STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155512	A. BUILDING 00 B. WING	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION LIVING SACRED HEART VILLAGE	515 N MAIN ST AVILLA, IN 46710

(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 Complaints IN00387787 and IN00387890. Complaint IN00387787 - Substantiated. Federal/state deficiencies related to the allegations are cited at F600 and F607. Complaint IN00387890 - Substantiated. Federal/state deficiencies related to the allegations are cited at F600 and F607. Survey dates: August 22 and 23, 2022 Facility number: 000404 Provider number: 155512 AIM number: 100290810 Census Bed Type: SNF/NF: 76 Total: 76 Census Payor Type: Medicare: 3 Medicaid: 60 Other: 13 Total: 76 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 25, 2022	F 0000		
F 0600 SS=G 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			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155512	A. BUILDING 00 B. WING	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION LIVING SACRED HEART VILLAGE	515 N MAIN ST AVILLA, IN 46710

(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
	abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, 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 observation, interview, and record review, the facility failed to prevent abuse for 1 of 4 residents reviewed for abuse (Resident B). Applying the reasonable person concept, emotional distress and possible fear could occur after physical abuse from staff member. Findings include: On 8/22/22 at 12:42 P.M., Resident B's record was reviewed. Diagnoses were dementia, mood disorder, anxiety disorder, impulse disorder, contracture of left hand, and pain. He resided on the secured memory care unit. MDS (Minimum Data Set) assessments, dated 11/2/21, 1/25/22, and 4/26/22, indicated the resident had severely impaired cognition and mood indicators of depression which were as follows: -Annual MDS 11/2/21-Mood indicators were feeling down (1 day), trouble sleeping, and little energy (2-6 days). He had no behaviors. -Quarterly MDS, dated 1/25/22 and 4/26/22, indicated his mood had worsened with mood indicators of feeling down (1 day), tired/little energy (7-11 days), poor appetite (2-6 days), and	F 0600	1.Corrective action for residents noted to have been affected by the deficient practice. ·Resident B was assessed by Nursing on 08-11-22 and treated /showed no ill effect. Care plan reviewed and updated 08-11-22. ·Resident B was assessed on 8-12-22 by Psych NP and treated/showed no ill effect. 1.How will the facility identify other residents having the potential to be affected by the same deficient practice? Residents residing in the community who are at risk were reviewed on 08-12-22 by Social Services and showed no ill effect. 1.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.	09/09/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155512	A. BUILDING 00 B. WING	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION LIVING SACRED HEART VILLAGE	515 N MAIN ST AVILLA, IN 46710

(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
	trouble concentrating (7-11) days with no behaviors. Care plans were: -Mood disorder: The goal was for the resident to not experience any increase in his behavioral episodes. Interventions included: monitor changes in his mood and record/monitor patterns of anxiety; determine source of his anxiety and precipitating events; and provide him with reassurance and support. -Anxiety: The goal was for the resident to accept reassurance from staff during episodes of anxiety. Interventions included: approach him warmly and positively at all times; convey acceptance of him; provide opportunities for him to vent his feelings and listen in a non-judgmental manner. -Depression: The goal was the resident would not experience an increase in his depressive symptoms. Interventions were: allow resident to select seating at activities, in the dining room and provide opportunities for increased socialization with others on the unit. -Difficulty finding room and may at times enter others rooms in attempt to find his room: The goal was the resident would be able to find his room by looking at his name plate or sign on his door. Interventions were to give verbal cues/reminders when he was unable to find his room; place familiar items in his room; redirect him when he enters another residents room; approach him positively and with warmth when redirecting him. An Indiana Department of Health report, dated 8/11/22 at 6:01 p.m., indicated a staff member had witnessed CNA 2 (Certified Nurse Assistant) push the resident against a wall. The resident was not found to have any injuries. CNA 2 was suspended pending investigation. A follow up report, dated 8/15/22, indicated the facility's		·Current associates will be re-educated by the Administrator or designee on or before 09-09-22 on Preventing, Recognizing and Reporting Abuse. ·Interdisciplinary team has reviewed Abuse Prevention and Reporting policy and procedure and it is in compliance with the CMS regulation F TAG 600. ·The Executive Director or designee will review grievances, abuse, neglect or exploitation investigations and abuse prevention monthly to monitor compliance ongoing. 1.Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent. · Monthly review of completed Grievances and abuse, neglect, or exploitation investigations results and trends will be completed by the Social Worker or designee and reported to the facility's QAPI Committee · Monthly for 6 months, QAPI Committee will review all submitted grievances and ANE investigations to ensure no ANE occurred and look for patterns and trends. Results and trends will be reviewed to determine compliance percentage. If compliance percentage is at or above 90%	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155512	A. BUILDING 00 B. WING	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION LIVING SACRED HEART VILLAGE	515 N MAIN ST AVILLA, IN 46710

(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
	investigation hadn't substantiated the allegation of abuse by CNA 2 who remained suspended pending further review. The allegation of abuse investigation, completed by the facility, was reviewed on 8/22/22 at 10:56 A.M. The investigation indicated on 8/11/22 at 5:50 p.m., Resident B was observed walking in the hallway past his room toward another resident's room. CNA 4 observed this and tried to re-direct him back to the living area. He turned back towards the living area with the CNA. CNA 2 then came down the hallway, yelled and stood in front of the resident which caused him to be agitated. He raised his arms to walk past when CNA 2 pushed him against the wall. He tried to kick CNA 2 while he was against the wall and she grabbed his leg which caused him to fall against the wall a 2nd time. LPN 7 (Licensed Practical Nurse) approached and observed CNA 2 holding the residents wrists with her hands as she told him that he was not going to the end of the hallway to enter another residents room. He raised his right arm in the air and made a fist while the CNA continued to hold his wrist. The nurse intervened and began talking with the resident to distract him. She told the CNAs to walk away and she would care for him. The nurse walked and talked with the resident who said "Those girls were trying to jump me". He was assisted to the lounge where he sat and watched television. A psychiatric progress note, dated 8/12/22 at unknown time, indicated Resident B had been visited due to allegations of abuse against the resident. The psychiatric NP (Nurse Practitioner) indicated during the visit, Resident B was seen in the dining area. He had been awake and alert and sitting in a chair. He was calm and not agitated. He denied depression and anxiety but was angry		average after six months, the committee will re-evaluate to determine if further monitoring is indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155512	A. BUILDING 00 B. WING	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION LIVING SACRED HEART VILLAGE	515 N MAIN ST AVILLA, IN 46710

(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
	when he stated "I've had this deal for about 3 days". He was not able to express what he was speaking about and appeared in distress. He was unable to recall the recent incident. Staff were to continue to assess for changes in his mood and behaviors, provide support to the resident, and encourage social activities. On 8/22/22 at 10:12 A.M., the Administrator, DON (Director of Nursing) and ADON (Assistant Director of Nursing) were interviewed. They indicated CNA 2 had been terminated and no longer worked at the facility. During CNA 2's employment, there were other unsubstantiated allegations of abuse following the facility's investigations and she had been allowed to remain working in the secured memory care unit with dementia residents. The facility's corporate staff had made the decision to terminate the CNA's employment following the latest abuse allegation. On 8/22/22 at 3:30 P.M., CNA 4 was interviewed. She indicated Resident B would often try and go into another's resident room whose room was a few doors down from his. Staff were to intervene and redirect this behavior. She had not ever seen the resident agitated and angry before and he was usually able to be redirected when wandering. When asked, she indicated the resident was initially cooperative and was walking back with her away from the other resident's room and towards the living area. He became agitated when CNA 2 yelled at him and came and stood in front of him. He tried to walk past CNA 2 when the she pushed him against the wall. The resident then tried to kick CNA 2 while he was against the wall and she grabbed his leg which made him fall back into the wall a second time. The nurse came down the hall and starting talking with the resident to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155512	A. BUILDING 00 B. WING	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION LIVING SACRED HEART VILLAGE	515 N MAIN ST AVILLA, IN 46710

(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
	calm him down. She and CNA 2 were told to walk away and the nurse would take care of him. She indicated she had never witnessed CNA 2 push a resident before although she'd overheard CNA 2 talking loudly and firmly with residents. On 8/23/22 at 11:25 A.M., LPN 7 was interviewed. She indicated she had heard something going on in the hallway and had overheard CNA 2 trying to redirect Resident B. When she went to where they were standing in the hallway, she saw CNA 2 holding both of the residents wrists. He then raised one of his hands and made a fist while the CNA continued to hold his wrists and told the resident that he wasn't going down to another residents room. She intervened and told CNA 2 and CNA 4 to walk away and she would walk with the resident. The 2 CNAs turned to walk away when CNA 2 turned back and told the resident that he was not going down to the other resident's room. She then repeated for the CNAs to walk away. She walked with the resident towards the lounge while he told her that "those girls had been trying to jump" him. She reassured him and he sat in the lounge and watched television. She reported the incident to the DON and CNA 2 left the facility as her shift had ended. The facility's current policy, titled "Abuse Prevention", provided on 8/22/22 at 10:29 A.M., stated the following: "All residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation...." This Federal tag relates to Complaints IN00387787 and IN00387890. 3.1-27(a)(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155512	A. BUILDING 00 B. WING	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION LIVING SACRED HEART VILLAGE	515 N MAIN ST AVILLA, IN 46710

(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 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 §483.12(b)(3) Include training as required at paragraph §483.95, Based on interview and record review, the facility failed to implement policies and procedures to prevent abuse for 1 of 4 residents reviewed (Resident B). Findings include: An Indiana Department of Health (IDOH) report, dated 8/11/22 at 6:01 p.m., indicated a staff member had witnessed CNA 2 (Certified Nurse Assistant) push a resident against a wall. The resident was not found to have any injuries. CNA 2 was suspended pending investigation. A follow up report, dated 8/15/22, indicated the facility's investigation hadn't substantiated the allegation of abuse by the CNA who remained suspended pending further review. On 8/22/22 at 10:12 A.M., the Administrator, DON (Director of Nursing) and ADON (Assistant Director of Nursing) were interviewed. They indicated CNA 2 had been terminated and no longer worked at the facility. During CNA 2's employment, there were other allegations of abuse	F 0607	1.Corrective action for residents noted to have been affected by the deficient practice. ·Resident B was assessed by Nursing on 08-11-22 and treated /showed no ill effects. Care plan was reviewed 08-11-22 and updated by the Director of Nursing. ·Resident B was assessed on 8-12-22 by Psych NP and treated/showed no ill effect. 1.How will the facility identify other residents having the potential to be affected by the same deficient practice? ·Residents residing in the community who are at risk were reviewed on 08-12-22 by Social Services and showed no ill effect. 1.The measures the facility will	09/09/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155512	A. BUILDING 00 B. WING	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION LIVING SACRED HEART VILLAGE	515 N MAIN ST AVILLA, IN 46710

(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
	that had been unsubstantiated. Prior to the incident on 8/11/22, an allegation of abuse had been made on 1/27/22 and reported to IDOH on 1/31/22. The facility had not substantiated the allegation and following their investigation, CNA 2 returned to work on the secured memory care unit with dementia residents. The ADON indicated CNA 2 had been counseled in the past about her approach when working with dementia residents but had no documentation to provide. The facility's current policy, titled "Abuse Prevention", provided on 8/22/22 at 10:29 A.M., stated the following: "All residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation...Abuse was the willful infliction of injury...intimidation or punishment with resulting physical harm, pain or mental anguish...Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation...The community's goal is to achieve and maintain an abuse-free environment...Training: The community will provide training for...Recognizing signs of and identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident property such as physical or psychosocial indicators..Understanding behavioral symptoms of residents that may increase the risk of abuse...Prevention...develop and implement policies and procedures to aid our community in preventing and prohibiting all types of abuse...Implement preventative measures to address factors that my lead to abusive situations, for example...4. Assist or rotate associates working with difficult or abusive residents...6. Help associates to recognize and deal appropriately with signs of burnout, frustration,		take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·Current associates will be re-educated by the Administrator or designee on or before 09-09-22 on Preventing, Recognizing and Reporting Abuse. ·Interdisciplinary team has reviewed Abuse Prevention and Reporting policy and procedure and it is in compliance with the CMS regulation F TAG 607. ·The Executive Director or designee will review grievances, abuse, neglect or exploitation investigations and abuse prevention to monitor compliance ongoing. 1.Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent. · Monthly review of completed Grievances and abuse, neglect, or exploitation investigations results and trends will be completed by the Social Worker or designee and reported to the facility's QAPI Committee for the next 3 months and then re-evaluated to determine if further monitoring is indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155512	A. BUILDING 00 B. WING	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION LIVING SACRED HEART VILLAGE	515 N MAIN ST AVILLA, IN 46710

(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
	stress and emotions that may lead to resident abuse...." A report to IDOH, dated 1/31/22 at 9:05 a.m., indicated a staff member alleged abusive behavior by CNA 2. The CNA had been suspended pending investigation. On 2/1/22, the investigation was completed and found to be unsubstantiated. Review of the investigation indicated the following: -1/27/22-A Registered Nurse (RN 1) went to the DON's office and reported concerns with CNA 2. The RN indicated the CNA "acts like a drill sergeant" and was a poor CNA. The RN requested the CNA be removed from the memory care unit. The DON requested the RN put in writing specific details of her concerns and names of specific residents she was concerned about. The DON then questioned CNA 2 who indicated she'd had no issues with nurses on the unit and had no problems that she was aware of. CNA 2 indicated she liked working with dementia residents and wasn't feeling burnt out. -1/30/22- RN 1 provided a written letter with her specific concerns with CNA2. She indicated CNA 2 was aggressive and used rough speech. She alleged the CNA yelled at 3 residents and described incidents. The CNA yelled at the residents in attempts to have them follow directions. Another resident, with attention seeking behaviors, was yelled at for not sitting in the right seat in the dining room. The RN alleged the CNA would point to where she wanted him to sit. She would put her hands on him to hold him in the chair when he attempted to stand. She alleged a 3rd resident was humiliated when CNA 2 removed her from a table where the resident had sat with her peers because she was touching another resident's wheelchair. She was moved to a table by herself . The RN believed this had been			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155512	A. BUILDING 00 B. WING	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION LIVING SACRED HEART VILLAGE	515 N MAIN ST AVILLA, IN 46710

(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
	punitive. The RN alleged another incident had occurred with a resident while performing mouth care. She provided other resident's names and statements alleged to have been spoken by CNA 2. -1/31/22-staff interviews were completed. 6 of 7 staff interviews completed indicated CNA 2 was firm, stern, and had an abrasive tone when speaking with residents, however, none believed the CNA to be abusive or had any intent to harm residents. -1/31/22-CNA 2 was interviewed about the allegations. She denied any abuse to residents. She made a derogatory comment about the RN and alleged the nurse changed the schedule to work only with the staff that she liked. CNA 2 indicated she loved working with dementia residents and was not burnt out. -1/31/22-Social Services staff conducted 4 random interviews on residents who resided on the memory care unit. No residents had concerns. Skin inspections for 7 residents who resided on the unit were conducted with no issues found. Confidential staff interviews were conducted on 8/22/22 and 8/23/22 and indicated the following: -Employee 10 indicated CNA 2 was harsh in the way she spoke with residents but thought it was just the CNA's personality and not intended to be abusive. At times, her voice sounded angry when she spoke with residents. -Employee 11-indicated CNA 2 had difficulty with some of the residents on the unit and was very short tempered when working with these residents. Employee 11 alleged at times, CNA 2 would speak to residents in an angry tone of voice. CNA 2 liked things to be a certain way on the unit and would get upset if residents wanted to do something different. CNA 2 worked many hours per week-almost every day-and would work			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155512	A. BUILDING 00 B. WING	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION LIVING SACRED HEART VILLAGE	515 N MAIN ST AVILLA, IN 46710

(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
	12 hour shifts. Employee 11 indicated it was their opinion CNA 2 wasn't a good fit to work with dementia residents because she wanted control of everything that went on in the unit. -Employee 12-indicated the 2nd time they worked on the unit, they overheard CNA 2 yelling at a resident. -Employee 13-indicated CNA 2 was not abusive but at times, would be abrasive with residents. The CNA always got her work done and took good care of the residents physical needs. -Employee 14-indicated they had never seen CNA 2 be abusive to residents but thought the CNA was too firm and decisive with residents. On 8/23/22 at 2:30 P.M., the DON and ADON were interviewed. Both indicated CNA 2 worked "all the time" and she had many hours in per week. The CNA had been asked several times if she felt burnt out from working on the dementia unit but had always denied this. She had not been taken off the unit and rotated to another area of the facility and staff had not identified her behaviors as signs of burnout. This Federal tag relates to Complaints IN00387787 and IN00387890. 3.1-28(a)			