hour before this "and			QUALITY ASSURANCE		
	it hurt and scared h	er. She was crying when she			PROGRAM WILL BE PUT INT	О	
	was trying to tell me this" CNA 4 indicated she				PLACE:		
	reported this to the DON as soon as she saw her				The corrective actions will be		
	in the building, around 8 or 8:30 a.m. She				monitored by the Administrato	r	
	indicated she did write a note around 7:00 a.m.,				and DON.		
	or 7:30 a.m., and put it in the DON's box				BY WHAT DATE THE		
		speak with the DON when she			SYSTEMIC CHANGES WILL I	BE	
	saw her in the building. In an interview with the Administrator on 11-4-21 at 10:35 a.m., he indicated an incident				COMPLETED:		
					Education and implementation		
					completed on November 19, 2	.021.	
					Administrator and DON		
	with Resident B occurred on 10-21-21.				responsible to ensure continue	ed	
	"Apparently, she was woken up and confused."				compliance.		
	He indicated he was out of state when he was				M/		
	informed of it and the investigation was				We are respectfully requesting		
	essentially completed by the time he was				paper compliance for tag F 61	0.	
	notified.						
	On 11 / 21 of 10.5	0 a.m., the Administrator					
		,					
	provided a copy of a "Resident Grievance/Complaint Form." It indicated on 10-21-21, Resident B "believed staff was 'mean to her." It indicated a staff member had shaken her awake, estimated time of occurrence was 6:00 a.m., on the same date. It indicated Resident B told the Social Services Designee						
	Vesident D foid file	Social Services Designee					

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	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155486		A. BU	(2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/05/2021	
NAME OF PROVIDER OR SUPPLIER MIDDLETOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 131 S 10TH ST MIDDLETOWN, IN 47356					
(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 APPROPRIAL DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	(SSD) the staff men spouse "who was sl SSD's note clarified resident of the faciliduring the night of The clinical record on 11-4-21 at 10:10 included, but was minfarction, atrial fib for assistance with precent Minimum Da 10-6-21, indicated scognitively intact, rhad difficulty in sle assistance with bed toileting, and uses a mobility in her roor On 11-4-21 at 10:25 provided a copy of "Investigating and I (Physical, Mental, VFinancial Exploitati Seclusion." This po 6-5-2013, and was in policy utilized by the indicated, "It is the Nursing and Rehabit resident's rights to be physical or mental a and involuntary secthoroughly investigation. During facility will prevent the investigation is the alleged perpetra completed [sic]Ph.	nber did not awaken her eeping next to her." The the resident's spouse is not a ity and was not in the facility 10-20-21 through 10-21-21. of Resident B was reviewed a.m. Her diagnoses to limited to cerebral rillation, hypertension, need bersonal care. Her most ata Assessment, dated the was moderately eported she was depressed, eping, requires extensive mobility, transfers, and walker or wheelchair for and in the facility. of a.m., the Administrator a policy entitled, Reporting Allegation of Abuse Verbal and Sexual) And/Or						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ì í	ULTIPLE CO JILDING	NSTRUCTION	(X3) DATE : COMPL			
155486		B. W		00	11/05/			
100400			D			11/03/	2021	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
MIDDLETOWN NURSING AND DELIABILITATION OFNITED			131 S 10TH ST					
MIDDLETOWN NURSING AND REHABILITATION CENTER				MIDDLE	ETOWN, IN 47356			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		includes controlling behavior						
	~ .	nishment. Report. Any						
		cal abuse should be reported						
	-	Administrator, Designee and						
	-	IMMEDIATELYNotify.						
		ng/certification agency						
	-	eying/licensing the facility later than two (2) hours. B.						
	•	resentative. C. The Resident's						
	-	n. D. The Facility Medical						
		Report. An incident report is						
		ternal investigation is						
	-	ly; the investigation will						
		ith residents, staff and family						
	members, observati	ons and record reviews as						
	appropriate to ensur	e a complete, accurate and						
	thorough investigat	onFollow-Up. A thorough						
	investigation will be	e completed within 5 days and						
	the results of their is	_						
		cally or faxed to the Indiana						
	-	f Health by or on the 5th						
		employees will be in-serviced						
		y thereafter on interventions						
	dealing withproper procedures on reporting any suspected abusive situations that							
	•							
	occurReporting. Names and telephone numbers of agencies to contact for reasonable							
	_							
	suspicion of crimes including abuse with be posted in conspicuous areas throughout the							
		in the elder justice act. All						
	violations and substantiated incidents will be							
	reported immediately to the proper licensing Board by the Administrator or D.O.N"							
	•							
	This Federal tag rel	ates to Complaint						
	IN00365590.							
	3.1-28(a)							
	3.1-28(c)							
	3.1-28(e)							

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPLETED		
		155486	B. WING			11/05/2021		
NAME OF PROVIDER OR SUPPLIER MIDDLETOWN NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 131 S 10TH ST MIDDLETOWN, IN 47356				
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
							1	

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