STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
1019 BELLE'S PLACE OF CRAWFORDSVILLE	100 BICKFORD LN CRAWFORDSVILLE, IN 47933

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00458587. Complaint IN00458587 - State deficiencies related to the allegations are cited at R0052. Survey date: May 1 and 2, 2025 Facility number: 003674 Residential Census: 28 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 15, 2025.	R 0000	The creation and submission of this plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulations. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of compliance effective Month day, year.	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense Based on record review and interview, the facility failed to prevent abuse and mistreatment of a cognitively impaired resident by two facility staff members when a resident was forced awake and cleaned up against their will for 1 of 4 residents reviewed for abuse (Resident C). This deficient practice resulted in harm when Resident C was moved repeatedly with a left hip fracture and while complaining of pain. Findings include: A facility reported incident (FRI), dated 2/28/25, indicated Resident C had a fall reported on 2/27/25 at 6:00 a.m. A staff written statement by CNA 1 following the	R 0052	In response to R 0052, one resident was affected, resident was admitted to hospice and has since passed. All residents had the potential to be affected, all residents were reviewed/interviewed, none were affected. All staff were Inservice/educated on resident rights, abuse and neglect. All inter-viewable residents and staff will be interviewed regarding resident abuse, resident rights and	05/29/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Debbie Polston	DON	05/29/2025

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	incident, included the following: "Around approx [approximately] 5:20 a.m. the morning of the 27th of Feb. The other aide and I entered residents room to get him ready for the day. He was asleep in his chair. After waking him up, he was screaming out in pain as we lowered the chair. We were able to get him to sit in his wheelchair and brought him into the bathroom. He fought us, grabbing on to anything he could get ahold of, making the transitions hard. He was still screaming out in pain, using inappropriate language to express himself and then would apologize. After getting him washed up, shaved, and dressed we tried to stand him again to transfer to his wheelchair from the toilet. At this point he was pushing down, not bearing any weight. The other aide and I could not hold him. We brought him down the rest of the way to the floor and I sat with him while the other aide called 911 for assistance with standing him....." During a telephone interview on 5/2/25 at 9:47 a.m., CNA 1 indicated it was routine to get Resident C up early. The grabbing things and difficult behavior was just the way he acted. The staff were instructed to get up all the residents on the "get-up" list, so that was what they did. She indicated her written statement was completed the day after the incident so would be accurate. During an interview on 5/1/25 at 2:13 p.m., CNA 5 indicated Resident C moaned out when they tried to move him to a seated position. They completed transferring him to his wheelchair and he continued to complain of pain. They moved him into the bathroom and transferred him to the toilet and performed morning care. They tried to stand him up off the toilet to pull up his pants, but he could not tolerate standing so would sit back down complaining of pain. After several times of		neglect. Random Residents and staff will be inter-viewed weekly for 2 months, bi-weekly for 2 months, then monthly x 1 month, then quarterly x 2. Staff to be in-serviced monthly related to resident abuse, neglect, resident rights, including caring for residents with dementia. Systemic changes completed by 5/29/2025	

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	standing and sitting on the toilet, they were able to get his pants up. When transferring him to his wheelchair, he started to go down to the floor. They eased him to the floor and called 911 for assistance to get him up. She contacted the DON via text message regarding the incident. Their was no licensed nursing staff in the building at the time they were getting him up. During an interview on 5/1/25 at 3:27 p.m., the DON indicated Resident C's resident representative had requested he be gotten out of bed in the morning. She had agreed to send the resident to the emergency department for evaluation due to his complaints of pain. The DON indicated she was unsure why the CNAs had not re-approached when he initially rejected getting up from his chair and was verbalizing pain. She indicated the staff sometimes felt a lot of pressure from the families to get the residents up and ready for the day. The clinical record for Resident C was reviewed on 5/1/25 at 11:20 a.m. Diagnoses included dementia, osteoarthritis, and mild cardiomyopathy. The resident had been admitted to the secured memory care facility on 1/5/24. A facility resident assessment, dated 2/17/25, indicated Resident C was always disoriented and needed extensive intervention and care coordination to support dementia-related concerns. He required daily interventions due to uncooperative and resistance to care assistance. These attitudes, disturbances and emotional states created less than daily difficulties, which were modifiable to tolerable levels given training and patience on the part of the caregiver. The resident was dependant on others for dressing, was a two person assist, and needs direct			

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	assistance from another person for parts of dressing and undressing. The written staff instructions for the Dressing section of the assessment included the following: "CNAs (Certified Nursing Assistant) will wake [Resident C] up in the morning to see if he is ready to get up and get ready for breakfast....Please provide [Resident C] with step-by-step instructions before the task you plan to complete so he does not get agitated. Allow him to be independent with each task as long as it is not a safety concern." A nursing progress note, dated 2/27/25 at 8:46 a.m., entered by the DON (Director of Nursing), indicated it had been reported to her that Resident C had slid onto the floor when being transferred by two CNAs that morning. The CNAs were unable to get the resident up off the floor and lift assist was called. The resident had no injuries and active range of motion was found to be within normal limits. No vital signs had been obtained. The date/time of the fall was 2/27/25 at 6:00 a.m. A progress note, dated 2/27/25 at 8:14 a.m., entered by QMA (Qualified Medication Assistant) 3, indicated Resident C had anxiety and was yelling. An as needed dose of alprazolam (to treat anxiety) was given with the DON's consent. The note indicated the dose was effective. A progress note, dated 2/27/25 at 8:49 a.m., entered by the DON, indicated Resident C was up in his wheelchair at a dining room table. He had complained of pain in his left upper leg. The resident was given his medications per physician order and provided Tylenol (to treat pain). There was no bruising or swelling noted. She would follow up with the Nurse Practitioner today. A progress note, dated 2/27/25 at 11:08 p.m.,			

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	entered by LPN (Licensed Practical Nurse) 4, indicated the resident was up in his wheelchair in the dining room and had complained of pain in his left leg. The mobile X-ray provider had been in and completed left hip and left femur X-rays per nurse practitioner orders. A progress note, dated 2/28/25 at 2:02 p.m., entered by the DON, indicated the X-ray results had been received. The resident had an acute left hip fracture. An order to send the resident to the emergency department had been received and the resident representative was notified. A progress note, dated 3/1/25 at 9:20 a.m., entered by the DON, indicated the resident had returned from the emergency department and had been admitted to hospice care. A current facility policy, undated, titled, "Abuse & Neglect Overview," provided by the Administrator on 5/2/25 at 10:50 a.m., included the following: "Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish. Willfull means the act was deliberate, not accidental. Even if the person did not specifically intend to harm someone, the fact that they acted intentionally is enough for it to be considered abuse. Types of Abuse....4. Mental abuse - Verbal or nonverbal violation of dignity, regardless of resident awareness, that would have potential to inflict anguish, pain, or distress....6. Mistreatment - Staff treating a Resident inappropriately or exploiting a Resident." This citation relates to Complaint IN00458587.			