STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155387			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI A. BUILDING 00 COMPLETED B. WING 10/03/2022			ETED	
	PROVIDER OR SUPPLIE			2500 IC	ADDRESS, CITY, STATE, ZIP COD DWA AVE ERSVILLE, IN 47331		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
F 0600 Bldg. 00 SS=D Bldg. 00	IN00390453. Complaint IN0039 Federal/state defic allegations are cite Survey dates: Sep Facility number: Provider number: AIM number: 100 Census Bed Type: SNF/NF: 47 Total: 47 Census Payor Type Medicare: 8 Medicaid: 35 Other: 4 Total: 47 These deficiencies accordance with 4 Quality review cor 483.12(a)(1) Free from Abuse §483.12 Freedon Exploitation The resident has abuse, neglect, negroerty, and expsubpart. This incompleted.	155387 266550 e: reflect State Findings cited in 10 IAC 16.2-3.1 mpleted on October 5, 2022	F 00	000	Preparation or execution of this plan of correction does constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Pl of Correction is prepared an executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to resport to the allegation of noncompliance cited during the complaint survey conducted on 9/30/22 to 10/3 Please accept this plan of correction as the provider's credible allegation of compliance. The facility would like to respectfully request a desk review. Tonya James, LNHA	an d s	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155387	B. W	ING		10/03	/2022
		_		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹		2500 IC	OWA AVE		
CAROLE	TON HEALTHCAR	E CENTER		CONNE	ERSVILLE, IN 47331		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		sion and any physical or					
	resident's medical	not required to treat the					
	resident's medical	i symptoms.					
	§483.12(a) The fa	icility must-					
	\$483.12(a)(1) Not	use verbal, mental, sexual,					
	. , , , ,	, corporal punishment, or					
	involuntary seclus						
	Based on interview	and record review, the facility	F 06	500	F 600 Free from Abuse and		10/21/2022
		allegation of staff to resident			Neglect		
		t occur and failed to ensure an			Corrective action for the		
	~	nt to resident verbal abuse did			residents found to have bee	n	
		residents reviewed for abuse.			affected by the deficient		
	(Residents C, D and	d E)			practice:	41	
	Findings include:				Resident C was not harmed b	y the	
	Findings include.				alleged deficient practice. Resident D was not harmed b	v tho	
	1 The clinical reco	ord of Resident C was reviewed			alleged deficient practice.	y iiie	
		a.m. Her diagnoses included,			Resident E was not harmed b	v the	
		d to, depression, Alzheimer's			alleged deficient practice.	y alo	
		communication deficit,			Corrective action taken for		
	age-related debility	and dementia without			those residents having the		
		nce. Her most recent Minimum			potential to be affected by th	ne	
		sessment, dated 7-28-22,			same deficient practice:		
		C has a moderate level of			All residents have the potentia	al to	
		ent, but is able to understand			be affected by the deficient		
		ted to her and to be able to be			practice.	.1	
		rs. It indicated she requires			Resident interviews complete		
		e of one to two persons for ing and hygiene care and she is			with any potential allegations resident to resident verbal ver		
		d requires the use of a			abuse or staff to resident verb		
	wheelchair for mob	-			abuse. Any identified concern		
	101 1100	•			were immediately addressed	.5	
	In an interview with	h Resident C on 10-3-22 at 1:15			Measures/systemic changes	put	
	p.m., she indicated	CNA 3 had recently yelled at			into place to ensure the	-	
	_	and wanted help to get up, so I			deficient practice does not		
	put my [call] light o	on and she came in and when I			recur:		
		elp me get up, she let loose			The Administrator/DON/Desig	nee	
	with her cussing an	d yelling at me." She indicated			held an in-service for facility s	taff	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155387	B. W	ING		10/03/	/2022
		<u> </u>		CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			OWA AVE		
CAROLE	TON HEALTHCAR	E CENTED			ERSVILLE, IN 47331		
CAROLE	TON HEALTHCAR	E CENTER		CONNE	ERSVILLE, IN 47551		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		n almost immediately and			to provide education and		
	ensured CNA 3 left	her room. She indicated she			expectations as it relates to the	е	
	has not seen CNA 3	3 since that time.			"Indiana Abuse & Neglect &		
					Misappropriation of Property"	and	
		p.m., the Director of Nursing			ensuring the policy is followed	for	
		copy of a state reportable			reporting and investigation of		
		2. It indicated on 9-11-22 at			allegations to ensure the verba	al	
		of CNA 3] allegedly spoke in a			abuse did not occur.		
	_	e of Resident C]." In a			Corrective actions to be		
	•	tial report, dated 9-15-22, it			monitored to ensure the		
		as immediately removed from			deficient practice will not		
		pended, pending the outcome			recur:		
	_	. Notifications were made to			The Administrator/DON/Desig		
	-	, the Executive Director, the			will interview 3 residents and 3	3	
		ysician and local police			staff members per week x 4		
	_	cated Resident C was followed			weeks, 2 residents and 2 staff		
		s for any psycho-social			members per week x 4 weeks		
		oncerns identified. The			then 1 resident and 1 staff per		
	facility conducted i				week x 4 weeks to ensure any		
	-	ble residents and skin			allegations of resident to resid	ent	
		same with no new concerns			and/or staff to resident verbal		
		ated the allegation of verbal			abuse have been reported and	d	
		iated, related to CNA 3 using			investigated to ensure the		
		the resident during a verbal			allegation did not occur. This		
	_	Resident C. It indicated the			occur for no less than 6 month		
	CNA's employmen	t was ended prior to 9-15-22.			and compliance is maintained.		
	In an intermious!41	h LPN 4 on 10-3-22 at 10:20 a.m.,			The DON/Designee will present the results of these sudits may		
					the results of these audits mor	-	
		e morning of 9-11-22, she was station and "heard 2 women			to the QAPI committee for no		
					than 6 months. Any patterns t are identified will have an Action		
		mediately ran down to where oming from. As I was walking			Plan initiated. The QAPI	UII	
		ne of CNA 3] was walking				•	
		ng that she was not going to			committee will determine when 100% compliance is achieved		
		she [Resident C] snaps." She			ongoing monitoring is required		
		entered Resident C's room to					
		the resident seemed upset. "She					
		ted [name of CNA 3] to get her					
		CNA 3] started yelling at her					
		vith somebody else and left					
	mai she was busy w	viai someoody eise and leit					

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Event ID:

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155387		(X2) MULTII A. BUILDI B. WING		nstruction 00	(X3) DATE COMPL 10/03/	ETED	
	PROVIDER OR SUPPLIEF		25	00 IO	DDRESS, CITY, STATE, ZIP COD WA AVE RSVILLE, IN 47331		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.	ATE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TA	G	DEFICIENCY)		DATE
		icated she then located CNA 3					
		uld not be taking care of CNA					
		e then notified the DON of the					
		aformed to have CNA 3 to					
		nt of the events and then to					
		the facility. She indicated her					
	_	lent C was "she seems to be					
	memory issues."	ome occasional short term					
	memory issues.						
	An associated prog	ress note, dated 9-11-22 at					
		by LPN 4 indicated, "This nurse					
		staff member yelling at each					
		umber of Resident C] while					
	_	se's station. I went down there					
		aid, 'She wants me to snap just					
		t gonna snap just like that. I'm					
		ping someone.' I went to the					
		I'm not gonna take that from					
	her. I asked to get	up to go outside and she got					
	an attitude like she	always does. I've had					
	problems with her l	pefore and I'm not gonna put					
	up with it. I'm sorr	y to get that way but I'm tired of					
		vas removed from the area. DON					
	_	Director] notified. Staff					
		at this time. Resident					
	_	tive psychosocial effects and					
		Convergence [medical					
		No N.O.'s [new orders].					
	Message left to upd	ate family."					
	A marriant of CNIA 2	la most recent					
	A review of CNA 3						
	_	For abuse prohibition indicated ainings on 1-14-22, 4-28-22,					
	7-11-22 and 8-11-2						
	/-11-22 and 0-11-2	4.					
	2. The clinical reco	ord of Resident D was reviewed					
		p.m. His diagnoses included,					
		to, cerebral infarction with					
		gia/hemiparesis, other signs					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	G	00	COMPL	
		155387	B. WING			10/03/	/2022
NAME OF T	DROLUDED OF CURRY TO		STR	EET A	ADDRESS, CITY, STATE, ZIP COD	-	
NAME OF F	PROVIDER OR SUPPLIER		250	00 10	WA AVE		
	TON HEALTHCAR	E CENTER	co	NNE	ERSVILLE, IN 47331		
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	TAC	j	DEFICIENCY		DATE
		lving cognitive function post					
		and cognitive communication					
		cent Minimum Data Set (MDS) -10-22, indicated he was					
		rely impaired and had verbal					
		others and other unspecified					
	behaviors toward of	-					
	A copy of a state re	portable event, dated 9-1-22,					
		at 8:07 p.m., Residents D and					
		nates, "allegedly had a verbal					
	disagreement with r	no physical contact was					
	made." It indicated	the residents were					
		ted, an investigation was					
		cation made to the Executive					
		ctor of Nursing (DON), families					
		cian. Resident D was moved					
		follow-up report was filed on					
		ated the residents were no					
	_	care plans for each resident					
	conducted with each	sycho-social follow-up was					
	conducted with each	n resident.					
	In an interview on 1	0-3-22 at 2:12 p.m., with CNA					
	5, she recalled work	ring with Resident D on the					
	_	She recalled she was assisting					
		e dining room to his room,					
		th Resident E. "He started					
		sident E] a son of a bh and					
		to be in the room with that a					
		got to his room. He kept					
	"	sident E] names. We, me and					
		tept them separated and went					
		of LPN 7]." She indicated ocated into a different room in					
		me. She reported while she					
		re out in the hallway with					
		ling at Resident E, Resident E					
		ughters on his phone to tell					
		on. CNA 5 indicated Resident					
			1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155387		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/03/2022	
	PROVIDER OR SUPPLIER		2500 IC	ADDRESS, CITY, STATE, ZIP COD DWA AVE ERSVILLE, IN 47331	•
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	O BE COMPLETION
TAG	E, "was very upset" indicated she has w years. I have worke indicated Resident I roommate before, k him names and beir 3. The clinical recon 10-3-22 at 12:55 but are not limited to cerebral infarction. Data Set (MDS) assindicated he is cognunderstands what is occasionally may not a copy of a state reindicated on 9-1-22 E, who were roomn disagreement with made." It indicated immediately separa initiated with notific Director (ED), Directo	ord of Resident E was reviewed p.m. His diagnoses include, o, Parkinson's disease and His most recent Minimum ressment, dated 8-22-22, ditively intact, always said or communicated and to be understood. portable event, dated 9-1-22, at 8:07 p.m., Residents D and mates, "allegedly had a verbal no physical contact was the residents were ted, an investigation was eation made to the Executive ector of Nursing (DON), families cian. Resident D was moved follow-up report was filed on ated the residents were no care plans for each resident sycho-social follow-up was	TAG	DEFICIENCY	DATE
	canning maine of Re	sident E] names. We, me and			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155387		(X2) MULTIPI A. BUILDIN B. WING		nstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/03/2022		
	PROVIDER OR SUPPLIER		250	STREET ADDRESS, CITY, STATE, ZIP (2500 IOWA AVE CONNERSVILLE, IN 47331			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFI TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI) DEFICIENCY)	ATE	(X5) COMPLETION DATE
	and got the [name of Resident D was relet the facility at that ti and Resident D wer Resident D still yell called one of his dather what was going E, "was very upset" indicated she has we years. I have worked indicated Resident I roommate before, keep him names and being In an interview with p.m., he recalled the approximately one Resident D was his indicated prior to the other negative encound started yelling a why he did it." He not return him into and has not seen him Resident D's common but did not cause him Resident D's com	tept them separated and went of LPN 7]." She indicated beated into a different room in me. She reported while she is out in the hallway with ing at Resident E, Resident E aughters on his phone to tell on. CNA 5 indicated Resident about the situation. CNA 5 orked at the facility for several and here about 6 years. She D "had problems with a ind of the same thing. Calling and very rude." A Resident E on 10-3-22 at 1:05 incident with Resident D from month ago. He indicated roommate at that time. He is incident, there had been no unters. "He was in the hall and cussing at me. Don't know indicated the nursing staff did their shared room at that time in since. He indicated ents were hurtful at the time, in any significant problems. D a.m., the Social Services ovided a copy of the facility's procedure, entitled, "Indiana of Misappropriation of vision date of 10-27-2021. This ferbal Abuse [definition]: In in, and/or gestured language aging and/or derogatory terms heir families, either directly or in this may include resident to ats of harm, but excludes of a cognitively impaired					

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

PRINTED: 10/24/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155387		 JILDING	00	COMPL 10/03/	ETED	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
CAROLE	TON HEALTHCARE	E CENTER		RSVILLE, IN 47331		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ſΈ	(X5) COMPLETION DATE
F 0607 SS=D Bldg. 00	resident such as repononsensical languag staff to resident epis facility to provide remeets the psychosomeeds and concerns intent of this facility mistreatment, or negmisappropriation of punishment and/or in provide guidance to concerns or allegation misappropriation of who is alleged or act abuse, neglect misappe immediately remersident care, interval a written statement a completing the state asked to vacate the frinvestigation of the This Federal tag relations and the state asked to vacate the frinvestigation of the This Federal tag relations and the state asked to vacate the frinvestigation of the S483.12(b)(1)-(3) Develop/Implement \$483.12(b) The facility in the state asked to vacate the state asked to vac	etitive name calling or e. Verbal abuse includes any odesIt is the policy of this esident centered care that cial, physical and emotional of the residents. It is the to prevent the abuse, glect of residents or the their property, corporal nvoluntary seclusion and to direct staff to manage any ons of abuse, neglect or their propertyAn employee cused of being a party to oppropriation of property, will oved from the area(s) of the iewed by facility leadership for and not left aloneAfter ments, the employee(s) will be				
	§483.12(b)(2) Esta procedures to inve allegations, and					

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Facility ID: 000318

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE :		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155387	B. W	NG		10/03/	2022
	ROVIDER OR SUPPLIER			2500 IO	ADDRESS, CITY, STATE, ZIP COD DWA AVE ERSVILLE, IN 47331		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
					PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
	,				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OR \$483.12(b)(3) Incl paragraph §483.9 Based on interview failed to ensure a stafacility's policies respecific to an allegast staff member towar residents reviewed to CNA 3) Findings include: The clinical record 10-3-22 at 11:17 a.r were not limited to, disease, cognitive cage-related debility behavioral disturbated Data Set (MDS) assindicated Resident cognitive impairment what is communicated understood by other extensive assistance bed mobility, toileting non-ambulatory and wheelchair for mobility. In an interview with p.m., she indicated ther. "I was in bed a put my [call] light casked to have her he with her cussing and a staff nurse came is ensured CNA 3 left.	and record review, the facility aff member followed the garding abuse prohibition, ation of verbal abuse from a ds a resident for 1 of 4 for abuse. (Resident C and of Resident C and of Resident C was reviewed on m. Her diagnoses included, but depression, Alzheimer's ommunication deficit, and dementia without nee. Her most recent Minimum resessment, dated 7-28-22, C has a moderate level of nt, but is able to understand ted to her and to be able to be res. It indicated she requires the of one to two persons for ing and hygiene care and she is direquires the use of a fility. The Resident C on 10-3-22 at 1:15 CNA 3 had recently yelled at and wanted help to get up, so I on and she came in and when I telp me get up, she let loose directly yelling at me." She indicated in almost immediately and ther room. She indicated she	F 00	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	the at e I to I food al al s	(X5) COMPLETION DATE 10/21/2022
	has not seen CNA 3 On 9-30-22 at 1:25				ensuring the policy is followed reporting and investigation of allegations to ensure the verba abuse did not occur.	for	

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Event ID:

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Facility ID: 000318

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

PRINTED: 10/24/2022 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155387	ľ í	JILDING	onstruction 00	(X3) DATE COMPL 10/03/	ETED
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 2500 IOWA AVE CONNERSVILLE, IN 47331				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	event, dated 9-11-2 9:05 a.m., "[Name or raised tone to [name follow-up to the initindicated CNA 3 with a facility and susported for facility conducted in reliably-interviewal assessments of the sidentified. It indicated the facility conducted in reliably-interviewal assessments of the sidentified. It indicates was substantial a raised voice with disagreement with a CNA's employment. In an interview with she indicated on the seated at the nurse's screaming and I imported for the seated at the fact of the seated at the fact of the seated and the seated she then expected for the day and [1] that she was busy with the fact of the fact o	2. It indicated on 9-11-22 at of CNA 3] allegedly spoke in a e of Resident C]." In a tial report, dated 9-15-22, it as immediately removed from bended, pending the outcome. Notifications were made to the texecutive Director, the sysician and local police cated Resident C was followed as for any psycho-social oncerns identified. The			Corrective actions to be monitored to ensure the deficient practice will not recur: The Administrator/DON/Desig will interview 3 residents and 3 staff members per week x 4 weeks, 2 residents and 2 staff members per week x 4 weeks then 1 resident and 1 staff per week x 4 weeks to ensure sta and residents understand the allegations of resident to resid and/or staff to resident verbal abuse have been reported an investigated to ensure the allegation did not occur. This occur for no less than 6 month and compliance is maintained The DON/Designee will prese the results of these audits more to the QAPI committee for no than 6 months. Any patterns are identified will have an Activate Plan initiated. The QAPI committee will determine whe 100% compliance is achieved ongoing monitoring is required.	B ff any ent d will ns nt nthly less that on or if	
		no maiontage of the maiontage men	1				

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Event ID:

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155387	B. W	NG		10/03/	2022
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			WA AVE		
CAROLE	TON HEALTHCAR	E CENTED			RSVILLE, IN 47331		
CANOLL	TONTIEALTHOAN	E CENTER		CONNE	ERSVILLE, IN 47551		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	impression of Resid	lent C was "she seems to be					
	pretty sharp with so	ome occasional short term					
	memory issues."						
	An associated progr	ress note, dated 9-11-22 at					
		by LPN 4 indicated, "This nurse					
		staff member yelling at each					
		umber of Resident C] while					
	I -	se's station. I went down there					
	and staff member sa	aid, 'She wants me to snap just					
	like that and I'm no	t gonna snap just like that. I'm					
	in the middle of hel	ping someone.' I went to the					
	resident who said, '	I'm not gonna take that from					
	her. I asked to get	up to go outside and she got					
	an attitude like she	always does. I've had					
	problems with her b	pefore and I'm not gonna put					
	up with it. I'm sorr	y to get that way but I'm tired of					
	it.' Staff member w	vas removed from the area. DON					
	and ED [Executive	Director] notified. Staff					
	member sent home	at this time. Resident					
	monitored for negat	tive psychosocial effects and					
	will continue to be.	Convergence [medical					
	provider] notified.	No N.O.'s [new orders].					
	Message left to upd						
		-					
	A review of CNA 3	's most recent					
	training/education f	for abuse prohibition indicated					
	_	ninings on 1-14-22, 4-28-22,					
	7-11-22 and 8-11-2	_					
	On 9-30-22 at 11:0	0 a.m., the Social Services					
		ovided a copy of the facility's					
		procedure, entitled, "Indiana					
		Misappropriation of					
	1	evision date of 10-27-2021. This					
		'erbal Abuse [definition]: In					
	Indiana, oral, written, and/or gestured language						
that includes disparaging and/or derogatory terms							
to the residents or their families, either directly or							
		g. This may include resident to					

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Event ID: 6T1011 Facility ID: 000318

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

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155387	î ′	ILDING	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/03/2022	
NAME OF PROVIDER OR SUPPLIER CAROLETON HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 2500 IOWA AVE CONNERSVILLE, IN 47331				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	resident verbal threa	ats of harm, but excludes					
		of a cognitively impaired					
		etitive name calling or					
		ge. Verbal abuse includes any					
		sodesIt is the policy of this					
		esident centered care that					
		cial, physical and emotional					
		of the residents. It is the					
	-	y to prevent the abuse,					
		glect of residents or the					
	* * *	their property, corporal					
	_	involuntary seclusion and to					
		o direct staff to manage any ons of abuse, neglect or					
	_	their propertyAn employee					
		ccused of being a party to					
	_	ppropriation of property, will					
		noved from the area(s) of the					
		riewed by facility leadership for					
	· ·	and not left aloneAfter					
		ements, the employee(s) will be					
		facility until further					
		incident is completed."					
	This Federal tag rela	ates to Complaint IN00390453.					
	3.1-28(a)						

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