STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAPTERS LIVING OF GREENSBURG	1034 CROWN POINTE BLVD, GREENSBURG, , 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00374717. Complaint IN00374717 - Substantiated. State Residential Findings related to the allegations are cited at R0052. Survey date: March 21, 2022 Facility number: 011914 Residential Census: 24 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on March 30, 2022.	R 0000	Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under state law. Please accept this Plan of Correction as our credible allegation of compliance. LPN #4 was relieved from her duties upon witness of the incident. Following investigation, she was terminated, the incident reported to IDOH, and a Consumer Report filed with the Office of the Attorney General as to her unprofessional conduct exhibited toward a resident. Resident B has continued to be monitored as to psycho-social needs and exhibits no further concern, as the nurse has been terminated from employment. As all residents could be affected, all residents have been interviewed as to staff interactions and the necessity to immediately report any allegation of abuse to staff on duty.	

			No other concerns were identified. As a means to ensure ongoing compliance, abuse inservice training was conducted with staff, reviewing the facility policy of abuse prohibition, immediate staff intervention should abuse be witnessed or reported, and immediate reporting to administration. As a means of quality assurance, the Administrator will meet with each resident on an, at least, weekly basis ongoing, inquiring of staff-to-resident interactions, concerns, conducting investigation, and taking any necessary actions accordingly. Staff will continue to receive training regarding abuse prohibition during initial orientation and periodically thereafter.	
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record	R 0052	Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under state law. Please accept this Plan of Correction as our credible allegation of compliance. LPN #4 was relieved from her duties upon witness of the incident. Following investigation, she was terminated, the incident reported to IDOH, and a Consumer Report filed with the Office of the Attorney	04/06/2022

	review, the facility failed to ensure staff to resident verbal abuse did not occur for 1 of 4 residents reviewed for Abuse. (Residents B) Findings include: During an interview on 3/21/22 at 9:39 p.m., Resident B indicated one staff member (LPN [licensed practical nurse] 4) was mean to her and was yelling at her when she tried to talk to her about why she did not like her. The facility took care of the situation and the LPN was no long working at the facility. The LPN had been very "hatefully" and talked abut her behind her back. The clinical record for Resident B was reviewed on 3/21/22 at 10:14 p.m. The resident's diagnoses included, but were not limited to, cerebral infarction, COPD, Type 2 diabetes, anxiety, insomnia, and depression. The resident's cognition was alert and oriented. During an interview on 3/21/22 at 9:48 p.m., Resident C indicated LPN 4 was mean in the dining room to Resident B.. The LPN acted like she was mad at the world and was screaming at the resident. During an interview on 3/21/22 at 10:48 p.m., the Administrator in training indicated she arrived to the facility due to a kitchen		General as to her unprofessional conduct exhibited toward a resident. Resident B has continued to be monitored as to psycho-social needs and exhibits no further concern, as the nurse has been terminated from employment. As all residents could be affected, all residents have been interviewed as to staff interactions and the necessity to immediately report any allegation of abuse to staff on duty. No other concerns were identified. As a means to ensure ongoing compliance, abuse inservice training was conducted with staff, reviewing the facility policy of abuse prohibition, immediate staff intervention should abuse be witnessed or reported, and immediate reporting to administration. As a means of quality assurance, the Administrator will meet with each resident on an, at least, weekly basis ongoing, inquiring of staff-to-resident interactions, concerns, conducting investigation, and taking any necessary actions accordingly. Staff will continue to receive training regarding abuse prohibition during initial orientation and periodically thereafter.	

issue and over heard screaming as she came in the front door. The LPN 4 and Resident B were yelling back and forth. She removed the staff member away from the resident. The resident was assessed and comforted.

The incident report, dated 3/4/22 at 9:30 p.m., indicated a staff member was over heard screaming at Resident B and the resident was observed to be crying.

The current facility policy, titled "Abuse Prohibition", dated September 2017. The policy indicated, "The facility shall prohibit and prevent abuse...Verbal Abuse-Oral,written and/or gestured language that willfully includes disparaging and/or derogatory terms to residents..."

This State tag relates to Complaint IN00374717.

Based on interview and record review, the facility failed to ensure staff to resident verbal abuse did not occur for 1 of 4 residents reviewed for Abuse. (Residents B)

Findings include:

During an interview on 3/21/22 at 9:39 p.m., Resident B indicated one staff member (LPN [licensed practical nurse] 4) was mean to her and was yelling at her when she tried to

talk to her about why she did not like her. The facility took care of the situation and the LPN was no long working at the facility. The LPN had been very "hatefully" and talked abut her behind her back.

The clinical record for Resident B was reviewed on 3/21/22 at 10:14 p.m. The resident's diagnoses included, but were not limited to, cerebral infarction, COPD, Type 2 diabetes, anxiety, insomnia, and depression. The resident's cognition was alert and oriented.

During an interview on 3/21/22 at 9:48 p.m., Resident C indicated LPN 4 was mean in the dining room to Resident B.. The LPN acted like she was mad at the world and was screaming at the resident.

During an interview on 3/21/22 at 10:48 p.m., the Administrator in training indicated she arrived to the facility due to a kitchen issue and over heard screaming as she came in the front door. The LPN 4 and Resident B were yelling back and forth. She removed the staff member away from the resident. The resident was assessed and comforted.

The incident report, dated 3/4/22 at 9:30 p.m., indicated a staff member was over heard screaming at Resident B and the resident was observed to be

	crying. The current facility policy, titled "Abuse Prohibition", dated September 2017. The policy indicated, "The facility shall prohibit and prevent abuse...Verbal Abuse-Oral,written and/or gestured language that willfully includes disparaging and/or derogatory terms to residents..." This State tag relates to Complaint IN00374717.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE