STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155672		06/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TR NEW CARLISLE, IN 46552

(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 survey was for the Investigation of Complaint IN00174861. Complaint IN00174861 - Substantiated. Federal/State deficiencies related to the allegation are cited at F223, F225 & F226. Survey date: June 29, 2015 Facility number: 000427 Provider number: 155672 AIM umber: 100275150 Census bed type: SNF/NF: 79 Residential: 80 Total: 159 Census payor type: Medicare: 9 Medicaid: 53 Other: 17 Total: 79 Sample: 3 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Neither the signing nor the submission of this plan shall constitute an admission of any deficency of any fact or conclusion set forth in the statement of deficiencies. The plan of correction is being submitted in good faith by the facility bcause it is reqiried by law. The facility reserves the right to contest the statement of deficiencies.	

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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F 0223 SS=G Bldg. 00	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review, observations and interviews, the facility failed to ensure a resident with dementia was free from physical and verbal abuse by CNA #5, for 1 of 3 residents reviewed for allegations of abuse. CNA #5 cursed at and forcefully pushed Resident "B" up against a wall. Finding includes: On 06/29/15 at 9:45 a.m., the Administrator provided a copy of the facility's investigation of physical and verbal abuse by CNA #5 to Resident "B" which occurred on 04/17/15 at approximately 5:05 p.m. On 06/29/15 at 9:50 a.m., during the initial tour, accompanied by the DNS (Director Nursing Services), Resident "B" was standing in his private room, talking on the phone, and smiled pleasantly and waved to the staff member. The DNS indicated the resident	F 0223	F 223 It is Hamilton Grove's policy and procedure to assure that all credible allegations of abuse violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. No residents were injured by this alleged deficiency. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** For Resident B sufficient time has	07/29/2015

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	had no recall of the 4/17/15 incident immediately following the occurrence and had not demonstrated any adverse effects since the occurrence. The DNS indicated "a CNA" had witnessed the tail end of the event and reported it to her. The DNS indicated the other residents in the common area during the incident, were not reliable witnesses due to cognitive status and she did not believe it was to the degree of abuse until the full investigation, including viewing a video of the event, was completed. The DNS had not reported the incident to the Administrator prior to the 05/19/15 Stand-up meeting. On 06/29/15 at 10:10 a.m., the Administrator indicated the DNS had been aware of an incident but the investigation was not thoroughly done and not reported to him immediately as directed by the facility's Abuse/Neglect Policy & Procedure and postings throughout the building. At the time of the interview, the Administrator provided for viewing a DVD which had recorded the event. The Administrator had in turn shown the recording to the County Sheriff's Department as well as sent to ISDH (Indiana State Department of Health). The video, which did not include audio, indicated CNA #5 physically approaching, handling, and		elapsed which precludes the immediate correction of this alleged deficiency. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;*** All residents at the facility have the potential to be adversely affected by this deficient practice. 1. A thorough investigation was completed on May 19, 2015. CNA #5 was immediately suspended pending the outcome of the investigation. CNA #5 was subsequently terminated on May 26, 2015. 2. Law enforcement authorities were notified on May 19, 2015 of this alleged incident. 3. Abuse/unusual occurrences postings were reposted on all units and in all departments stating "*All allegations of resident abuse, whether resident to resident or staff to resident, needs to be reported* ***directly*** *to the Administrator. Call any time day or night* (574) _ _ _-_ _	

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	moving Resident "B" against a wall. It appeared CNA #5 was verbally interacting with Resident "B." Although several other staff members were noted in the general area, the video did not distinguish what staff members might have observed the incident. It was noted the Unit Nurse, at the time, had entered another resident's room and was not in the area at the time of the incident. The record of Resident "B" was reviewed on 06/29/15 at 10:30 a.m. Resident "B" was admitted to the facility, on 03/31/15, with diagnoses including, but not limited to, diabetes, dementia, depression, and difficult ambulation. Review of a 14 day MDS (Minimum Data Set) Assessment, dated 04/13/15, indicated the resident ambulated with oversight and was not cognitive for interview. On 06/29/15 at 10:45 a.m., the facility's investigation of the 4/17/15 incident of abuse by CNA #5 to Resident "B" was reviewed. The report indicated Resident B sat down behind the nurse ' s station. The CNA tried to get the resident to move, but the resident did not move. A witness said CNA#5 " picked the resident up by the collar and forcefully pushed him against the wall, away from the nurses station and said something to the effect ' you are not f---- coming back		– – ." 4. All staff members were re-inserviced on abuse, neglect and reportable occurrences on June 5 & 6, 2015. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;*** 1. An Abuse/Unusual Occurrence Incident Reporting form will be developed and all staff in-services on completing the abuse reporting form will be scheduled. 2. All staff members have been issued at hiring/orientation badge cards directing staff on procedures for reporting incidents stating: "**IF YOU WITNESS ABUSE** ANY STAFF WHO: Has knowledge or reasonable cause to believe that a Resident is being or has been abused must initial the following course of action: **IMMEDIATELY:** 1. INSURE RESIDENT SAFETY., 2. REPORT TO YOUR IMMEDIATE	

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	here again'." On 05/19/15, the Administrator immediately suspended CNA #5 and the investigation was initiated. The investigation, which included a video via the facility's closed circuit monitoring, resulted in termination of the CNA and arrest by the County Sheriff's Dept. (Department). Review of the Administrative Investigation handwritten statements by staff members working at the time of the incident indicated: 1. CNA #7: A written statement that she observed Resident "B" behind the nurses station and attempted to divert the resident to the common area. CNA #5 then gave "verbal warnings" to Resident "B," "before getting physical & [and] verbally abusive," followed by CNA #5 "grabbed" Resident "B" by the collar before slamming the resident against a wall. 2. LPN #2: A written statement that she was working on a connected unit and was walking by the nearby kitchenette between units when she heard a "loud commotion." LPN #2 indicated she witnessed CNA #5 forcibly pushing Resident "B" up against a wall.		SUPERVISOR, DIR. OF NUSRING AND ADMINISTRATOR **IMMEDIATELY.,** 3. DOCUMENT IN WRITING EXACTLY WHAT YOU WITNESSED/HEARD. INCLUDE DATE, TIME, LOCATION & PERTINENT FACTS. SIGN AND GIVE TO YOUR SUPERVISOR, DIR. OF NURSING OR ADMINISTRATOR." The Administrator/designee will randomly interview at least five (5) staff members per week for the presence of these cards. New ones will be issued as needed. 3. The Director of Nursing/designee will interview at least 15 residents per month to determine whether they have experienced abuse of any type e.g., verbal, physical, sexual, mental, etc. a. The results of these interviews will be submitted to the Quality Assurance Committee for further review and recommendations. b. An immediate investigation will be initiated in the event a resident answers in the affirmative i.e., they have experienced abuse. c. Interviewable residents will be questioned directly. For non-interviewable residents the	

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	3. CNA #5: A written statement: "...My recollection was that (Resident "B" name) gait appear (sic) to be unsteady when I came up to him he pushed on me which in turn caused him to stumble at that point. I helped him into a chair to negate a fall." On 06/29/15 at 9:45 a.m., the Administrator provided the facility's "ABUSE/UNUSUAL OCCURRENCES" Policy & Procedure, dated 06/2012, and indicated it was the one currently used by the facility. The Policy and Procedure indicated the following: "PURPOSE: To establish guidelines for assuring residents are free of all abusive acts and establish guidelines for investigation, resolving, and reporting abuse; as well as recognizing employee burnout, stress, or frustration. POLICY: It is the policy of Hamilton Communities, Inc. to protect residents from all abusive acts and to comply with the state and federal laws and regulations for reporting suspected or actual acts or unusual occurrences... DEFINITIONS: 1. ABUSE: Abuse means - the willful infliction of injury, unreasonable		responsible party will be given the opportunity to reply on their behalf. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** The Administrator/designee will review the results of the Resident/Family interviews to ensure compliance. The results of these interviews will be submitted to the Quality Assurance committee for further review and evaluation. These resident/family interviews will be conducted monthly for the first 90 days then quarterly thereafter or until a 95% threshold is met. - ***Date certain that this will be accomplished by:*** **July 29, 2015**	

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	confinement, intimidation or punishment with resulting physical harm, pain or anguish, or the deprivation by an individual, of goods and services that are necessary to attain or maintain physical, mental, and psychosocial well-being.... Physical Abuse - includes hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through rough corporeal punishment, or restraining without authorization for discipline or convenience. Physical abuse includes: ...2) Staff to resident abuse with or without injury;... Verbal Abuse - refers to any use of oral, written, or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing distance,... Verbal abuse includes: 1) Staff to resident - a single traumatic episode..." This Federal tag relates to Complaint IN00174861. 3.1-27(a)(1) 3.1-27(b)			

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F 0225 SS=D Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).			

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	The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interviews, the facility failed to immediately report an allegation of abuse to the administrator and failed to investigate an incident of staff to resident abuse in a timely manner. This affected 1 of 3 residents in a sample of 3 investigated for allegations of abuse. (Resident "B") Finding includes: On 06/29/15 at 9:45 a.m., the Administrator provided a copy of the facility's investigation of physical and verbal abuse by CNA #5 to Resident "B" which occurred on 04/17/15 at approximately 5:05 p.m. The Administrator indicated he was unaware of the incident until the morning "Stand-up" (morning meeting between	F 0225	F 225 It is Hamilton Grove's policy and procedure to assure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported ***immediately t***o the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). In addition, Hamilton Grove shall have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. No residents were injured by this alleged deficiency. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient***	07/29/2015

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	departments to review issues within the facility) on 05/19/15. The Administrator indicated the DNS (Director of Nursing Services) had been aware of an incident but the investigation was not thoroughly done and not reported to him immediately as directed by the facility's Abuse/Unusual Occurrence Policy & Procedure. On 06/29/15 at 9:50 a.m., the DNS indicated "a CNA" had witnessed the tail end of the event and reported it to her. The DNS indicated the other residents in the common area during the incident, were not reliable witnesses due to cognitive status and she did not believe it was to the degree of abuse until the full investigation, including viewing a video of the event, was completed. The DNS had not reported the incident to the Administrator prior to the 05/19/15 Stand-up. On 06/29/15 at 10:10 a.m., the Administrator provided for viewing a DVD which had recorded the event. The Administrator had in turn shown the recording to the County Sheriff's Department as well as sent to ISDH (Indiana State Department of Health). The video, which did not include audio, indicated CNA #5 physically approaching, handling, and moving		***practice?*** For Resident B sufficient time has elapsed which precludes the immediate correction of this alleged deficiency. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** All residents at the facility have the potential to be adversely affected by this deficient practice. 1. The staff to resident altercation that occurred on April 17, 2015 was reported by the nurse who witnessed it to her supervisor. The Administrator first learned of the event on May 19, 2015 and immediately reported it to the Indiana State Department of Health and to law enforcement authorities. 2. An investigation was immediately launched and concluded with the termination of CNA #5. 3. Abuse/unusual occurrences postings were reposted on all units and in all departments stating "*All allegations of resident abuse, whether resident to resident or staff to resident, needs to be reported **directly** to the Administrator. Call any time day or night (574) _ _ _-_ _ _ _ .*" 1.All staff members were re-inserviced on abuse, neglect and reportable occurrences on June 5 & 6, 2015. ***What measures will be put into place or what systemic changes will be made to***	

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	Resident "B" against a wall. It appeared CNA #5 was verbally interacting with Resident "B." Although several other staff members were noted in the general area, the video did not distinguish what staff members might have observed the incident. It was noted the Unit Nurse, at the time, had entered another resident's room and was not in the area at the time of the incident. The facility's investigation of an occurrence of abuse by CNA #5 to Resident "B" was reviewed on 06/29/15 at 10:45 a.m. and indicated: The Administrator immediately suspended CNA #5 and the investigation was initiated. The investigation, which included a video via the facility's closed circuit monitoring, resulted in termination of the CNA and arrest by the County Sheriff's Dept. (Department). Review of the facility's current "ABUSE/UNUSUAL OCCURRENCES" Policy & Procedure, dated 06/2012 and provided by the Administrator on 06/29/15 at 9:45 a.m., indicated: "PURPOSE: To establish guidelines for assuring residents are free of all abusive acts and establish guidelines for investigation, resolving, and reporting		***ensure that the deficient practice does not recur?*** Director of Nursing/Designee will randomly quiz at least five (5) staff members per week regarding the facility's procedures for timely reporting incidents involving resident abuse. Staff who fail to provide accurate information will be immediately re-inserviced . ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** The Administrator/designee will review the findings of these staff interviews and submit them to the Quality Assurance Committee for further evaluation and recommendations. These staff interviews will be conducted monthly for the first 90 days then quarterly thereafter or until a 95% threshold is met. ***by what date the systemic changes will be completed: July 29, 2015***	

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	abuse; as well as recognizing employee burnout, stress, or frustration. POLICY: It is the policy of Hamilton Communities, Inc. to protect residents from all abusive acts and to comply with the state and federal laws and regulations for reporting suspected or actual acts or unusual occurrences... Reportable occurrences: In the event the resident or another individual makes an allegation, the licensed nurse shall initiate 1. Interventions to safeguard the resident; 2. Report immediately to the Administrator and the Director of Nursing.... This Federal tag relates to Complaint IN00174861. 3.1-28(b)(2)(c)			
F 0226 SS=D Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident			

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	property. Based on record reviews and interviews, the facility failed to implement the facility's Abuse & Neglect Policy & Procedure in regards to immediately notifying the administrator, timely investigation and reporting following an incident of staff (CNA #5) to resident (Resident "B") abuse for 1 of 3 residents in a sample of 3 reviewed for Abuse & Neglect. Finding includes: On 06/29/30 at 9:45 a.m., the Administrator provided a copy of the facility's investigation of an occurrence of abuse by CNA #5 to Resident "B" for review. The Administrator reported the incident, which occurred on 04/17/15 at approximately 5:05 p.m., to ISDH (Indiana State Department of Health) via (by way of) fax on 05/19/15. Interview with the Administrator indicated he was unaware of the incident until the morning "Stand-up" (morning meeting between departments to review issues within the facility) on 05/19/15. The Administrator indicated the DNS had been aware of an incident but the investigation was not thoroughly done nor reported to him as directed by the facility's Abuse &	F 0226	F226 It is Hamilton Grove's policy to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. No residents were injured by this alleged deficiency. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** For Resident B sufficient time has elapsed which precludes the immediate correction of this alleged deficiency. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** All residents at the facility have the potential to be adversely affected by this deficient practice. 1. A thorough investigation was completed on May 19, 2015. CNA #5 was immediately suspended pending the outcome of the investigation. CNA #5 was subsequently terminated on May 26, 2015. 2. Law enforcement authorities were notified on May 19, 2015 of this alleged incident. 3. Abuse/unusual occurrences postings were reposted on all units and in all departments stating "*All allegations of resident abuse, whether resident to resident or staff to resident,*	07/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155672	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/29/2015
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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
	Unusual Occurrence Policy & Procedure as well as postings throughout the building in regards to reporting suspected abuse. On 06/29/15 at 9:50 a.m., the DNS indicated "a CNA" had witnessed the tail end of the event and reported it to her. The DNS indicated the other residents in the common area during the incident, were not reliable witnesses due to cognitive status and she did not believe it was to the degree of abuse until the full investigation, including viewing a video of the event, was completed. The DNS had not reported the incident to the Administrator prior to the 05/19/15 Stand-up. On 06/29/15 at 10:10 a.m., the Administrator provided for viewing a DVD which had recorded the event. The Administrator had in turn shown the recording to the County Sheriff's Department as well as sent to ISDH (Indiana State Department of Health). The video, which did not include audio, indicated CNA #5 physically approaching, handling, and moving Resident "B" against a wall. It appeared CNA #5 was verbally interacting with Resident "B." Although several other staff members were noted in the general area, the video did not distinguish what		*needs to be reported **directly** to the Administrator. Call any time day or night (574) _ _ _-_ _* 4. All staff members were re-inserviced on abuse, neglect and reportable occurrences on June 5 & 6, 2015. As well as the timely reporting of such incidents to the Indiana State Department of Health. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** The Director of Nursing/designee will manually record/compile a list of reportable episodes noting the time the incident occurred, the time it was reported to the Administrator and the time of the initial/follow-up report to assure timely investigations and notifications. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** The Administrator/designee will review and assess the compiled report for accuracy and timely notification and submit the results to the Quality Assurance Committee for further evaluation and recommendations. These reviews will be conducted monthly for the first 90 days then quarterly thereafter or until a 95% threshold is met. ***Date certain that this will be accomplished by: July 29, 2015***	

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	staff members might have observed the incident. It was noted the Unit Nurse, at the time, had entered another resident's room and was not in the area at the time of the incident. The facility's investigation of an occurrence of abuse by CNA #5 to Resident "B" was reviewed on 06/29/15 at 10:45 a.m. and indicated: The Administrator immediately suspended CNA #5 and the investigation was initiated. The investigation, which included a video via the facility's closed circuit monitoring, resulted in termination of the CNA and arrest by the County Sheriff's Dept. (Department). Review of the facility's current "ABUSE/UNUSUAL OCCURRENCES" Policy & Procedure, dated 06/2012 and provided by the Administrator on 06/29/15 at 9:45 a.m., indicated: "PURPOSE: To establish guidelines for assuring residents are free of all abusive acts and establish guidelines for investigation, resolving, and reporting abuse; as well as recognizing employee burnout, stress, or frustration. POLICY: It is the policy of Hamilton Communities, Inc. to protect residents			

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	from all abusive acts and to comply with the state and federal laws and regulations for reporting suspected or actual acts or unusual occurrences... DEFINITIONS: 1. ABUSE: Abuse means - the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or anguish, or the deprivation by an individual, of goods and services that are necessary to attain or maintain physical, mental, and psychosocial well-being.... Physical Abuse - includes hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through rough corporeal punishment, or restraining without authorization for discipline or convenience. Physical abuse includes: ...2) Staff to resident abuse with or without injury;... Verbal Abuse - refers to any use of oral, written, or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing distance, ... Verbal abuse includes: 1) Staff to resident - a single traumatic episode...			

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	Reportable occurrences: In the event the resident or another individual makes an allegation, the licensed nurse shall initiate 1. Interventions to safeguard the resident; 2. Report immediately to the Administrator and the Director of Nursing.... All reportable unusual occurrences, including reports of suspected or known abuse shall be reported immediately and note to exceed 24 hours to the Indiana State Department of Health...." This Federal tag relates to Complaint IN00174861. 3.1-28(a)			