STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	01/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER PLACE	741 PARK EAST BLVD, LAFAYETTE, , 47905

(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 Investigation of Complaints IN00370428 and IN00371017. Complaint IN00370428-Substantiated. State deficiencies related to the allegations were cited at R52, R53 and R59. Complaint IN00371017-Substantiated. State deficiencies related to the allegations were cited at R52 and R53. Survey dates: January 21 and 24, 2022 Facility number: 013045 Residential: 99 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on February 2, 2022.	R 0000		

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 review, the facility failed to ensure LPN (Licensed Practical Nurse) 3 did not mentally abuse a resident with a dementia diagnosis (Resident B) and failed to ensure PCA (Personal Care Assistant) 4 did not physically abuse two residents with dementia diagnoses (Residents C and D) for 3 of 5 residents reviewed for abuse. Resident B felt dissatisfied in her living arrangements at the facility and she felt like anytime she came out of her room when LPN 3 was working, she was going to be punished. Resident's C and D were forcibly removed from their beds against their wishes by PCA 4. Findings include: 1. A Facility Reported Incident	R 0052	Deficiency ID:K _ 0000 Plan of Correction Text: Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the complaint survey on January 24th. Please accept this Plan of Correction as the provider's credible allegation of compliance as of 2/14/2022. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	03/01/2022

	(FRI) was reported to the Indiana Department of Health (IDOH) on 1/13/22 at 9:04 a.m. The FRI incident occurred on 1/12/22 at 2:01 p.m. The Executive Director (ED) at the facility reported Resident B, who had diagnoses, which included, but were not limited to, dementia without behavioral disturbance, chronic kidney disease stage 3 and Type 2 diabetes mellitus was the resident involved and the staff member involved was LPN 3. Resident B's family member, during a care plan meeting, had reported she witnessed LPN 3 speak to Resident B in an inappropriate tone and verbiage which was disparaging to the resident. During an interview, on 1/21/22 at 3:35 p.m., the ED and the Director of Nursing (DON) was in attendance. The ED indicated on 1/7/22, while conducting an exit interview with PCA 4, PCA 4 reported to her LPN 3 spoke to the residents in a negative and derogatory manner. The ED placed LPN 3 on suspension and she started an investigation, which she unsubstantiated on 1/10/22 and completed customer service training for all the staff. On 1/12/22, during a care plan meeting with Resident B's family member, the family member indicated to the ED, LPN 3 spoke to Resident B in an		Deficiency ID:R052 Completion Date:2/14/2022 Plan of Correction Text: WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DIFICIENT PRACTICE: Termination of employment for the employees that took place during the investigation period and prior to complaint investigation. Education provided to all staff members on Abuse and Resident Rights. Education provided to all Residents-on-Residents Rights. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTICE ACTION WILL BE TAKEN: All residents have the potential to be affected. Sample	

	inappropriate tone and verbiage, which was disparaging to the resident. LPN 3 was placed on leave and an investigation was completed. On 1/18/22, the incident was substantiated and LPN 3 was terminated due to the severity of the incident. During an interview, on 1/21/22 at 5:00 p.m., Resident B indicated LPN 3 and her never got along, since she moved into the facility. The mistreatment got worse about two to three weeks ago. LPN 3 yelled at Resident B in front of all the other residents in the dining room for taking food from her tablemate. She took the food away from Resident B and gave it back to her tablemate. LPN 3 told her tablemate and Resident B they were not allowed to sit together anymore because Resident B was "stealing" food off her tablemate's plate. Her tablemate would give her the food she was not going to eat because LPN 3 would not allow Resident B to have seconds of any of the food which was being served. LPN 3 indicated the resident was overweight, diabetic and did not need extra food. When she went to ask for seconds, LPN 3 told her she was not allowed to have second helpings or there were no second helpings left for the meal, when the resident knew there was food left. Overtime,		of residents were interviewed during investigation on 1/12/22 for any signs and symptoms for loss of rights and or abuse. No residents reported any additional allegations during investigation. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES THE FACILITY WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT REUR: Abuse and Resident Rights training occurred on 1/31/21 training to maintain the knowledge of Resident Rights as well as the understanding what the rights entail and the importance of reporting when the rights are in question. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DIFICIENT PRACTIVE WILL NOT RECUR: Documentation of education received on Resident Rights that were provided to Staff as well as residents. We will retrain staff 2 times a week for 2 weeks, 1 time per week for 2 weeks, then monthly for 6 months, also both Resident	

	anything she did, LPN 3 "jumped on me" and yelled at her and she was "always" getting punished by LPN 3. LPN 3 would not allow the resident to talk to any of the other residents because she thought she was going to "steal" their food. Resident B used to help the other residents. She used to wrap the silverware, with gloves on, to help the kitchen staff. She would push residents back to their rooms in their wheelchairs. She loved to help others, but when LPN 3 was on duty, she was not allowed to help the other residents. She was not even allowed to visit her tablemate's room and talk to her. She had been a girl scout leader and a teacher, so she was used to helping others all her life and she enjoyed helping others, but not when LPN 3 was on duty. She was told to stay in her own room by LPN 3 because of the pandemic. When other nurses were on duty, she could help others, sit with her tablemate, visit her tablemate's room, and talk with anyone she wanted. She never understood why LPN 3 targeted and punished her only. She stayed in her room except for meals, but she had to eat by herself when LPN 3 worked. She was getting to the point, she was tired of living at the facility because she got yelled at and punished by LPN		rights and Abuse will be educated to all new employees. BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED: 3/1/22	

	3 for everything she did or said, so she stayed in her room when LPN 3 was working to stay out of her way. After the last ED left, LPN 3 thought she was the boss of everyone on the unit and she even had the staff afraid of her. She finally had enough and she notified her sister. Resident B's sister informed the ED of the concerns with LPN 3, then she was fired. Resident B had been able to eat with her tablemate friend since then, she received second helpings when she wanted them, and she visited her tablemate friend in her apartment when she wanted now. She was able to talk to any of the other residents on the unit and she was able to do activities again instead of staying in her room. She felt bad, LPN 3 was fired because of her, but she could not live in that "miserable" environment anymore. A document, titled "Employee Communication Form," dated 1/13/22 and provided by the DON on 1/24/22 at 3:00 p.m., indicated LPN 3 was suspended on 1/12/22, then later terminated on 1/13/22 for violating the abuse and resident rights policies. The policy violations were verbal abuse regarding LPN 3 saying disparaging and derogatory terms to a resident and mistreatment regarding LPN 3 treated a resident			

	inappropriately. A document, titled "Witness Statement-Confidential," undated and provided by the DON on 1/24/22 at 3:00 p.m., indicated the investigation being investigated was regarding "Abuse." The incident occurred on 1/12/22. The ED spoke to the sister of Resident B who indicated LPN 3 was very rude to the resident in her presence. While the resident's sister was visiting, she was signing some paperwork while the resident was present, She had gone to the memory care nurses station to ask LPN 3 a question. While asking her a question about all the paperwork, LPN 3 indicated to Resident B the paperwork was none of her business and she needed to go sit down and be quiet. Resident B's sister indicated she corrected LPN 3 at that time. She indicated to LPN 3 the conversation the two of them were discussing was Resident B's business because it was about her. A document, titled "Witness Statement-Confidential," undated and provided by the DON on 1/24/22 at 3:00 p.m., indicated the investigation being investigated was regarding "Abuse." The incident occurred on 1/12/22. The ED interviewed Resident B regarding the incident on 1/12/22. Resident B indicated she did not like LPN 3			

	because she was "always" yelling at her. LPN 3 would not allow her to sit with her friend. When she asked for second helpings of food, LPN 3 told her she was overweight, diabetic and she was not allowed to have more food. LPN 3 would not let her help do anything, so she stayed in her room to avoid being yelled at and getting punished by LPN 3. Resident B's record was reviewed on 1/24/22 at 4:10 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbances, major depressive disorder, Type 2 diabetes mellitus and chronic kidney disease stage 3. The resident's face sheet indicated she was not responsible for herself. Her durable POA (Power of Attorney) was her sister. The resident's current Brief Interview for Mental Status (BIMS), dated 7/30/21, indicated the score was 7/15, which indicated she was severely cognitively impaired. A Resident Progress Note, dated 1/13/22 at 2:30 p.m., indicated the ED spoke to Resident B regarding a situation her POA had described during a care conference. The resident was very upset during the conversation while she gave a			

	few situations, which made her feel uncomfortable, like she had been punished. 2. During an interview, on 1/21/22 at 3:35 p.m., the ED and the Director of Nursing (DON) was in attendance. The ED indicated PCA (Patient Care Assistant) 4 was rough while providing care when getting two residents (Residents C and D) out of bed. A CNA witnessed both of these incidents and reported them immediately. The first incident was not as severe as the second incident. The second incident was stopped by the CNA and PCA 4 was told to leave the room and the CNA finished the care of Resident D. PCA 4 was terminated after the abuse was substantiated. A document, titled "Indiana State Department of Health Survey Report System," dated 1/21/22 and provided by the DON on 1/24/22 at 3:00 p.m., indicated the incident occurred on 1/5/22 at 4:01 p.m. The incident involved a staff member (CNA 9) who witnessed another staff member (Patient Care Assistant 4) performing her job duties in a rough and aggressive way. CNA 9 witnessed PCA (Patient Care Assistant) 4 assist Resident's C and D out of bed, when they did not want to get out of bed, in a way which caused the residents to visually be in discomfort. After			

	the investigation of abuse was completed, the abuse was substantiated and PCA 4 was terminated. A document, titled "Employee Communication Form," dated 1/13/22 and provided by the DON on 1/24/22 at 3:00 p.m., indicated PCA 4 was suspended on 1/5/22, then later terminated on 1/7/22 for violating the abuse policy. The policy violations were verbal abuse regarding PCA 4 saying disparaging and derogatory terms to a resident and mistreatment regarding PCA 4 treated a resident inappropriately. A handwritten statement, dated 1/5/22 from 6:30 a.m. to 7:00 a.m., CNA 9 indicated she was assisting another aide (PCA 4) get a resident (Resident C) dressed and out of the bed when she witnessed PCA 4 "rip" Resident C's brief off and the resident "coward (sic)" because she took her brief off in that manner. PCA 4 "grabbed" the resident's arm and "pulled" her up off the bed. PCA 4 indicated to the resident "You have to get dressed and I will not fight with you today." CNA 9 indicated the resident was upset, but she did not try to fight or hurt PCA 4 or herself in anyway. They both went to another resident's room (Resident D). PCA 4 removed the resident's blankets and told the resident they had to get her			

	up, get her dressed and indicated to Resident D she would not "fight" us. CNA 9 indicated Resident D had back problems and when staff got her up she would complain her back hurt, so they got her up easily. PCA 4 got the resident out of bed by "pulling" her up by her arms. Resident D became upset indicating PCA 4 was hurting her. PCA 4 indicated to the resident, she and CNA 9 had to get her up and ready for the day. CNA 9 indicated she had worked with Residents C and D for approximately five months and she had never had issues with either of them, they were both pleasant and she was always able to redirect them. a. During an interview, on 1/24/22 at 2:19 p.m., Resident C indicated someone used to hurt her, but that person did not hurt her anymore. She did not specify any further information regarding this statement. A written interview, completed by the DON on 1/5/22 at 5:20 p.m., revealed Resident C indicated if anyone at the facility made her feel uncomfortable she "just would not do it." When the DON asked her what that meant, she indicated she would not do what the person who made her feel uncomfortable asked her to do. Resident C's record was			

	reviewed on 1/24/22 at 4:20 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, major depressive disturbance and rheumatoid arthritis with rheumatoid factor of unspecified site. The resident's face sheet indicated she was not responsible for herself and she did have durable POA. The resident's current BIMS, dated 6/11/21, indicated the score was 4/15, which indicated she was severely cognitively impaired. A Resident Progress Note, dated 1/5/22 at 6:59 p.m., indicated the ED was informed by a staff member this resident was mishandled by another staff member. The staff member reported to the ED, the other staff member removed the resident from the bed with force and removed her brief inappropriately. b. Confidential interview was conducted during the course of the survey. The Confidential Interviewee indicated on 1/8/22, after the incident occurred with PCA 4 having an abuse allegation with Resident D, the Confidential Interviewee went into the resident's room to assist another employee with her. When the Confidential			

Interviewee walked into the room, Resident D indicated "Please don't hit me!" The Confidential Interviewee had never provided care for this resident before this day.

During an interview, on 1/24/22 at 2:46 p.m., Resident D indicated no one had mistreated her that she could remember.

A written interview, completed by the DON on 1/5/22 at 5:05 p.m., revealed Resident D indicated there was staff who made her feel uncomfortable who worked day shift at the facility, but that person was not in the room with her at that particular time.

Resident D's record was reviewed on 1/24/22 at 4:30 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, expressive language disorder, transient cerebral scenic attack and rheumatic heart disease.

The resident's face sheet indicated she was not responsible for herself and she did have durable POA.

The resident's current BIMS, dated 11/4/21, indicated the score was 3/15, which indicated she was severely cognitively impaired.

A Resident Progress Note, dated 1/5/22 at 7:00 p.m.,

	indicated the ED was informed by a staff member, this resident was mishandled by another staff member. The staff member reported to the ED, the other staff member removed the resident from the bed with force and removed her brief inappropriately. A current policy, titled "Unusual Occurrences for Residents-Residential Care," dated 8/98 with a revision date of 8/15 and provided by the ED on 1/21/22 at 4:15 p.m., indicated "...Definitions: Abuse-the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish. This includes deprivation by an individual, including a caretaker, of goods or services that are necessary or attain or maintain physical, mental, or psychosocial well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain, or mental anguish. Willful-the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm. Physical abuse-willful act against a resident by another resident, staff or other individuals. Examples: hitting, beating, slapping, punching, shoving,			

	spitting, striking with an object, pulling/twisting, squeezing, pinching, scratching, tripping, biting, burning, using overly hot/cold water, and/or improper use of restraints...Verbal Abuse-oral, written, or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing, regardless of their age, ability to comprehend, or disability. Examples would include, but are not limited to: threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family member again; or scolding and /or speaking to them in harsh voice tones... 3. Staff to resident-any episode. Mental Abuse-Verbal or nonverbal infliction or anguish, pain, or distress that results in psychological or emotional suffering. 1. Staff to resident-any episode...Examples: humiliation, harassment, threats of punishment or deprivation, bullying...Mistreatment-staff treating a resident inappropriately or exploiting a resident. Examples: rough treatment...." This State finding relates to Complaints IN00370428 and IN00371017. Based on interview and record			

	review, the facility failed to ensure LPN (Licensed Practical Nurse) 3 did not mentally abuse a resident with a dementia diagnosis (Resident B) and failed to ensure PCA (Personal Care Assistant) 4 did not physically abuse two residents with dementia diagnoses (Residents C and D) for 3 of 5 residents reviewed for abuse. Resident B felt dissatisfied in her living arrangements at the facility and she felt like anytime she came out of her room when LPN 3 was working, she was going to be punished. Resident's C and D were forcibly removed from their beds against their wishes by PCA 4. Findings include: 1. A Facility Reported Incident (FRI) was reported to the Indiana Department of Health (IDOH) on 1/13/22 at 9:04 a.m. The FRI incident occurred on 1/12/22 at 2:01 p.m. The Executive Director (ED) at the facility reported Resident B, who had diagnoses, which included, but were not limited to, dementia without behavioral disturbance, chronic kidney disease stage 3 and Type 2 diabetes mellitus was the resident involved and the staff member involved was LPN 3. Resident B's family member, during a care plan meeting, had reported she witnessed LPN 3 speak to Resident B in an			

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	and rheumatoid arthritis with rheumatoid factor of unspecified site. The resident's face sheet indicated she was not responsible for herself and she did have durable POA. The resident's current BIMS, dated 6/11/21, indicated the score was 4/15, which indicated she was severely cognitively impaired. A Resident Progress Note, dated 1/5/22 at 6:59 p.m., indicated the ED was informed by a staff member this resident was mishandled by another staff member. The staff member reported to the ED, the other staff member removed the resident from the bed with force and removed her brief inappropriately. b. Confidential interview was conducted during the course of the survey. The Confidential Interviewee indicated on 1/8/22, after the incident occurred with PCA 4 having an abuse allegation with Resident D, the Confidential Interviewee went into the resident's room to assist another employee with her. When the Confidential Interviewee walked into the room, Resident D indicated "Please don't hit me!" The Confidential Interviewee had never provided care for this			

resident before this day.

During an interview, on 1/24/22 at 2:46 p.m., Resident D indicated no one had mistreated her that she could remember.

A written interview, completed by the DON on 1/5/22 at 5:05 p.m., revealed Resident D indicated there was staff who made her feel uncomfortable who worked day shift at the facility, but that person was not in the room with her at that particular time.

Resident D's record was reviewed on 1/24/22 at 4:30 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, expressive language disorder, transient cerebral scenic attack and rheumatic heart disease.

The resident's face sheet indicated she was not responsible for herself and she did have durable POA.

The resident's current BIMS, dated 11/4/21, indicated the score was 3/15, which indicated she was severely cognitively impaired.

A Resident Progress Note, dated 1/5/22 at 7:00 p.m., indicated the ED was informed by a staff member, this resident was mishandled by another staff member. The staff member reported to the ED, the other

	staff member removed the resident from the bed with force and removed her brief inappropriately. A current policy, titled "Unusual Occurrences for Residents-Residential Care," dated 8/98 with a revision date of 8/15 and provided by the ED on 1/21/22 at 4:15 p.m., indicated "...Definitions: Abuse-the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish. This includes deprivation by an individual, including a caretaker, of goods or services that are necessary or attain or maintain physical, mental, or psychosocial well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain, or mental anguish. Willful-the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm. Physical abuse-willful act against a resident by another resident, staff or other individuals. Examples: hitting, beating, slapping, punching, shoving, spitting, striking with an object, pulling/twisting, squeezing, pinching, scratching, tripping, biting, burning, using overly hot/cold water, and/or improper			

	use of restraints...Verbal Abuse-oral, written, or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing, regardless of their age, ability to comprehend, or disability. Examples would include, but are not limited to: threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family member again; or scolding and /or speaking to them in harsh voice tones... 3. Staff to resident-any episode. Mental Abuse-Verbal or nonverbal infliction or anguish, pain, or distress that results in psychological or emotional suffering. 1. Staff to resident-any episode...Examples: humiliation, harassment, threats of punishment or deprivation, bullying...Mistreatment-staff treating a resident inappropriately or exploiting a resident. Examples: rough treatment...." This State finding relates to Complaints IN00370428 and IN00371017.			
R 0053	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(w) (w) Residents have the right to be	R 0053	Deficiency ID: R053 Completion	03/01/2022

	free from verbal abuse. Based on interview and record review, the facility failed to ensure LPN (Licensed Practical Nurse) 3 and PCA (Personal Care Assistant) 4 did not verbally abuse residents with dementia diagnoses for 3 of 5 residents reviewed for verbal abuse. (Resident B, C and D) Findings include: 1. A Facility Reported Incident (FRI) was reported to the Indiana Department of Health (IDOH) on 1/13/22 at 9:04 a.m. The FRI incident occurred on 1/12/22 at 2:01 p.m. The Executive Director (ED) at the facility reported Resident B, who had diagnoses, which included, but were not limited to, dementia without behavioral disturbance, chronic kidney disease stage 3 and Type 2 diabetes mellitus was the resident involved and the staff member involved was LPN 3. Resident B's family member, during a care plan meeting, had reported she witnessed LPN 3 speak to Resident B in an inappropriate tone and verbiage which was disparaging to the resident. During an interview, on 1/21/22 at 3:35 p.m., the ED and the Director of Nursing (DON) was in attendance. The ED indicated on 1/12/22, during a care plan		Date: 2/14/22 Plan of Correction text: WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DIFICIENT PRACTICE: Termination of employment for the employees that took place during the investigation period and prior to complaint investigation. Education provided to all staff members on Abuse and Resident Rights. Education provided to all Residents-on-Residents Rights. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTICE ACTION WILL BE TAKEN: : All residents have the potential to be affected. Sample of residents were interviewed during investigation on 1/12/22 for any signs and symptoms for loss of rights and or abuse. No residents reported	

	meeting with Resident B's family member, the family member indicated to the ED, LPN 3 spoke to Resident B in an inappropriate tone and verbiage, which was disparaging to the resident. LPN 3 was placed on leave and an investigation was completed. On 1/18/22, the incident was substantiated and LPN 3 was terminated due to the severity of the incident. During an interview, on 1/21/22 at 5:00 p.m., Resident B indicated LPN 3 and her never got along, since she moved into the facility. The mistreatment got worse about two to three weeks ago. LPN 3 yelled at Resident B in front of all the other residents in the dining room for taking food from her tablemate. LPN 3 told her tablemate and Resident B they were not allowed to sit together anymore because Resident B was "stealing" food off her tablemate's plate. Her tablemate would give her the food she was not going to eat because LPN 3 would not allow Resident B to have seconds of any of the food which was being served. LPN 3 indicated the resident was overweight, diabetic and did not need extra food. When she went to ask for seconds, LPN 3 told her she was not allowed to have second helpings or there were no second helpings left for the meal, when the resident		any additional allegations during investigation. WHAT MEASURES WILL BE PUT INTO PLAVE OR WHAT SYSTEMIC CHANGES THE FACILITY WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT REUR: Abuse and Resident Rights training occurred on 1/31/21 training to maintain the knowledge of Resident Rights as well as the understanding what the rights up to and including being free from verbal abuse. Also the importance of reporting when the rights are in question. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DIFICIENT PRACTIVE WILL NOT RECUR: Documentation of education received on Resident Rights that were provided to Staff as well as residents. We will retrain staff 2 times a week for 2 weeks, 1 time per week for 2 weeks, then monthly for 6 months, also both Resident rights and Abuse will be educated to all new employees.	

	knew there was food left. Overtime, anything she did, LPN 3 "jumped on me" and yelled at her and she was "always" getting punished by LPN 3. She was told to stay in her own room by LPN 3 because of the pandemic. She never understood why LPN 3 targeted and punished her only. She stayed in her room except for meals and she had to eat by herself when LPN 3 worked. She was getting to the point, she was tired of living at the facility because she got yelled at and punished by LPN 3 for everything she did or said, so she stayed in her room when LPN 3 was working to stay out of her way. A document, titled "Employee Communication Form," dated 1/13/22 and provided by the DON on 1/24/22 at 3:00 p.m., indicated LPN 3 was suspended on 1/12/22, then later terminated on 1/13/22 for violating the abuse and resident rights policies. The policy violations were verbal abuse regarding LPN 3 saying disparaging and derogatory terms to a resident and mistreatment regarding LPN 3 treated a resident inappropriately. A document, titled "Witness Statement-Confidential," undated and provided by the		BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED: 3/1/22	

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	the CNA and PCA 4 was told to leave the room and the CNA finished the care of Resident D. PCA 4 was terminated after the abuse was substantiated. A document, titled "Indiana State Department of Health Survey Report System," dated 1/21/22 and provided by the DON on 1/24/22 at 3:00 p.m., indicated the incident occurred on 1/5/22 at 4:01 p.m. The incident involved a staff member (CNA 9) who witnessed another staff member (Patient Care Assistant 4) performing her job duties in a rough and aggressive way. CNA 9 witnessed PCA (Patient Care Assistant) 4 assist Resident's C and D out of bed, when they did not want to get out of bed, in a way which caused the residents to visually be in discomfort. After the investigation of abuse was completed, the abuse was substantiated and PCA 4 was terminated. A document, titled "Employee Communication Form," dated 1/13/22 and provided by the DON on 1/24/22 at 3:00 p.m., indicated PCA 4 was suspended on 1/5/22, then later terminated on 1/7/22 for violating the abuse policy. The policy violations were verbal abuse regarding PCA 4 saying disparaging and derogatory terms to a resident and mistreatment regarding PCA 4 treated a resident			

	inappropriately. A handwritten statement, dated 1/5/22 from 6:30 a.m. to 7:00 a.m., CNA 9 indicated she was assisting another aide (PCA 4) get a resident (Resident C) dressed and out of the bed when she witnessed PCA 4 "rip" Resident C's brief off and the resident "coward (sic)" because she took her brief off in that manner. PCA 4 "grabbed" the resident's arm and "pulled" her up off the bed. PCA 4 indicated to the resident "You have to get dressed and I will not fight with you today." CNA 9 indicated the resident was upset, but she did not try to fight or hurt PCA 4 or herself in anyway. They both went to another resident's room (Resident D). PCA 4 removed the resident's blankets and told the resident they had to get her up, get her dressed and indicated to Resident D she would not "fight" us. CNA 9 indicated Resident D had back problems and when staff got her up she would complain her back hurt, so they got her up easily. PCA 4 got the resident out of bed by "pulling" her up by her arms. Resident D became upset indicating PCA 4 was hurting her. PCA 4 indicated to the resident, she and CNA 9 had to get her up and ready for the day. CNA 9 indicated she had worked with Residents C and D for approximately five months and she had never had issues			

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residents reviewed for verbal abuse. (Resident B, C and D)

Findings include:

1. A Facility Reported Incident (FRI) was reported to the Indiana Department of Health (IDOH) on 1/13/22 at 9:04 a.m. The FRI incident occurred on 1/12/22 at 2:01 p.m. The Executive Director (ED) at the facility reported Resident B, who had diagnoses, which included, but were not limited to, dementia without behavioral disturbance, chronic kidney disease stage 3 and Type 2 diabetes mellitus was the resident involved and the staff member involved was LPN 3. Resident B's family member, during a care plan meeting, had reported she witnessed LPN 3 speak to Resident B in an inappropriate tone and verbiage which was disparaging to the resident.

During an interview, on 1/21/22 at 3:35 p.m., the ED and the Director of Nursing (DON) was in attendance. The ED indicated on 1/12/22, during a care plan meeting with Resident B's family member, the family member indicated to the ED, LPN 3 spoke to Resident B in an inappropriate tone and verbiage, which was disparaging to the resident. LPN 3 was placed on leave and an investigation was completed. On

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Resident B's record was

	reviewed on 1/24/22 at 4:10 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbances, major depressive disorder, Type 2 diabetes mellitus and chronic kidney disease stage 3. A Resident Progress Note, dated 1/13/22 at 2:30 p.m., indicated the ED spoke to Resident B regarding a situation her POA had described during a care conference. The resident was very upset during the conversation while she gave a few situations, which made her feel uncomfortable, like she had been punished. 2. During an interview, on 1/21/22 at 3:35 p.m., the ED and the Director of Nursing (DON) was in attendance. The ED indicated PCA (Patient Care Assistant) 4 was rough while providing care when getting two residents (Residents C and D) out of bed. A CNA witnessed both of these incidents and reported them immediately. The first incident was not as severe as the second incident. The second incident was stopped by the CNA and PCA 4 was told to leave the room and the CNA finished the care of Resident D. PCA 4 was terminated after the abuse was substantiated. A document, titled "Indiana State Department of Health Survey Report System," dated			

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R 0059	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(cc) (cc) Residents have the right to choose with whom they associate. The facility shall provide reasonable visiting hours, which should include at least twelve (12) hours a day, and the hours shall be made available to each resident. Policies shall also provide for emergency visitation at other hours. The facility shall not restrict visits from the resident ' s legal representative or spiritual advisor,	R 0059	Deficiency ID: Completion Date: 2/14/22 Plan of Correction text: WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE	03/01/2022

except at the request of the resident.

Based on interview and record review, the facility failed to ensure a resident had the choice to choose who she wanted to sit with at mealtime and what other resident's in the facility she wanted to visit for 1 of 3 residents reviewed for the right to choose whom the residents associate with (Resident B).

Finding includes:

A Facility Reported Incident (FRI) was reported to the Indiana Department of Health (IDOH) on 1/13/22 at 9:04 a.m. The FRI incident occurred on 1/12/22 at 2:01 p.m. The Executive Director (ED) at the facility reported Resident B, who had diagnoses, which included, but were not limited to, dementia without behavioral disturbance, chronic kidney disease stage 3 and Type 2 diabetes mellitus was the resident involved and the staff member involved was LPN 3. Resident B's family member, during a care plan meeting, had reported she witnessed LPN 3 speak to Resident B in an inappropriate tone and verbiage which was disparaging to the resident.

During an interview, on 1/21/22 at 3:35 p.m., the ED and the

RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DIFICIENT PRACTICE:
Termination of employment for the employees that took place during the investigation period and prior to complaint investigation. Education provided to all staff members on Abuse and Resident Rights. Education provided to all Residents-on-Residents Rights.

HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTICE ACTION WILL BE TAKEN: All residents have the potential to be affected. Sample of residents were interviewed during investigation on 1/12/22 for any signs and symptoms for loss of rights and or abuse. No residents reported any additional allegations during investigation.

WHAT MEASURES WILL BE PUT INTO PLAVE OR WHAT SYSTEMIC CHANGES THE FACILITY WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT

	Director of Nursing (DON) was in attendance. The ED indicated on 1/7/22, while conducting an exit interview with PCA 4, PCA 4 reported to her LPN 3 spoke to the residents in a negative and derogatory manner. The ED placed LPN 3 on suspension and she started an investigation, which she unsubstantiated on 1/10/22 and completed customer service training for all the staff. On 1/12/22, during a care plan meeting with Resident B's family member, the family member indicated to the ED, LPN 3 spoke to Resident B in an inappropriate tone and verbiage, which was disparaging to the resident. LPN 3 was placed on leave and an investigation was completed. On 1/18/22, the incident was substantiated and LPN 3 was terminated due to the severity of the incident. During an interview, on 1/21/22 at 5:00 p.m., Resident B indicated LPN 3 and her never got along, since she moved into the facility. The mistreatment got worse about two to three weeks ago. LPN 3 yelled at Resident B in front of all the other residents in the dining room for taking food from her tablemate. She took the food away from Resident B and gave it back to her tablemate. LPN 3 told her tablemate and Resident B they were not allowed to sit		REUR: Abuse and Resident Rights training occurred on 1/31/21 training to maintain the knowledge of Resident Rights up to and including the right of choice of whom they associate and visitation rights. As well as the understanding what the rights entail and the importance of reporting when the rights are in question. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DIFICIENT PRACTIVE WILL NOT RECUR: Documentation of education received on Resident Rights that were provided to Staff as well as residents. We will retrain staff 2 times a week for 2 weeks, 1 time per week for 2 weeks, then monthly for 6 months, also both Resident rights and Abuse will be educated to all new employees. BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED: 3/1/22	

	together anymore because Resident B was "stealing" food off her tablemate's plate. Her tablemate would give her the food she was not going to eat because LPN 3 would not allow Resident B to have seconds of any of the food which was being served. LPN 3 indicated the resident was overweight, diabetic and did not need extra food. When she went to ask for seconds, LPN 3 told her she was not allowed to have second helpings or there were no second helpings left for the meal, when the resident knew there was food left. Overtime, anything she did, LPN 3 "jumped on me" and yelled at her and she was "always" getting punished by LPN 3. LPN 3 would not allow the resident to talk to any of the other residents because she thought she was going to "steal" their food. Resident B used to help the other residents. She used to wrap the silverware, with gloves on, to help the kitchen staff. She would push residents back to their rooms in their wheelchairs. She loved to help others, but when LPN 3 was on duty, she was not allowed to help the other residents. She was not even allowed to visit her tablemate's room and talk to her. She had been a girl scout leader and a teacher, so she was used to helping others all her life and she enjoyed helping others, but not when LPN 3 was				

on duty.

She was told to stay in her own room by LPN 3 because of the pandemic. When other nurses were on duty, she could help others, sit with her tablemate, visit her tablemate's room, and talk with anyone she wanted. She never understood why LPN 3 targeted and punished her only. She stayed in her room except for meals, but she had to eat by herself when LPN 3 worked. She was getting to the point, she was tired of living at the facility because she got yelled at and punished by LPN 3 for everything she did or said, so she stayed in her room when LPN 3 was working to stay out of her way. After the last ED left, LPN 3 thought she was the boss of everyone on the unit and she even had the staff afraid of her. She finally had enough and she notified her sister. Resident B's sister informed the ED of the concerns with LPN 3, then she was fired. Resident B had been able to eat with her tablemate friend since then, she received second helpings when she wanted them, and she visited her tablemate friend in her apartment when she wanted now. She was able to talk to any of the other residents on the unit and she was able to do activities again instead of staying in her room. She felt bad, LPN 3 was fired because of her, but she

could not live in that "miserable" environment anymore.

A document, titled "Employee Communication Form," dated 1/13/22 and provided by the DON on 1/24/22 at 3:00 p.m., indicated LPN 3 was suspended on 1/12/22, then later terminated on 1/13/22 for violating the abuse and resident rights policies. The policy violations were verbal abuse regarding LPN 3 saying disparaging and derogatory terms to a resident and mistreatment regarding LPN 3 treated a resident inappropriately.

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Resident B's record was reviewed on 1/24/22 at 4:10 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbances, major depressive disorder, Type 2 diabetes mellitus and chronic kidney disease stage 3.

The resident's face sheet indicated she was not responsible for herself. Her

durable POA (Power of Attorney) was her sister.

The resident's current Brief Interview for Mental Status (BIMS), dated 7/30/21, indicated the score was 7/15, which indicated she was severely cognitively impaired.

A Resident Progress Note, dated 1/13/22 at 2:30 p.m., indicated the ED spoke to Resident B regarding a situation her POA had described during a care conference. The resident was very upset during the conversation while she gave a few situations, which made her feel uncomfortable, like she had been punished.

A current policy titled "Unusual Occurrences for Residents-Residential Care" dated 8/98 with a revision date 8/15, provided by the ED on 1/21/22 at 4:15 p.m., indicated "...Definitions: Abuse-the wilful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish. This includes deprivation by an individual, including a caretaker, of goods or services that are necessary or attain or maintain physical, mental, or psychosocial well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain, or

	mental anguish. Willful-the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm. Physical abuse-willful act against a resident by another resident, staff or other individuals. Examples: hitting, beating, slapping, punching, shoving, spitting, striking with an object,, pulling/twisting, squeezing, pinching, scratching, tripping, biting, burning, using overly hot/cold water, and/or improper use of restraints...Verbal Abuse-oral, written, or gestured language tat includes disparaging and derogatory terms to residents or their families, or within their hearing, regardless of their age, ability to comprehend, or disability. Examples would include, but are not limited to: threats of harm, saying things to frighten a resident, such as telling a resident that he/she ill never be able to see his/her family member again; or scolding and /or speaking to them in harsh voice tones... 3. Staff to resident-any episode. Mental Abuse-Verbal or nonverbal infliction or anguish, pain, or distress that results in psychological or emotional suffering. 1. Staff to resident-any episode...Examples: humiliation, harassment, threats of punishment or deprivation,			

bullying...Mistreatment-staff treating a resident inappropriately or exploiting a resident. Examples: rough treatment...."

This State finding relates to Complaint IN00370428.

Based on interview and record review, the facility failed to ensure a resident had the choice to choose who she wanted to sit with at mealtime and what other resident's in the facility she wanted to visit for 1 of 3 residents reviewed for the right to choose whom the residents associate with (Resident B).

Finding includes:

A Facility Reported Incident (FRI) was reported to the Indiana Department of Health (IDOH) on 1/13/22 at 9:04 a.m. The FRI incident occurred on 1/12/22 at 2:01 p.m. The Executive Director (ED) at the facility reported Resident B, who had diagnoses, which included, but were not limited to, dementia without behavioral disturbance, chronic kidney disease stage 3 and Type 2 diabetes mellitus was the resident involved and the staff member involved was LPN 3. Resident B's family member, during a care plan meeting, had reported she witnessed LPN 3 speak to Resident B in an

inappropriate tone and verbiage which was disparaging to the resident.

During an interview, on 1/21/22 at 3:35 p.m., the ED and the Director of Nursing (DON) was in attendance. The ED indicated on 1/7/22, while conducting an exit interview with PCA 4, PCA 4 reported to her LPN 3 spoke to the residents in a negative and derogatory manner. The ED placed LPN 3 on suspension and she started an investigation, which she unsubstantiated on 1/10/22 and completed customer service training for all the staff. On 1/12/22, during a care plan meeting with Resident B's family member, the family member indicated to the ED, LPN 3 spoke to Resident B in an inappropriate tone and verbiage, which was disparaging to the resident. LPN 3 was placed on leave and an investigation was completed. On 1/18/22, the incident was substantiated and LPN 3 was terminated due to the severity of the incident.

During an interview, on 1/21/22 at 5:00 p.m., Resident B indicated LPN 3 and her never got along, since she moved into the facility. The mistreatment got worse about two to three weeks ago. LPN 3 yelled at Resident B in front of all the other residents in the dining

room for taking food from her tablemate. She took the food away from Resident B and gave it back to her tablemate. LPN 3 told her tablemate and Resident B they were not allowed to sit together anymore because Resident B was "stealing" food off her tablemate's plate. Her tablemate would give her the food she was not going to eat because LPN 3 would not allow Resident B to have seconds of any of the food which was being served. LPN 3 indicated the resident was overweight, diabetic and did not need extra food. When she went to ask for seconds, LPN 3 told her she was not allowed to have second helpings or there were no second helpings left for the meal, when the resident knew there was food left. Overtime, anything she did, LPN 3 "jumped on me" and yelled at her and she was "always" getting punished by LPN 3. LPN 3 would not allow the resident to talk to any of the other residents because she thought she was going to "steal" their food. Resident B used to help the other residents. She used to wrap the silverware, with gloves on, to help the kitchen staff. She would push residents back to their rooms in their wheelchairs. She loved to help others, but when LPN 3 was on duty, she was not allowed to help the other residents. She was not even allowed to visit her

tablemate's room and talk to her. She had been a girl scout leader and a teacher, so she was used to helping others all her life and she enjoyed helping others, but not when LPN 3 was on duty.

She was told to stay in her own room by LPN 3 because of the pandemic. When other nurses were on duty, she could help others, sit with her tablemate, visit her tablemate's room, and talk with anyone she wanted. She never understood why LPN 3 targeted and punished her only. She stayed in her room except for meals, but she had to eat by herself when LPN 3 worked. She was getting to the point, she was tired of living at the facility because she got yelled at and punished by LPN 3 for everything she did or said, so she stayed in her room when LPN 3 was working to stay out of her way. After the last ED left, LPN 3 thought she was the boss of everyone on the unit and she even had the staff afraid of her. She finally had enough and she notified her sister. Resident B's sister informed the ED of the concerns with LPN 3, then she was fired. Resident B had been able to eat with her tablemate friend since then, she received second helpings when she wanted them, and she visited her tablemate friend in her apartment when she wanted

now. She was able to talk to any of the other residents on the unit and she was able to do activities again instead of staying in her room. She felt bad, LPN 3 was fired because of her, but she could not live in that "miserable" environment anymore.

A document, titled "Employee Communication Form," dated 1/13/22 and provided by the DON on 1/24/22 at 3:00 p.m., indicated LPN 3 was suspended on 1/12/22, then later terminated on 1/13/22 for violating the abuse and resident rights policies. The policy violations were verbal abuse regarding LPN 3 saying disparaging and derogatory terms to a resident and mistreatment regarding LPN 3 treated a resident inappropriately.

A document, titled "Witness Statement-Confidential," undated and provided by the DON on 1/24/22 at 3:00 p.m., indicated the investigation being investigated was regarding "Abuse." The incident occurred on 1/12/22. The ED spoke to the sister of Resident B who indicated LPN 3 was very rude to the resident in her presence. While the resident's sister was visiting, she was signing some paperwork while the resident was present, She had gone to the memory care nurses station to ask LPN 3 a question. While

asking her a question about all the paperwork, LPN 3 indicated to Resident B the paperwork was none of her business and she needed to go sit down and be quiet. Resident B's sister indicated she corrected LPN 3 at that time. She indicated to LPN 3 the conversation the two of them were discussing was Resident B's business because it was about her.

A document, titled "Witness Statement-Confidential," undated and provided by the DON on 1/24/22 at 3:00 p.m., indicated the investigation being investigated was regarding "Abuse." The incident occurred on 1/12/22. The ED interviewed Resident B regarding the incident on 1/12/22. Resident B indicated she did not like LPN 3 because she was "always" yelling at her. LPN 3 would not allow her to sit with her friend. When she asked for second helpings of food, LPN 3 told her she was overweight, diabetic and she was not allowed to have more food. LPN 3 would not let her help do anything, so she stayed in her room to avoid being yelled at and getting punished by LPN 3.

Resident B's record was reviewed on 1/24/22 at 4:10 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbances, major depressive disorder, Type

2 diabetes mellitus and chronic kidney disease stage 3.

The resident's face sheet indicated she was not responsible for herself. Her durable POA (Power of Attorney) was her sister.

The resident's current Brief Interview for Mental Status (BIMS), dated 7/30/21, indicated the score was 7/15, which indicated she was severely cognitively impaired.

A Resident Progress Note, dated 1/13/22 at 2:30 p.m., indicated the ED spoke to Resident B regarding a situation her POA had described during a care conference. The resident was very upset during the conversation while she gave a few situations, which made her feel uncomfortable, like she had been punished.

A current policy titled "Unusual Occurrences for Residents-Residential Care" dated 8/98 with a revision date 8/15, provided by the ED on 1/21/22 at 4:15 p.m., indicated "...Definitions: Abuse-the wilful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish. This includes deprivation by an individual, including a caretaker, of goods or services that are necessary

	or attain or maintain physical, mental, or psychosocial well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain, or mental anguish. Willful-the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm. Physical abuse-willful act against a resident by another resident, staff or other individuals. Examples: hitting, beating, slapping, punching, shoving, spitting, striking with an object,, pulling/twisting, squeezing, pinching, scratching, tripping, biting, burning, using overly hot/cold water, and/or improper use of restraints...Verbal Abuse-oral, written, or gestured language tat includes disparaging and derogatory terms to residents or their families, or within their hearing, regardless of their age, ability to comprehend, or disability. Examples would include, but are not limited to: threats of harm, saying things to frighten a resident, such as telling a resident that he/she ill never be able to see his/her family member again; or scolding and /or speaking to them in harsh voice tones... 3. Staff to resident-any episode. Mental Abuse-Verbal or nonverbal infliction or anguish, pain, or distress that results in			

	psychological or emotional suffering. 1. Staff to resident-any episode...Examples: humiliation, harassment, threats of punishment or deprivation, bullying...Mistreatment-staff treating a resident inappropriately or exploiting a resident. Examples: rough treatment...." This State finding relates to Complaint IN00370428.			

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