STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BIRCH OF MUNCIE	2500 W KILGORE AVENUE, MUNCIE, , 47304

(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 IN00460218. Complaint IN00460218 - State Residential Findings related to the allegations are cited at R0052 and R0053. Survey date: June 30 and July 1, 2025. Facility number: 014034 Residential Census: 113 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed July 6, 2025	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:	R 0052	***Silver Birch of Muncie***	08/27/2025

	(1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review and interview, the facility failed to ensure residents were free from physical abuse for 1 of 3 residents reviewed. [Resident B] Finding Include: The clinical record of Resident B was reviewed on 6/30/2025 at 11:00 a.m. Diagnoses included anxiety, fractured left ankle, type 2 diabetes, hypertension, and atrial fibrillation. Review of a facility reported incident, dated 6/4/2025, indicated CNA 1 and CNA 2 were located in the room of Resident B. CNA 1 called QMA 3 and indicated the resident was asking them to get ice and refusing to go to the bathroom. During an interview, on 6/30/2025 at 10:48 a.m., QMA 3 indicated CNA 1 called her and indicated the resident had asked CNA 1 and CNA 2 to get her ice and was refusing to stand up to go to the bathroom. QMA 3 told CNA 1 the resident		***2500 W Kilgore Ave*** ***Muncie, IN 47304*** *Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction for this survey. Please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance by a desk review. Should additional information be necessary to confirm said compliance, please feel free to contact Joe Collins, Executive Director, Silver Birch of Muncie.*	

	was non-weight bearing due to a fractured left ankle she sustained during a fall on 6/2/2025. QMA 3 indicated she had already made sure all staff knew of the fractured ankle and the resident's non-weight bearing status. QMA 3 and CNA 4 went to the resident's room and saw CNA 1 and CNA 2. CNA 3 left the resident's room shortly after they arrived. The resident was sitting on the sofa and CNA 1 "grabbed her (Resident B) under her arm and yanked her up." CNA 4 told CNA 1 to leave the resident's room, and they would take care of it. CNA 1 left the resident's room and QMA 3 and CNA 4 assisted the resident to the bathroom. They went to report the incident to the DON, but she as in a meeting with a new resident. They did not go to the Administrator, but waited for the DON's meeting to end. During an interview, on 6/30/2025 at 11:28 a.m., the DON indicated on 6/2/2025, Resident B fell in the elevator and complained of pain in the left leg, but refused to go to the hospital. Approximately one hour later the resident requested to go to the hospital. The resident returned to the facility with a diagnoses of a fractured left ankle. On morning of 6/3/2025, 2 staff members reported they had witnessed CNA 1 yelling at Resident B,		**Prefix Tag # R 052** **Plan of Correction for Tag R052 – Residents' Rights** **Regulation Cited:**410 IAC 16.2-5-1.2(v)(1-6) **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B that was on Leave of Absence to the hospital for another reason, was interviewed within 24 hours by the Executive Director/Administrator and discussed the alleged altercation of abuse to her by an employee. She also received emotional support and discussed the need to report any concerns to the Administrator.	

	telling her to stand up. The resident stated she could not stand and CNA 1 grabbed Resident B under the arm and "yanked" her off the sofa. CNA 4 told CNA 1 to move and not touch the resident. QMA 3 and CNA 4 reported the incident around 11:00 a.m. They were very upset. The DON instructed the facility to write out statements. Resident B's cardiologist called and said the resident needed to return to the hospital as soon as possible due to pacemaker misfires. The resident was transported to the hospital via the facility bus. The DON did not talk to CNA 1, nor did she send the CNA home after being informed of the allegation. The DON indicated she gave the statements to the Administrator, but was unable to remember the time. The next day (6/4/2025), during the morning meeting the Maintenance Supervisor (who transported the resident to the hospital) indicated Resident B told him she had been mistreated by a staff member. After the morning meeting, CNA 1 was brought into the office to speak with the Administrator and DON. CNA 1 was sent home pending investigation. During an interview, on 6/30/2025 at 11:57 a.m., CNA 4 indicated on the morning of 6/30/2025, QMA 3 received a phone call from CNA 1. CNA 1		Accused staff member was put on administrative leave, investigated, and terminated within 24 hours of alleged abuse. Immediate in-service of proper notifications, administrative leave requirements, and protocol done with management. **2.How will the facility identify other residents who may have been affected by the same deficient practice?** • Open discussions regarding Resident Rights and Abuse will occur weekly in our resident chat meetings held on Mondays and Thursdays for the next 30 days. • A full review of incident reports and grievance records from the past 60 days well be conducted to identify any other residents who may have experienced abuse, neglect, or delayed care.	

	was complaining that Resident B was asking for ice and assistance to the bathroom. QMA 3 reminded CNA 1 that the resident was non-weight bearing due to a fractured ankle. CNA 1 was told QMA 3 and CNA 4 would get the ice and CNA 1 and CNA 2 should get a wheelchair to transfer the resident to the bathroom. When they arrived to the resident's room CNA 2 left. CNA 1 was being "rude" and could not understand why the resident could not get up and go to the bathroom. CNA 1 got upset and "yanked" the resident by the arm. CNA 4 told CNA 1 to leave and CNA 4 and QMA 3 would provide resident care. CNA 4 indicated she felt the interaction was both physically and verbally abusive. During an interview, on 6/30/2025 at 12:31 p.m., the Administrator indicated he was informed of the incident on 6/3/2025 at approximately 4:00 p.m. CNA 1 had already clocked out for the day. The Administrator reached out to the corporate office for guidance. On 6/4/2025 durging the morning meeting, the Maintenance Supervisor indicated while he was transporting the resident to the hospital, the resident told him she had been mistreated by a staff member. After the morning meeting on 6/4/2025, at		• Interviews will be conducted with residents and families to uncover any unreported concerns. **3.What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** • All staff will receive mandatory retraining on abuse prevention, residents' rights, and timely response to resident needs through our Relias training modules and in-service trainings. • A new ombudsman abuse and residents rights reporting hotline poster has been posted in clinical waiting areas and common areas frequented by residents. • The facility's abuse prevention policy reviewed with all staff via in-service training.	

	approximately 11:00 a.m., CNA 1 was called to the Administrator's office and suspended pending investigation. Review of CNA 1's time card indicated on 6/3/2025, CNA 1 clocked in at 6:45 a.m. and clocked out at 3:15 p.m. On 6/4/2025, CNA 1 clocked in at 6:45 a.m. and clocked out at 11:00 a.m. CNA 1 was not reachable during the survey. Review of a current policy, dated 11/2024, titled "Abuse And Neglect Prevention" indicated the following: "Residents of the Premises have the right to be free of abuse, neglect and exploitation. Staff members will conduct themselves in a manner that is always respectful and courteous. Staff behavior that is abusive, neglectful or exploits residents will not be tolerated by the management of the Premises." The policy was provided on 6/30/2025 at 10:45 a.m. This citation is related to complaint IN00460218. Based on record review and interview, the facility failed to ensure residents were free from physical abuse for 1 of 3 residents reviewed. [Resident B]		**4.How will the facility monitor its corrective actions to ensure the deficient practice is being corrected and will not recur?** • The Administrator or designee will conduct weekly audits of call light response times and resident care interactions for 90 days. • The Quality Assurance and Performance Improvement (QAPI) committee will review audit results monthly and address staffing concerns and/or provide training as needed. • Starting with the next Resident council meetings on August 17, 2025,will include a standing agenda item on safety and rights to encourage open communication. • Any new allegations of violation of Resident	

	Finding Include: The clinical record of Resident B was reviewed on 6/30/2025 at 11:00 a.m. Diagnoses included anxiety, fractured left ankle, type 2 diabetes, hypertension, and atrial fibrillation. Review of a facility reported incident, dated 6/4/2025, indicated CNA 1 and CNA 2 were located in the room of Resident B. CNA 1 called QMA 3 and indicated the resident was asking them to get ice and refusing to go to the bathroom. During an interview, on 6/30/2025 at 10:48 a.m., QMA 3 indicated CNA 1 called her and indicated the resident had asked CNA 1 and CNA 2 to get her ice and was refusing to stand up to go to the bathroom. QMA 3 told CNA 1 the resident was non-weight bearing due to a fractured left ankle she sustained during a fall on 6/2/2025. QMA 3 indicated she had already made sure all staff knew of the fractured ankle and the resident's non-weight bearing status. QMA 3 and CNA 4 went to the resident's room and saw CNA 1 and CNA 2. CNA 3 left the resident's room shortly after they arrived. The resident was sitting on the sofa and CNA 1 "grabbed her (Resident B) under her arm and yanked her up." CNA 4 told CNA 1 to leave the resident's		Rights and/or abuse will be reviewed within 24 hours by the Administrator. **5.By what date will the systemic changes be completed?** • All corrective actions and systemic changes will be completed by August 17, 2025. **The facility respectfully requests a paper compliance review.**	

	room, and they would take care of it. CNA 1 left the resident's room and QMA 3 and CNA 4 assisted the resident to the bathroom. They went to report the incident to the DON, but she as in a meeting with a new resident. They did not go to the Administrator, but waited for the DON's meeting to end. During an interview, on 6/30/2025 at 11:28 a.m., the DON indicated on 6/2/2025, Resident B fell in the elevator and complained of pain in the left leg, but refused to go to the hospital. Approximately one hour later the resident requested to go to the hospital. The resident returned to the facility with a diagnoses of a fractured left ankle. On morning of 6/3/2025, 2 staff members reported they had witnessed CNA 1 yelling at Resident B, telling her to stand up. The resident stated she could not stand and CNA 1 grabbed Resident B under the arm and "yanked" her off the sofa. CNA 4 told CNA 1 to move and not touch the resident. QMA 3 and CNA 4 reported the incident around 11:00 a.m. They were very upset. The DON instructed the facility to write out statements. Resident B's cardiologist called and said the resident needed to return to the hospital as soon as possible due to pacemaker misfires. The resident was transported to the			

	hospital via the facility bus. The DON did not talk to CNA 1, nor did she send the CNA home after being informed of the allegation. The DON indicated she gave the statements to the Administrator, but was unable to remember the time. The next day (6/4/2025), during the morning meeting the Maintenance Supervisor (who transported the resident to the hospital) indicated Resident B told him she had been mistreated by a staff member. After the morning meeting, CNA 1 was brought into the office to speak with the Administrator and DON. CNA 1 was sent home pending investigation. During an interview, on 6/30/2025 at 11:57 a.m., CNA 4 indicated on the morning of 6/30/2025, QMA 3 received a phone call from CNA 1. CNA 1 was complaining that Resident B was asking for ice and assistance to the bathroom. QMA 3 reminded CNA 1 that the resident was non-weight bearing due to a fractured ankle. CNA 1 was told QMA 3 and CNA 4 would get the ice and CNA 1 and CNA 2 should get a wheelchair to transfer the resident to the bathroom. When they arrived to the resident's room CNA 2 left. CNA 1 was being "rude" and could not understand why the resident could not get up and go to the bathroom. CNA 1 got upset and			

	"yanked" the resident by the arm. CNA 4 told CNA 1 to leave and CNA 4 and QMA 3 would provide resident care. CNA 4 indicated she felt the interaction was both physically and verbally abusive. During an interview, on 6/30/2025 at 12:31 p.m., the Administrator indicated he was informed of the incident on 6/3/2025 at approximately 4:00 p.m. CNA 1 had already clocked out for the day. The Administrator reached out to the corporate office for guidance. On 6/4/2025 durging the morning meeting, the Maintenance Supervisor indicated while he was transporting the resident to the hospital, the resident told him she had been mistreated by a staff member. After the morning meeting on 6/4/2025, at approximately 11:00 a.m., CNA 1 was called to the Administrator's office and suspended pending investigation. Review of CNA 1's time card indicated on 6/3/2025, CNA 1 clocked in at 6:45 a.m. and clocked out at 3:15 p.m. On 6/4/2025, CNA 1 clocked in at 6:45 a.m. and clocked out at 11:00 a.m. CNA 1 was not reachable during the survey. Review of a current policy, dated 11/2024, titled "Abuse			

	And Neglect Prevention" indicated the following: "Residents of the Premises have the right to be free of abuse, neglect and exploitation. Staff members will conduct themselves in a manner that is always respectful and courteous. Staff behavior that is abusive, neglectful or exploits residents will not be tolerated by the management of the Premises." The policy was provided on 6/30/2025 at 10:45 a.m. This citation is related to complaint IN00460218.			
R 0053	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(w) (w) Residents have the right to be free from verbal abuse. Based on record review and interview, the facility failed to ensure residents were free from verbal abuse, for 1 of 3 residents reviewed. (Resident B). Finding Include:	R 0053	*Silver Birch of Muncie* *2500 W Kilgore Ave* *Muncie, IN 47304* *Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on*	08/17/2025

	The clinical record of Resident B was reviewed on 6/30/2025 at 11:00 a.m. Diagnoses included anxiety, fractured left ankle, type 2 diabetes, hypertension, and atrial fibrillation. Review of a facility reported incident, dated 6/4/2025, indicated CNA 1 and CNA 2 were located in the room of Resident B. CNA 1 called QMA 3 and indicated the resident was asking them to get ice and refusing to go to the bathroom. During an interview, on 6/30/2025 at 10:48 a.m., QMA 3 indicated CNA 1 called her and indicated the resident had asked CNA 1 and CNA 2 to get her ice and was refusing to stand up to go to the bathroom. QMA 3 told CNA 1 the resident was non-weight bearing due to a fractured left ankle she sustained during a fall on 6/2/2025. QMA 3 indicated she had already made sure all staff knew of the fractured ankle and the resident's non-weight bearing status. QMA 3 and CNA 4 went to the resident's room and saw CNA 1 and CNA 2 in the room. CNA 3 left the resident's room shortly after they arrived. The resident was sitting on the sofa and CNA 1 "grabbed her (Resident B)under her arm and yanked her up." CNA 4 told CNA 1 to leave the resident's room, and they would take care of it. CNA 1 left the		*the statement* *of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction* *for this survey. Please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests* *the granting of paper compliance by a desk review. Should additional* *information be necessary to confirm said compliance, please feel free to* *contact Joe Collins, Executive Director, Silver Birch of Muncie.* **Prefix Tag # R 053** **Plan of Correction for Tag R053 – Verbal Abuse** **Regulation Cited:410 IAC 16.2-5-1.2(w)** **Violation:Failure to ensure residents were free from verbal abuse by a**	

	resident's room and QMA 3 and CNA 4 assisted the resident to the bathroom. They went to report the incident to the DON, but she as in a meeting with a new resident. They did not go to the Administrator, but waited for the DON's meeting to end. During an interview, on 6/30/2025 at 11:28 a.m., the DON indicated on 6/2/2025, Resident B fell in the he elevator and complained of pain in the left leg, but refused to go to the hospital. Approximately one hour later the resident requested to go to the hospital. The resident returned to the facility with a diagnoses of a fractured left ankle. On morning of 6/3/2025, 2 staff members reported they had witnessed CNA 1 yelling at Resident B, telling her to stand up. The resident stated she could not stand and CNA 1 grabbed her under the arm and "yanked" her off the sofa. CNA 4 told CNA 1 to move and not touch the resident. QMA 3 and CNA 4 reported the incident around 11:00 a.m. They were very upset. The DON instructed the facility to write out statements. Resident B's cardiologist called and said the resident needed to return to the hospital as soon as possible due to pacemaker misfires. The resident was transported to the hospital via the facility bus. The DON did not talk to CNA 1, nor did she send		**staff member.** **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • Resident B, who was subjected to verbal abuse, was interviewed by the Administrator Director within 24 hours and reminded the resident of her rights and that that the DON and Executive Director/Administrator is always open for conversation of concerns. • The involved staff member was removed from duty pending investigation and subsequently terminated following confirmation of the incident. • The resident’s care plan was updated to include enhanced emotional support and regular check-ins by the facility’s	

	the CNA home after being informed of the allegation. The DON indicated she gave the statements to the Administrator, but was unable to remember the time. The next day (6/4/2025), during the morning meeting the Maintenance Supervisor (who transported the resident to the hospital) indicated Resident B told him she had been mistreated by a staff member. After the morning meeting, CNA 1 was brought into the office to speak with the Administrator and DON. CNA 1 was sent home pending investigation. During an interview, on 6/30/2025 at 11:57 a.m., CNA 4 indicated on the morning of 6/30/2025, QMA 3 received a phone call from CNA 1. CNA 1 was complaining that Resident B was asking for ice and assistance to the bathroom. QMA 3 reminded CNA 1 that the resident was non-weight bearing due to a fractured ankle. CNA 1 was told QMA 3 and CNA 4 would get the ice and CNA 1 and CNA 2 should get a wheelchair to transfer the resident to the bathroom. When they arrived to the resident's room, CNA 2 left. CNA 1 was being "rude", yelling at the resident, and could not understand why the resident could not get up and go to the bathroom. CNA 1 got upset and "yanked" the resident by the arm. CNA 4 told CNA 1 to leave		mental health liaison. **2.How will the facility identify other residents who may have been affected by the same deficient practice?** • The facility will review grievance logs, incident reports, and staff assignments for the past 60 days and interview those that may have potential concerns regarding the accused staff member or other staff. • Completed resident satisfaction surveys will be reviewed to identify residents and families that may have unreported concerns related to staff behavior.	

	and CNA 4 and QMA 3 would provide resident care. CNA 4 indicated she felt the interaction was both physically and verbally abusive. During an interview, on 6/30/2025 at 12:31 p.m., the Administrator indicated he was informed of the incident on 6/3/2025 at approximately 4:00 p.m. CNA 1 had already clocked out for the day. The Administrator reached out to the corporate office for guidance. On 6/4/2025 dunging the morning meeting, the Maintenance Supervisor indicated while he was transporting the resident to the hospital, the resident told him she had been mistreated by a staff member. After the morning meeting on 6/4/2025, at approximately 11:00 a.m., CNA 1 was called to the Administrator's office and suspended pending investigation. Review of CNA 1's time card indicated on 6/3/2025, CNA 1 clocked in at 6:45 a.m. and clocked out at 3:15 p.m. On 6/4/2025, CNA 1 clocked in at 6:45 a.m. and clocked out at 11:00 a.m. CNA 1 was not reachable during the survey.		**3.What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** • All staff received mandatory retraining on professional communication, residents' rights, and abuse prevention. Relias training: Abuse and Neglect: Resident Abuse • A zero-tolerance policy for verbal abuse was and will be emphasized and posted in all staff areas. • Supervisors were instructed to increase unannounced observations of staff-resident interactions and report incidents of concern. • A new "Report It" will be launched to allow residents and staff to report concerns anonymously. • A "Caring, Approachable, Kind and Empathetic C.A.K.E. Communication"	

Review of a current policy, dated 11/2024, titled "Abuse And Neglect Prevention" indicated the following:

".... Reporting ....Staff members are required to immediately report suspect behaviors to their Department Manager. .... The Department Manager will immediately inform the Executive Director. Once an allegation of abuse has been reported, the accused individual will be immediately removed from the facility and suspended pending the outcome of the investigation. ...." The policy was provided on 6/30/2025 at 10:45 a.m.

This citation is related to complaint IN00460218.

Based on record review and interview, the facility failed to ensure residents were free from verbal abuse, for 1 of 3 residents reviewed. (Resident B).

Finding Include:

The clinical record of Resident B was reviewed on 6/30/2025 at 11:00 a.m. Diagnoses included anxiety, fractured left ankle, type 2 diabetes, hypertension, and atrial fibrillation.

Review of a facility reported incident, dated 6/4/2025, indicated CNA 1 and CNA 2 were located in the room of

campaign was launched, including posters, staff huddles,
and role-playing exercises.

- Any new allegations of verbal abuse will be reviewed
within 24 hours by the Administrator.

4.How will the facility monitor its corrective actions to ensure the deficient practice is being corrected and will not recur?

- The Administrator or designee will conduct random
weekly audits of staff-resident interactions for 90 days.
- The QAPI (Quality Assurance and Performance Improvement) committee will review all
abuse-related reports monthly.
- Resident satisfaction surveys will include specific
questions about staff communication and

	Resident B. CNA 1 called QMA 3 and indicated the resident was asking them to get ice and refusing to go to the bathroom. During an interview, on 6/30/2025 at 10:48 a.m., QMA 3 indicated CNA 1 called her and indicated the resident had asked CNA 1 and CNA 2 to get her ice and was refusing to stand up to go to the bathroom. QMA 3 told CNA 1 the resident was non-weight bearing due to a fractured left ankle she sustained during a fall on 6/2/2025. QMA 3 indicated she had already made sure all staff knew of the fractured ankle and the resident's non-weight bearing status. QMA 3 and CNA 4 went to the resident's room and saw CNA 1 and CNA 2 in the room. CNA 3 left the resident's room shortly after they arrived. The resident was sitting on the sofa and CNA 1 "grabbed her (Resident B)under her arm and yanked her up." CNA 4 told CNA 1 to leave the resident's room, and they would take care of it. CNA 1 left the resident's room and QMA 3 and CNA 4 assisted the resident to the bathroom. They went to report the incident to the DON, but she as in a meeting with a new resident. They did not go to the Administrator, but waited for the DON's meeting to end. During an interview, on 6/30/2025 at 11:28 a.m., the		respect. **5.By what date will the systemic changes be completed?** • All corrective actions and systemic changes will be completed by**August 17, 2025**. **The facility respectfully requests a paper compliance review.**	

DON indicated on 6/2/2025, Resident B fell in the he elevator and complained of pain in the left leg, but refused to go to the hospital. Approximately one hour later the resident requested to go to the hospital. The resident returned to the facility with a diagnoses of a fractured left ankle. On morning of 6/3/2025, 2 staff members reported they had witnessed CNA 1 yelling at Resident B, telling her to stand up. The resident stated she could not stand and CNA 1 grabbed her under the arm and "yanked" her off the sofa. CNA 4 told CNA 1 to move and not touch the resident. QMA 3 and CNA 4 reported the incident around 11:00 a.m. They were very upset. The DON instructed the facility to write out statements. Resident B's cardiologist called and said the resident needed to return to the hospital as soon as possible due to pacemaker misfires. The resident was transported to the hospital via the facility bus. The DON did not talk to CNA 1, nor did she send the CNA home after being informed of the allegation. The DON indicated she gave the statements to the Administrator, but was unable to remember the time. The next day (6/4/2025), during the morning meeting the Maintenance Supervisor (who transported the resident to the hospital) indicated Resident B told him she had been

mistreated by a staff member. After the morning meeting, CNA 1 was brought into the office to speak with the Administrator and DON. CNA 1 was sent home pending investigation.

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During an interview, on 6/30/2025 at 12:31 p.m., the Administrator indicated he was informed of the incident on 6/3/2025 at approximately 4:00

p.m. CNA 1 had already clocked out for the day. The Administrator reached out to the corporate office for guidance. On 6/4/2025 dunging the morning meeting, the Maintenance Supervisor indicated while he was transporting the resident to the hospital, the resident told him she had been mistreated by a staff member. After the morning meeting on 6/4/2025, at approximately 11:00 a.m., CNA 1 was called to the Administrator's office and suspended pending investigation.

Review of CNA 1's time card indicated on 6/3/2025, CNA 1 clocked in at 6:45 a.m. and clocked out at 3:15 p.m. On 6/4/2025, CNA 1 clocked in at 6:45 a.m. and clocked out at 11:00 a.m. CNA 1 was not reachable during the survey.

Review of a current policy, dated 11/2024, titled "Abuse And Neglect Prevention" indicated the following:

".... Reporting ....Staff members are required to immediately report suspect behaviors to their Department Manager. .... The Department Manager will immediately inform the Executive Director. Once an allegation of abuse has been reported, the accused individual will be immediately removed

	from the facility and suspended pending the outcome of the investigation. ...." The policy was provided on 6/30/2025 at 10:45 a.m. This citation is related to complaint IN00460218.			

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