DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155486	A. BUILDING 00 B. WING	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDDLETOWN NURSING AND REHABILITATION CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00365590. Complaint IN00365590 - Substantiated. Federal/state deficiencies related to the allegations are cited at F607, F609 and F610. Survey dates: November 4 and 5, 2021 Facility number: 000343 Provider number: 155486 AIM number: 100289600 Census Bed Type: SNF/NF: 15 Total: 15 Census Payor Type: Medicare: 4 Medicaid: 5 Other: 6 Total: 15 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on November 12, 2021	F 0000	This plan of correction is submitted to serve as a credible allegation of compliance in association with stated completion dates. Preparation and/or execution of this plan of correction does not constitute an admission or agreement, the provider of conclusion set facts on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by state and federal law.	
F 0607 SS=D Bldg. 00	483.12(b)(1)-(3) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and			

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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	misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, Based on interview and record review, the facility failed to implement their policies and procedures related to not immediately reporting an allegation of staff to resident abuse to the Administrator, not reporting an allegation of staff to resident abuse to the Indiana Department of Health's IDOH) Long-Term Care (LTC) Division for 1 of 3 residents reviewed for abuse and failed to ensure 2 of 4 staff members reviewed for abuse prohibition and prevention education had this education in the last 12 months. (Resident B, Administrator, CNA 4) Findings include: In an interview on 11-4-21 at 1:43 p.m., with the interim Director of Nursing (DON) indicated when she arrived to work on 10-21-21 at approximately 8:00 a.m., she found a hand-written note in a plastic caddy, located on the door of the DON's door, along with a variety of other paperwork. She estimated she found the note at approximately 8:15 a.m., from CNA 4, a day shift aide, regarding Resident B. The note included, but was not limited to, "[Name of Resident B] stated the aide that got her out of bed was 'rude and rough'." The DON indicated she "immediately went to look for the aide to find out what was going on...She told me that [name of Resident B] had told her when she went to get her up that the aide that woke her up that morning was rough and rude." She immediately sought the	F 0607	**WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** All allegations of abuse, of any type, be substantiated or unsubstantiated by other sources, will be reported immediately to the Administrator, DON, resident's physician/medical director, and an investigation will commence immediately. All alert and oriented residents will be interviewed as well as all visitors and staff present at the time of the incident. Also the responsible party/family member of the resident will be interviewed. This process will be completed by members of the administrative team; i.e., Administrator, DON, ADON, MDS coordinator, and social services. The Administrator will be responsible for monitoring. **HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:**	11/19/2021

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	assistance of the SSD to go with her to speak to Resident B. She indicated in interview with Resident B, they learned Resident B was shaken "real hard to wake her up, but did not understand why the aide didn't wake up [name of Resident B's spouse]. To be honest, at the time, I did not have any feeling whatsoever of her alleging any concerns about possible abuse. In an interview with CNA 4 on 11-5-21 at 11:29 a.m. She indicated on 10-21-21 around 6:45 a.m., she entered Resident B's room to get her up, as per her usual routine and asked how she was doing. Resident B told her "that girl" had shook her real hard and yanked her up out of bed. CNA 4 indicated Resident B told her it had happened about an hour before this "and it hurt and scared her. CNA 4 indicated she reported this to the DON as soon as she saw her in the building, around 8 or 8:30 a.m. She indicated she did write a note around 7:00 a.m., or 7:30 a.m., and put it in the DON's box previously, but did speak with the DON when she saw her in the building. In an interview with the Administrator on 11-4-21 at 10:35 a.m., he indicated an incident with Resident B occurred on 10-21-21. "Apparently, she was woken up and confused." He indicated he was out of state when he was informed of it and the investigation was essentially completed by the time he was notified. I didn't tell anyone to report it. In an interview on 11-4-21 at 11:25 a.m., with the SSD, she indicated the DON told her Resident B had told an aide she had been treated rough by a staff member. She indicated she and the DON notified the Administrator of the incident, but was not aware if the incident was or		All staff were re-educated on investigating and reporting allegation of abuse (Physical, Mental, Verbal and Sexual) and/or financial exploitation and involuntary seclusion and reviewed the Elder Justice Act. The training specifies reporting any allegation of abuse to the Administrator or DON immediately, in order for the responsible party to report such allegation to IDOH within 2 hours. Please see attachment #1 and #3. **WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:** All allegations of abuse, of any type, be substantiated or unsubstantiated by other sources, will be reported immediately to the Administrator, DON, resident’s physician/medical director, and an investigation will commence immediately. All alert and oriented residents will be interviewed as well as all visitors and staff present at the time of the incident. Also the responsible party/family member of the resident will be interviewed. This process will be completed by members of the administrative team; i.e., Administrator, DON, ADON, MDS coordinator, and social services. The Administrator will be responsible for monitoring.	

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	was not reported to the state as an allegation of abuse. "It was pretty evident at the time that she was somewhat confused. I did a BIMS [Brief Interview of Mental Status] on her that day and it was an 8 [indicating moderate cognitive impairment]. I noticed her BIMS scores have fluctuated since she has been here...has had some problems with being delusional and confused." She indicated she was not aware of the timing of the actual alleged event or the persons involved with the allegation. On 11-4-21 at 10:50 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. In an interview on 11-5-21 at 1:10 p.m., with Resident B's spouse, he indicated he was aware of the the allegations of abuse towards staff by his spouse. He indicated, "I wanted you to know that my wife has had trouble telling what's real and what's not. She had told me about somebody shaking her and I have found no evidence to suggest that she has been treated anything other than wonderful here. He added since her stroke, Resident B has had similar statements that have no basis in truth, "She just comes up with these things and it seemed to happen overnight since her stroke." The clinical record of Resident B was reviewed on 11-4-21 at 10:10 a.m. Her diagnoses included, but was not limited to cerebral infarction, atrial fibrillation, hypertension, need for assistance with personal care. Her most recent Minimum Data Assessment, dated		**HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:** The corrective actions will be monitored by the Administrator and DON. **BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED:** All staff will be in-serviced by Friday, November 19, 2021 on investigating and reporting allegation of abuse (physical, mental, verbal and sexual) and/or financial exploitation and involuntary seclusion. Please see attachment #2. We respectfully request paper compliance for tag F 607.	

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	10-6-21, indicated she was moderately cognitively intact, reported she was depressed, had difficulty in sleeping, requires extensive assistance with bed mobility, transfers, and toileting, and uses a walker or wheelchair for mobility in her room and in the facility. In review of abuse prohibition and prevention education, the Administrator provided a copy of the facility's most recent training, dated 3-19-21. He indicated he was unable to find a signature for himself or CNA 4 and indicated it has been over one year since the facility has documented training for himself or CNA 4. CNA 4 indicated her last abuse prohibition and prevention education was upon hire in March, 2020, with no further such education since. CNA 4 indicated she was aware of the need to report any abuse allegations as soon as possible, at least within 2 hours. On 11-4-21 at 10:25 a.m., the Administrator provided a copy of a policy entitled, "Investigating and Reporting Allegation of Abuse (Physical, Mental, Verbal and Sexual) And/Or Financial Exploitation and Involuntary Seclusion." This policy has a revision date of 6-5-2013, and was 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, physical or mental abuse, corporal punishment and involuntary seclusion...the facility will thoroughly investigate all allegations of violations and document the results of such investigation. During the investigation, the facility will prevent further potential abuse while the investigation is in progress by suspension of			

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	the alleged perpetrator while the investigation is completed [sic]...Physical Abuse. Includes, but is not limited to hitting, slapping, kicking, pinching, etc. It all includes controlling behavior through corporal punishment. Report. Any allegations of physical abuse should be reported to the charge nurse, Administrator, Designee and Director of Nursing IMMEDIATELY...Notify. A. The State licensing/certification agency responsible for surveying/licensing the facility immediately, but no later than two (2) hours. B. The Resident's Representative. C. The Resident's Attending Physician. D. The Facility Medical Director. Incident Report. An incident report is completed and as internal investigation is initiated immediately; the investigation will include interview with residents, staff and family members, observations and record reviews as appropriate to ensure a complete, accurate and thorough investigation...Follow-Up. A thorough investigation will be completed within 5 days and the results of their investigation will be submitted electronically or faxed to the Indiana State Department of Health by or on the 5th day...Training. All employees will be in-serviced upon hire and yearly thereafter on interventions dealing with...proper procedures on reporting any suspected abusive situations that occur...Reporting. Names and telephone numbers of agencies to contact for reasonable suspicion of crimes including abuse with be posted in conspicuous areas throughout the building as covered 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 relates to Complaint IN00365590.			

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	3.1-28(a) 3.1-28(c) 3.1-28(e)			
F 0609 SS=D Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(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 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. §483.12(c)(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 interview and record review, the facility failed to ensure an allegation of abuse was immediately reported to the Administrator and then failed to report the allegation of abuse	F 0609	**WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY**	11/19/2021

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	to the Indiana Department of Health within two hours of the allegation being made for 1 of 3 residents reviewed for allegations of abuse. (Resident B) Findings include: In an interview on 11-4-21 at 1:43 p.m., with the interim Director of Nursing (DON) she indicated when she arrived to work on 10-21-21 at approximately 8:00 a.m., she found a hand-written note in a plastic caddy, located on the door of the DON's door, along with a variety of other paperwork. She estimated she found the note at approximately 8:15 a.m., from CNA 4, a day shift aide, regarding Resident B. The note included, but was not limited to, "[Name of Resident B] stated the aide that got her out of bed was 'rude and rough'." In an interview with CNA 4 on 11-5-21 at 11:29 a.m. On 10-21-21 around 6:45 a.m., she entered Resident B's room to get her up, as per her usual routine and asked how she was doing. She indicated Resident B told her "that girl" had shook her real hard and yanked her up out of bed. CNA 4 indicated Resident B told her it had happened about an hour before this "and it hurt and scared her..." CNA 4 indicated she reported this to the DON as soon as she saw her in the building, around 8 or 8:30 a.m. She indicated she did write a note around 7:00 a.m., or 7:30 a.m., and put it in the DON's box previously, but did speak with the DON when she saw her in the building. CNA 4 indicated she was aware of the need to report any abuse allegations as soon as possible, at least within 2 hours. In an interview with the Administrator on 11-4-21 at 10:35 a.m., he indicated an incident		**THE DEFICIENT PRACTICE:** All allegations of abuse, of any type, be substantiated or unsubstantiated by other sources, will be reported immediately to the Administrator, DON, resident's physician/medical director, and an investigation will commence immediately. All allegations of abuse will be reported to IDOH within 2 hours. The Administrator will be responsible for monitoring. **HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:** All staff were re-educated on investigating and reporting allegation of abuse (Physical, Mental, Verbal and Sexual) and/or financial exploitation and involuntary seclusion and reviewed the Elder Justice Act. The training specifies reporting any allegation of abuse to the Administrator or DON immediately, in order for the responsible party to report such allegation to IDOH within 2 hours. Please see attachment #1. **WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:** All allegations of abuse, of any	

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	with Resident B occurred on 10-21-21. "Apparently, she was woken up and confused." He indicated he was out of state when he was informed of it and the investigation was essentially completed by the time he was notified. I didn't tell anyone to report it. On 11-4-21 at 10:50 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. The clinical record of Resident B was reviewed on 11-4-21 at 10:10 a.m. Her diagnoses included, but was not limited to cerebral infarction, atrial fibrillation, hypertension, need for assistance with personal care. Her most recent Minimum Data Assessment, dated 10-6-21, indicated she was moderately cognitively intact, reported she was depressed, had difficulty in sleeping, requires extensive assistance with bed mobility, transfers, and toileting, and uses a walker or wheelchair for mobility in her room and in the facility. On 11-4-21 at 10:25 a.m., the Administrator provided a copy of a policy entitled, "Investigating and Reporting Allegation of Abuse (Physical, Mental, Verbal and Sexual) And/Or Financial Exploitation and Involuntary Seclusion." This policy has a revision date of 6-5-2013, and was 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, physical or mental abuse, corporal punishment		type, be substantiated or unsubstantiated by other sources, will be reported immediately to the Administrator, DON, resident's physician/medical director, and an investigation will commence immediately. All allegations of abuse will be reported to IDOH within 2 hours. The Administrator will be responsible for monitoring. **HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:** The corrective actions will be monitored by the Administrator and DON. **BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED:** All staff will be in-serviced by Friday, November 19, 2021 on investigating and reporting allegation of abuse (physical, mental, verbal and sexual) and/or financial exploitation and involuntary seclusion. Please see attachment #2. We respectfully request paper compliance for tag F 609.	

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	and involuntary seclusion...the facility will thoroughly investigate all allegations of violations and document the results of such investigation. During the investigation, the facility will prevent further potential abuse while the investigation is in progress by suspension of the alleged perpetrator while the investigation is completed [sic]...Physical Abuse. Includes, but is not limited to hitting, slapping, kicking, pinching, etc. It all includes controlling behavior through corporal punishment. Report. Any allegations of physical abuse should be reported to the charge nurse, Administrator, Designee and Director of Nursing IMMEDIATELY...Notify. A. The State licensing/certification agency responsible for surveying/licensing the facility immediately, but no later than two (2) hours. B. The Resident's Representative. C. The Resident's Attending Physician. D. The Facility Medical Director. Incident Report. An incident report is completed and as internal investigation is initiated immediately; the investigation will include interview with residents, staff and family members, observations and record reviews as appropriate to ensure a complete, accurate and thorough investigation...Follow-Up. A thorough investigation will be completed within 5 days and the results of their investigation will be submitted electronically or faxed to the Indiana State Department of Health by or on the 5th day...Training. All employees will be in-serviced upon hire and yearly thereafter on interventions dealing with...proper procedures on reporting any suspected abusive situations that occur...Reporting. Names and telephone numbers of agencies to contact for reasonable suspicion of crimes including abuse with be posted in conspicuous areas throughout the building as covered in the elder justice act. All violations and substantiated incidents will be			

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	reported immediately to the proper licensing Board by the Administrator or D.O.N..." This Federal tag relates to Complaint IN00365590. 3.1-28(a) 3.1-28(c) 3.1-28(e)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(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 interview and record review, the facility failed to ensure an allegation of abuse was completely investigated for 1 of 3 residents reviewed for allegations of abuse. (Resident B) Findings include: In an interview on 11-4-21 at 1:43 p.m., with the interim Director of Nursing (DON) she indicated	F 0610	**WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** All allegations of abuse, of any type, be substantiated or unsubstantiated by other sources, will be reported immediately to the	11/19/2021

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(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
	when she arrived to work on 10-21-21 at approximately 8:00 a.m., she found a hand-written note in a plastic caddy, located on the door of the DON's door, along with a variety of other paperwork. She estimated she found the note at approximately 8:15 a.m., from CNA 4, a day shift aide, regarding Resident B. The note included, but was not limited to, "[Name of Resident B] stated the aide that got her out of bed was 'rude and rough'." The DON indicated she "immediately went to look for the aide to find out what was going on...She told me that [name of Resident B] had told her when she went to get her up that the aide that woke her up that morning was rough and rude." She indicated she immediately sought the assistance of the SSD to go with her to speak to Resident B. She indicated in interview with Resident B, they learned Resident B was shaken "real hard to wake her up. The DON indicated she then asked Resident B what happened next, after she was shaken awake and Resident B "responded she smacked the aide's hand. We then asked her if she felt safe her and she responded she felt safe. The DON indicated she did conduct a full body assessment with the SSD present and found no concerns. She indicated she did notify Resident B's daughter of the incident. The DON indicated she did speak with CNA 3. CNA 3 shared with the DON when she went in to wake up Resident B, she "very gentle touched on her shoulder or upper arms, definitely no violent shaking" and as soon as Resident B "started slapping at her hands, she stopped and got the nurse. When I spoke with [name of LPN 5], she said the aide had come and got her and told her the resident was slapping at her and would she go and help her. [Name of LPN 5] said that when she and the aide went in to get her cleaned up, the resident was cooperative		Administrator, DON, resident's physician/medical director, and an investigation will commence immediately. All allegations of abuse will be reported to IDOH within 2 hours. Nursing will be sure to complete all charting on allegations reported to them by the residents. The Administrator and DON will be responsible for monitoring. **HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE 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 immediately notify and DON and/or Administrator, and then write a thorough progress note. **WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:** All allegations of abuse, of any type, be substantiated or unsubstantiated by other sources, will be reported immediately to the Administrator, DON, resident's physician/medical director, and an investigation will commence immediately. All allegations of	

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	155486	A. BUILDING 00 B. WING	11/05/2021

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	and there was no further issues...there was no mention of the aide being rough with her at all. I will tell you, a lot of this, I did not document, but will add it as a late entry to her chart." In an interview with CNA 4 on 11-5-21 at 11:29 a.m. She indicated on 10-21-21 around 6:45 a.m., she entered Resident B's room to get her up, as per her usual routine and asked how she was doing. She indicated Resident B told her "that girl" had shook her real hard and yanked her up out of bed. CNA 4 indicated Resident B told her it had happened about an hour before this "and it hurt and scared her. She was crying when she was trying to tell me this. ." CNA 4 indicated she reported this to the DON as soon as she saw her in the building, around 8 or 8:30 a.m. She indicated she did write a note around 7:00 a.m., or 7:30 a.m., and put it in the DON's box previously, but did speak with the DON when she saw her in the building. In an interview with the Administrator on 11-4-21 at 10:35 a.m., he indicated an incident with Resident B occurred on 10-21-21. "Apparently, she was woken up and confused." He indicated he was out of state when he was informed of it and the investigation was essentially completed by the time he was notified. On 11-4-21 at 10:50 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		abuse will be reported to IDOH within 2 hours. Nursing will be sure to complete all charting on allegations reported to them by the residents. The Administrator and DON will be responsible for monitoring. **HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:** The corrective actions will be monitored by the Administrator and DON. **BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED:** Education and implementation completed on November 19, 2021. Administrator and DON responsible to ensure continued compliance. We are respectfully requesting paper compliance for tag F 610.	

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	(SSD) the staff member did not awaken her spouse "who was sleeping next to her." The SSD's note clarified the resident's spouse is not a resident of the facility and was not in the facility during the night of 10-20-21 through 10-21-21. The clinical record of Resident B was reviewed on 11-4-21 at 10:10 a.m. Her diagnoses included, but was not limited to cerebral infarction, atrial fibrillation, hypertension, need for assistance with personal care. Her most recent Minimum Data Assessment, dated 10-6-21, indicated she was moderately cognitively intact, reported she was depressed, had difficulty in sleeping, requires extensive assistance with bed mobility, transfers, and toileting, and uses a walker or wheelchair for mobility in her room and in the facility. On 11-4-21 at 10:25 a.m., the Administrator provided a copy of a policy entitled, "Investigating and Reporting Allegation of Abuse (Physical, Mental, Verbal and Sexual) And/Or Financial Exploitation and Involuntary Seclusion." This policy has a revision date of 6-5-2013, and was 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, physical or mental abuse, corporal punishment and involuntary seclusion...the facility will thoroughly investigate all allegations of violations and document the results of such investigation. During the investigation, the facility will prevent further potential abuse while the investigation is in progress by suspension of the alleged perpetrator while the investigation is completed [sic]...Physical Abuse. Includes, but is not limited to hitting, slapping, kicking,			

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	pinching, etc. It all includes controlling behavior through corporal punishment. Report. Any allegations of physical abuse should be reported to the charge nurse, Administrator, Designee and Director of Nursing IMMEDIATELY...Notify. A. The State licensing/certification agency responsible for surveying/licensing the facility immediately, but no later than two (2) hours. B. The Resident's Representative. C. The Resident's Attending Physician. D. The Facility Medical Director. Incident Report. An incident report is completed and as internal investigation is initiated immediately; the investigation will include interview with residents, staff and family members, observations and record reviews as appropriate to ensure a complete, accurate and thorough investigation...Follow-Up. A thorough investigation will be completed within 5 days and the results of their investigation will be submitted electronically or faxed to the Indiana State Department of Health by or on the 5th day...Training. All employees will be in-serviced upon hire and yearly thereafter on interventions dealing with...proper procedures on reporting any suspected abusive situations that occur...Reporting. Names and telephone numbers of agencies to contact for reasonable suspicion of crimes including abuse with be posted in conspicuous areas throughout the building as covered 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 relates to Complaint IN00365590. 3.1-28(a) 3.1-28(c) 3.1-28(e)			

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