STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155387	A. BUILDING 00 B. WING	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CAROLETON HEALTHCARE CENTER	2500 IOWA AVE CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00390453. Complaint IN00390453 - Substantiated. Federal/state deficiencies related to the allegations are cited at F600 and F607. Survey dates: September 30 and October 3, 2022 Facility number: 000318 Provider number: 155387 AIM number: 100266550 Census Bed Type: SNF/NF: 47 Total: 47 Census Payor Type: Medicare: 8 Medicaid: 35 Other: 4 Total: 47 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on October 5, 2022	F 0000	**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 State 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 allegation of noncompliance cited during the complaint survey conducted on 9/30/22 to 10/3/22.** **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**	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment,			

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

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	involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to ensure an allegation of staff to resident verbal abuse did not occur and failed to ensure an allegation of resident to resident verbal abuse did not occur for 3 of 4 residents reviewed for abuse. (Residents C, D and E) Findings include: 1. The clinical record of Resident C was reviewed on 10-3-22 at 11:17 a.m. Her diagnoses included, but were not limited to, depression, Alzheimer's disease, cognitive communication deficit, age-related debility and dementia without behavioral disturbance. Her most recent Minimum Data Set (MDS) assessment, dated 7-28-22, indicated Resident C has a moderate level of cognitive impairment, but is able to understand what is communicated to her and to be able to be understood by others. It indicated she requires extensive assistance of one to two persons for bed mobility, toileting and hygiene care and she is non-ambulatory and requires the use of a wheelchair for mobility. In an interview with Resident C on 10-3-22 at 1:15 p.m., she indicated CNA 3 had recently yelled at her. "I was in bed and wanted help to get up, so I put my [call] light on and she came in and when I asked to have her help me get up, she let loose with her cussing and yelling at me." She indicated	F 0600	**F 600 Free from Abuse and Neglect** **Corrective action for the residents found to have been affected by the deficient practice:** Resident C was not harmed by the alleged deficient practice. Resident D was not harmed by the alleged deficient practice. Resident E was not harmed by the alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected by the deficient practice. Resident interviews completed with any potential allegations of resident to resident verbal verbal abuse or staff to resident verbal abuse. Any identified concerns were immediately addressed **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/DON/Designee held an in-service for facility staff	10/21/2022

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	a staff nurse came in almost immediately and ensured CNA 3 left her room. She indicated she has not seen CNA 3 since that time. On 9-30-22 at 1:25 p.m., the Director of Nursing (DON) provided a copy of a state reportable event, dated 9-11-22. It indicated on 9-11-22 at 9:05 a.m., "[Name of CNA 3] allegedly spoke in a raised tone to [name of Resident C]." In a follow-up to the initial report, dated 9-15-22, it indicated CNA 3 was immediately removed from the facility and suspended, pending the outcome of the investigation. Notifications were made to Resident C's family, the Executive Director, the DON, attending physician and local police department. It indicated Resident C was followed closely for 72-hours for any psycho-social concerns, with no concerns identified. The facility conducted interviews with all reliably-interviewable residents and skin assessments of the same with no new concerns identified. It indicated the allegation of verbal abuse was substantiated, related to CNA 3 using a raised voice with the resident during a verbal disagreement with Resident C. It indicated the CNA's employment was ended prior to 9-15-22. In an interview with LPN 4 on 10-3-22 at 10:20 a.m., she indicated on the morning of 9-11-22, she was seated at the nurse's station and "heard 2 women screaming and I immediately ran down to where the screams were coming from. As I was walking down the hall, [name of CNA 3] was walking toward me and saying that she was not going to snap to it just when she [Resident C] snaps." She indicated she then entered Resident C's room to check on her and the resident seemed upset. "She told me she had asked [name of CNA 3] to get her up for the day and [CNA 3] started yelling at her that she was busy with somebody else and left		to provide education and expectations as it relates to the "Indiana Abuse & Neglect & Misappropriation of Property" and ensuring the policy is followed for reporting and investigation of allegations to ensure the verbal abuse did not occur. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/DON/Designee 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 any allegations of resident to resident and/or staff to resident verbal abuse have been reported and investigated to ensure the allegation did not occur. This will occur for no less than 6 months and compliance is maintained. The DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	her room." She indicated she then located CNA 3 and told her she would not be taking care of CNA 3. She indicated she then notified the DON of the situation and was informed to have CNA 3 to write out a statement of the events and then to have CNA 3 leave the facility. She indicated her impression of Resident C was "she seems to be pretty sharp with some occasional short term memory issues." An associated progress note, dated 9-11-22 at 10:54 a.m., written by LPN 4 indicated, "This nurse heard resident and staff member yelling at each other from [room number of Resident C] while [LPN 4] was at nurse's station. I went down there and staff member said, 'She wants me to snap just like that and I'm not gonna snap just like that. I'm in the middle of helping 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 before and I'm not gonna put up with it. I'm sorry to get that way but I'm tired of it.' Staff member was removed from the area. DON and ED [Executive Director] notified. Staff member sent home at this time. Resident monitored for negative psychosocial effects and will continue to be. Convergence [medical provider] notified. No N.O.'s [new orders]. Message left to update family." A review of CNA 3's most recent training/education for abuse prohibition indicated she had received trainings on 1-14-22, 4-28-22, 7-11-22 and 8-11-22. 2. The clinical record of Resident D was reviewed on 10-3-22 at 12:37 p.m. His diagnoses included, but were not limited to, cerebral infarction with right-sided hemiplegia/hemiparesis, other signs			

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	and symptoms involving cognitive function post cerebral infarction and cognitive communication deficit. His most recent Minimum Data Set (MDS) assessment, dated 8-10-22, indicated he was moderately cognitively impaired and had verbal behaviors towards others and other unspecified behaviors toward others. A copy of a state reportable event, dated 9-1-22, indicated on 9-1-22 at 8:07 p.m., Residents D and E, who were roommates, "allegedly had a verbal disagreement with no physical contact was made." It indicated the residents were immediately separated, an investigation was initiated with notification made to the Executive Director (ED), Director of Nursing (DON), families and attending physician. Resident D was moved to another room. A follow-up report was filed on 9-7-22, which indicated the residents were no longer roommates, care plans for each resident were updated and psycho-social follow-up was conducted with each resident. In an interview on 10-3-22 at 2:12 p.m., with CNA 5, she recalled working with Resident D on the evening of 9-1-22. She recalled she was assisting Resident D from the dining room to his room, which he shared with Resident E. "He started calling [name of Resident E] a son of a b---h and that he didn't want to be in the room with that a----e, before we even got to his room. He kept calling [name of Resident E] names. We, me and [name of CNA 6], kept them separated and went and got the [name of LPN 7]." She indicated Resident D was relocated into a different room in the facility at that time. She reported while she and Resident D were out in the hallway with Resident D still yelling at Resident E, Resident E called one of his daughters on his phone to tell her what was going on. CNA 5 indicated Resident			

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	E, "was very upset" about the situation. CNA 5 indicated she has worked at the facility for several years. I have worked here about 6 years. She indicated Resident D "had problems with a roommate before, kind of the same thing. Calling him names and being very rude." 3. The clinical record of Resident E was reviewed on 10-3-22 at 12:55 p.m. His diagnoses include, but are not limited to, Parkinson's disease and cerebral infarction. His most recent Minimum Data Set (MDS) assessment, dated 8-22-22, indicated he is cognitively intact, always understands what is said or communicated and occasionally may not be understood. A copy of a state reportable event, dated 9-1-22, indicated on 9-1-22 at 8:07 p.m., Residents D and E, who were roommates, "allegedly had a verbal disagreement with no physical contact was made." It indicated the residents were immediately separated, an investigation was initiated with notification made to the Executive Director (ED), Director of Nursing (DON), families and attending physician. Resident D was moved to another room. A follow-up report was filed on 9-7-22, which indicated the residents were no longer roommates, care plans for each resident were updated and psycho-social follow-up was conducted with each resident. In an interview on 10-3-22 at 2:12 p.m., with CNA 5, she recalled working with Resident D on the evening of 9-1-22. She recalled she was assisting Resident D from the dining room to his room, which he shared with Resident E. "He started calling [name of Resident E] a son of a b---h and that he didn't want to be in the room with that a----e, before we even got to his room. He kept calling [name of Resident E] names. We, me and			

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	[name of CNA 6], kept them separated and went and got the [name of LPN 7]." She indicated Resident D was relocated into a different room in the facility at that time. She reported while she and Resident D were out in the hallway with Resident D still yelling at Resident E, Resident E called one of his daughters on his phone to tell her what was going on. CNA 5 indicated Resident E, "was very upset" about the situation. CNA 5 indicated she has worked at the facility for several years. I have worked here about 6 years. She indicated Resident D "had problems with a roommate before, kind of the same thing. Calling him names and being very rude." In an interview with Resident E on 10-3-22 at 1:05 p.m., he recalled the incident with Resident D from approximately one month ago. He indicated Resident D was his roommate at that time. He indicated prior to this incident, there had been no other negative encounters. "He was in the hall and started yelling and cussing at me. Don't know why he did it." He indicated the nursing staff did not return him into their shared room at that time and has not seen him since. He indicated Resident D's comments were hurtful at the time, but did not cause him any significant problems. On 9-30-22 at 11:00 a.m., the Social Services Designee (SSD) provided a copy of the facility's current policy and procedure, entitled, "Indiana Abuse & Neglect & Misappropriation of Property", with a revision date of 10-27-2021. This policy indicates, "Verbal 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 within their hearing. This may include resident to resident verbal threats of harm, but excludes random statements of a cognitively impaired			

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	resident such as repetitive name calling or nonsensical language. Verbal abuse includes any staff to resident episodes...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. It is the intent of this facility to prevent the abuse, mistreatment, or neglect of residents or the misappropriation of their property, corporal punishment and/or involuntary seclusion and to provide guidance to direct staff to manage any concerns or allegations of abuse, neglect or misappropriation of their property...An employee who is alleged or accused of being a party to abuse, neglect misappropriation of property, will be immediately removed from the area(s) of the resident care, interviewed by facility leadership for a written statement and not left alone...After completing the statements, the employee(s) will be asked to vacate the facility until further investigation of the incident is completed." This Federal tag relates to Complaint IN00390453. 3.1-27(b)			
F 0607 SS=D Bldg. 00	483.12(b)(1)-(3) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and			

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	§483.12(b)(3) Include training as required at paragraph §483.95, Based on interview and record review, the facility failed to ensure a staff member followed the facility's policies regarding abuse prohibition, specific to an allegation of verbal abuse from a staff member towards a resident for 1 of 4 residents reviewed for abuse. (Resident C and CNA 3) Findings include: The clinical record of Resident C was reviewed on 10-3-22 at 11:17 a.m. Her diagnoses included, but were not limited to, depression, Alzheimer's disease, cognitive communication deficit, age-related debility and dementia without behavioral disturbance. Her most recent Minimum Data Set (MDS) assessment, dated 7-28-22, indicated Resident C has a moderate level of cognitive impairment, but is able to understand what is communicated to her and to be able to be understood by others. It indicated she requires extensive assistance of one to two persons for bed mobility, toileting and hygiene care and she is non-ambulatory and requires the use of a wheelchair for mobility. In an interview with Resident C on 10-3-22 at 1:15 p.m., she indicated CNA 3 had recently yelled at her. "I was in bed and wanted help to get up, so I put my [call] light on and she came in and when I asked to have her help me get up, she let loose with her cussing and yelling at me." She indicated a staff nurse came in almost immediately and ensured CNA 3 left her room. She indicated she has not seen CNA 3 since that time. On 9-30-22 at 1:25 p.m., the Director of Nursing (DON) provided a copy of a state reportable	F 0607	**F 607 Develop/Implement Abuse/Neglect policies** **Corrective action for the residents found to have been affected by the deficient practice:** Resident C was not harmed by the alleged deficient practice. CNA 3 is no longer employed at the facility **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected by the deficient practice. Resident interviews completed with any potential allegations of resident to resident verbal verbal abuse or staff to resident verbal abuse. Any identified concerns were immediately addressed **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/DON/Designee held an in-service for facility staff to provide education and expectations as it relates to the "Indiana Abuse & Neglect & Misappropriation of Property" and ensuring the policy is followed for reporting and investigation of allegations to ensure the verbal abuse did not occur.	10/21/2022

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	event, dated 9-11-22. It indicated on 9-11-22 at 9:05 a.m., "[Name of CNA 3] allegedly spoke in a raised tone to [name of Resident C]." In a follow-up to the initial report, dated 9-15-22, it indicated CNA 3 was immediately removed from the facility and suspended, pending the outcome of the investigation. Notifications were made to Resident C's family, the Executive Director, the DON, attending physician and local police department. It indicated Resident C was followed closely for 72-hours for any psycho-social concerns, with no concerns identified. The facility conducted interviews with all reliably-interviewable residents and skin assessments of the same with no new concerns identified. It indicated the allegation of verbal abuse was substantiated, related to CNA 3 using a raised voice with the resident during a verbal disagreement with Resident C. It indicated the CNA's employment was ended prior to 9-15-22. In an interview with LPN 4 on 10-3-22 at 10:20 a.m., she indicated on the morning of 9-11-22, she was seated at the nurse's station and "heard 2 women screaming and I immediately ran down to where the screams were coming from. As I was walking down the hall, [name of CNA 3] was walking toward me and saying that she was not going to snap to it just when she [Resident C] snaps." She indicated she then entered Resident C's room to check on her and the resident seemed upset. "She told me she had asked [name of CNA 3] to get her up for the day and [CNA 3] started yelling at her that she was busy with somebody else and left her room." She indicated she then located CNA 3 and told her she would not be taking care of CNA 3. She indicated she then notified the DON of the situation and was informed to have CNA 3 to write out a statement of the events and then to have CNA 3 leave the facility. She indicated her		**Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/DON/Designee 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 staff and residents understand the any allegations of resident to resident and/or staff to resident verbal abuse have been reported and investigated to ensure the allegation did not occur. This will occur for no less than 6 months and compliance is maintained. The DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	impression of Resident C was "she seems to be pretty sharp with some occasional short term memory issues." An associated progress note, dated 9-11-22 at 10:54 a.m., written by LPN 4 indicated, "This nurse heard resident and staff member yelling at each other from [room number of Resident C] while [LPN 4] was at nurse's station. I went down there and staff member said, 'She wants me to snap just like that and I'm not gonna snap just like that. I'm in the middle of helping 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 before and I'm not gonna put up with it. I'm sorry to get that way but I'm tired of it.' Staff member was removed from the area. DON and ED [Executive Director] notified. Staff member sent home at this time. Resident monitored for negative psychosocial effects and will continue to be. Convergence [medical provider] notified. No N.O.'s [new orders]. Message left to update family." A review of CNA 3's most recent training/education for abuse prohibition indicated she had received trainings on 1-14-22, 4-28-22, 7-11-22 and 8-11-22. On 9-30-22 at 11:00 a.m., the Social Services Designee (SSD) provided a copy of the facility's current policy and procedure, entitled, "Indiana Abuse & Neglect & Misappropriation of Property", with a revision date of 10-27-2021. This policy indicates, "Verbal 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 within their hearing. This may include resident to			

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CAROLETON HEALTHCARE CENTER	2500 IOWA AVE CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident verbal threats of harm, but excludes random statements of a cognitively impaired resident such as repetitive name calling or nonsensical language. Verbal abuse includes any staff to resident episodes...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. It is the intent of this facility to prevent the abuse, mistreatment, or neglect of residents or the misappropriation of their property, corporal punishment and/or involuntary seclusion and to provide guidance to direct staff to manage any concerns or allegations of abuse, neglect or misappropriation of their property...An employee who is alleged or accused of being a party to abuse, neglect misappropriation of property, will be immediately removed from the area(s) of the resident care, interviewed by facility leadership for a written statement and not left alone...After completing the statements, the employee(s) will be asked to vacate the facility until further investigation of the incident is completed." This Federal tag relates to Complaint IN00390453. 3.1-28(a)			