PRINTED: 12/07/2022 FORM APPROVED OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES						
CENTERS FOR MEDICARE & MEDICAID SERVICES						
am i men renim of preproventores	****					

OF CORRECTION	IDENTIFICATION NUMBER 155473	A. BUILDING 00 B. WING			COMPLETED 11/22/2022	
NAME OF PROVIDER OR SUPPLIER ENVIVE OF BERNE		STREET ADDRESS, CITY, STATE, ZIP COD 1065 PARKWAY ST BERNE, IN 46711				
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
IN00393506 and IN Complaint IN00393 Federal/state deficie allegations are cited Complaint IN00394 lack of evidence. Survey dates: Nover Facility number: 000 Provider number: 13 AIM number: 10026 Census Bed Type: SNF/NF: 32 Total: 32 Census Payor Type: Medicare: 5 Medicaid: 22 Other: 5 Total: 32 These deficiencies r accordance with 416 Quality review completes a \$483.12(a)(1) Free from Abuse a \$483.12 Freedom	200394788 200394	F 00	000	of berne F0000 INITIAL COMMENTS Preparation or execution of thi plan of correction does not constitute admission or agreer of provider of the truth of the fa alleged or conclusions set fortl the Statement of Deficiencies. Plan of Correction is prepared executed solely because it is required by the position of Fed and State Law. The Plan of Correction is submitted to resp to the allegation of noncomplia- cited during the Complaint Sur IN00393506 conducted Nov. 2 2022. Please accept this Plan of Correction as the provider's credible allegation of complian as of, Dec. 7, 2022. The provio respectfully requests desk revi with paper compliance to be	ment acts in on The and deral cond ance vey 22,	
•	he right to be free from					
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIENT REGULATORY OR This visit was for th IN00393506 and IN Complaint IN00393 Federal/state deficie allegations are cited Complaint IN00394 lack of evidence. Survey dates: Nover Facility number: 000 Provider number: 1: AIM number: 10020 Census Bed Type: SNF/NF: 32 Total: 32 Census Payor Type: Medicare: 5 Medicaid: 22 Other: 5 Total: 32 These deficiencies r accordance with 410 Quality review com 483.12(a)(1) Free from Abuse a §483.12 Freedom Exploitation	ROVIDER OR SUPPLIER OF BERNE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION This visit was for the Investigation of Complaints IN00393506 and IN00394788 Complaint IN00393506 - Substantiated. Federal/state deficiencies related to the allegations are cited at F600 and F609. Complaint IN00394788 - Unsubstantiated due to lack of evidence. Survey dates: November 22, 2022 Facility number: 000546 Provider number: 155473 AIM number: 100267370 Census Bed Type: SNF/NF: 32 Total: 32 Census Payor Type: Medicare: 5 Medicaid: 22 Other: 5 Total: 32 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 23, 2022 483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and	ROVIDER OR SUPPLIER OF BERNE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION This visit was for the Investigation of Complaints IN00393506 and IN00394788 Complaint IN00393506 - Substantiated. Federal/state deficiencies related to the allegations are cited at F600 and F609. Complaint IN00394788 - Unsubstantiated due to lack of evidence. 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Survey dates: November 22, 2022 Facility number: 000546 Provider number: 155473 AIM number: 100267370 Census Bed Type: SNF/NF: 32 Total: 32 Census Payor Type: Medicare: 5 Medicare: 5 Medicare: 5 Total: 32 Chall 34 Cha	ROVIDER OR SUPPLIER OF BERNE SIZE ADDRESS, CITY, STATE, ZIP COD 1065 PARKWAY ST BERNE, IN 46711 REGULATORY OR LSC IDENTIFYING INFORMATION This visit was for the Investigation of Complaints IN00393506 and IN00394788 Complaint IN00394788 - Unsubstantiated. Federal/state deficiencies related to the allegations are cited at F600 and F609. Complaint IN00394788 - Unsubstantiated due to lack of evidence. Facility number: 000546 Provider number: 155473 AIM number: 100267370 Census Bed Type: SNF/NF: 32 Census Payor Type: Medicare: 5 Medicare: 5 Medicare: 5 Total: 32 These deficiencies reflect State Findings cited in accordance with 410 IAC I6.2-3.1. Quality review completed November 23, 2022 483.12(a)(1) Free from Abuse and Neglect, and Exploitation STREET ADDRESS, CITY, STATE, ZIP COD 1065 PARKWAY ST BERNE, IN 46711 Tones Transported and State Aux or consecution of the PREPARK OF COMPLET ACTION SOBILIDER CROSS REFERENCES TO THE APPROPRIATE PREPART TAG Plan of Correction FOR Envive of berne F0000 INITIAL COMMENTS 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 Statement of Deficiencies. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey IN00393506 conducted Nov. 22, 2022. Please accept this Plan of Correction as the provider's credible allegation of compliance as of, Dec. 7, 2022. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.

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

Shelley Miller

TITLE

Chief Nursing Officer

12/05/2022

(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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: E02L11 Facility ID: 000546 If continuation sheet Page 1 of 8

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l ′		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING D0 B. WING		00	COMPLETED 11/22/2022			
		133473				11/22/	2022
NAME OF I	PROVIDER OR SUPPLIER	3			DDRESS, CITY, STATE, ZIP COD		
ENI/II/E	OF BERNE				ARKWAY ST , IN 46711		
	- -				, 111 407 11		T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		EFIX FAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		isappropriation of resident	<u> </u>	IAG			DATE
	1	loitation as defined in this					
		udes but is not limited to					
	freedom from corp						
	-	ion and any physical or					
	chemical restraint	not required to treat the					
	resident's medical	l symptoms.					
	§483.12(a) The fa	icility must-					
	8/83 12(a)(1) Not	use verbal, mental, sexual,					
	or physical abuse, corporal punishment, or						
	involuntary seclus						
			F 0600	0	F 600 - Free from Abuse and		12/07/2022
	Based on interview	and record review the facility	1 000		Neglect		12/0//2022
		resident's right to be free from			SS=D		
	abuse for 1 of 5 res	idents reviewed for abuse			"The facility failed to protect th	ne .	
	(Resident B)				resident's right to be free from		
					abuse for 1 of 5 residents		
	Findings include:				reviewed for abuse (Resident	•	
					1: What corrective action(s)	will	
	_	dated 10/7/22, was provided			be accomplished for those		
		or on 11/22/22 at 2:48 PM. The			residents found to have		
	_	10/7/22 "a third party had			affected by the deficient		
		that a former resident had			practice?		
	1 -	of sexual assault." The report			- Resident B no longer		
		nt no longer resided in the			resides at the facility.		
		tified Nursing Assistant (CNA) loyed by the facility. The			- Staff member no longe	I	
		ye any grievances regarding			employed by the facility.		
		nd the facility was unable to			2: How other residents having	na	
	substanitate the alle				the potential to be affected b	-	
					the same deficient practice v	-	
	A statement was pro	ovided by the Administrator			be identified and what		
	_	PM. The statement indicated			corrective action will be take	n.	
		ninistrator was notified of an			- All residents have the		
	inappropriate intera	action between a facility			potential to be affected by the		
		ility resident: Resident B and			alleged deficient practice.		
		ent indicated "both individuals			- All alert and oriented		

are alert and orientated x4 and highly aware of

residents were interviewed and no

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 11/22/2022 155473 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1065 PARKWAY ST **ENVIVE OF BERNE BERNE. IN 46711** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE what they say and do and what is acceptable allegations of abuse noted. behavior and what is not, any inappropriate activity between residents and employees are not 3: What measures will be put acceptable and a violation of company policies. into place or what systemic Other corporate individuals were notified of report changes will be made to and company Vice President of Human Resources ensure that the deficient was dispatched to the facility to facilitate practice does not recur? investigation." The statement indicated the Administrator was present during the interview All staff were in-serviced with CNA 2 and CNA 2 denied any inappropriate on: interactions with any resident, by self or other o "Resident Abuse, Neglect and employees. HR 3 indicated the facility had **Exploitation Procedural** received reports of inappropriate interactions, Guidelines" then CNA 2 decided to resign her position. The report also indicated Resident B was "interviewed 4: How the corrective action and denied having any inappropriate interaction will be monitored to ensure the with any staff member while at the facility." deficient practice will not recur i.e., what quality assurance In a confidential interivew on 11/22/22, an program will be put into place? employee indicated CNA 2 had told another staff member about her sexual relationship with ED will interview/audit 5 Resident B. The staff member then reported the random residents weekly M-F x8 allegation to the Administrator. weeks, then biweekly x8 weeks then monthly times x2 months to In an interview on 11/22/22 at 2:48 PM, the ensure residents feel safe and Administrator indicated on 9/16/22 an employee there are no allegations of abuse. reported Resident B and CNA 2 were in a sexual relationship. The Administrator indicated he The results of these audits interviewed CNA 2 and Resident B on 9/16/22 and will be reviewed by the QA both parties denied the relationship. The committee overseen by the Administrator indicated CNA 2 resigned during Executive Director. If a threshold the interview. The Adminsitrator indicated at a of 95% is not achieved, an action later date, the facility had found information plan will be developed. The posted on social media accounts by Resident B facility through the QAPI program, that he was in a relationship with CNA 2. The will review, update, and make Administrator indicated on 10/5/22 the police changes to the POC as needed for department indicated Resident B had filed charges sustaining substantial compliance of sexual assault against CNA 2. The for no less than 6 months. Administrator indicated there was no other documentation he could provide at the time. 5. Date of completion:

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CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			ON	4B NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	00	COMPLETED		
		155473	B. WING		11/22	2/2022	
			CTDEE	TADDRESS CITY STATE ZIR COD			
NAME OF 1	PROVIDER OR SUPPLIEF	₹		T ADDRESS, CITY, STATE, ZIP COD PARKWAY ST			
ENI\/I\/E	OE DEDNE						
EINVIVE	OF BERNE		DERI	NE, IN 46711			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	BE RIATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
				12/07/2022			
	In an interview on	11/22/22 at 3:26 PM, Police					
	Officer 5 indicated	Resident B had called on					
	10/2/22 and filed cl	harges against CNA 2 regarding					
		ce Officer 5 indicated the					
		till pending and he was unable					
	_	formation at the time.					
	lo give any other in	normation at the time.					
	The Surveyor after	npted to call Resident B on					
	1	M, but Resident B's phone went	1				
		il and the voicemail was full.					
	straight to voicema	ir and the voiceman was rain.					
	Resident B's record	review was conducted on					
		Diagnoses included: unspecified					
		ed level of lumbar spinal cord					
		disease, post traumatic stress					
	disorder and depres	-					
	disorder and depres	sion.					
	A quarterly Minim	um Data Set (MDS)					
		7/15/22 indicated Resident B					
		ew of Mental Status (BIMS) of					
	13/15 (cognitively	intact).					
	Progress notes were	e reviewed between 9/1/22 and					
		ndicated any allegation,	1				
		s were exhibited from Resident	1				
		s were exhibited from Resident					
	B at the time.						
	A policy dated 9/2	022, titled "Resident Abuse,					
		tation Procedural Guidelines,"	1				
		e Administrator on 11/22/22 at	1				
	1 .		1				
		y indicated"abuse is the	1				
		injury, unreasonable	1				
		idation, or punishment with	1				
		l harm, pain or mental anguish.	1				
		s the deprivation by an	1				
	· ·	g a caretaker, of goods or	1				
		cessary to attain or maintain	1				
	physical, mental an	d psychosocial well being.	1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Instances of abuse of all residents, irrespective of

Event ID:

E02L11

Facility ID: 000546

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155473	B. WI	NG		11/22/2022	
NAME OF PROVIDER OR SUPPLIER ENVIVE OF BERNE		•	1065 PA	ADDRESS, CITY, STATE, ZIP COD ARKWAY ST , IN 46711			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROMISSING BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	· L	DATE
F 0609 SS=D Bldg. 00	hamr pain or mental abuse, sexual abuse, sexual abuse, abus including abuse through the use of to means the individua not that the individua inflict injury or harm nonconsensual sexuresident." This Federal Citation IN00393506 3.1-27(a)(1) 483.12(b)(5)(i)(A)(Reporting of Allege §483.12(c) In respabuse, neglect, exthe facility must: §483.12(c)(1) Ensiviolations involving exploitation or misinjuries of unknown misappropriation or reported immediate hours after the allegevents that cause or result in serious than 24 hours if the allegation do not in result in serious be administrator of the officials (including Agency and adult state law provides	ed Violations conse to allegations of colorisation, or mistreatment, cure that all alleged g abuse, neglect, ctreatment, including en source and of resident property, are ctely, but not later than 2 cegation is made, if the the allegation involve abuse es bodily injury, or not later en events that cause the envolve abuse and do not codily injury, to the en facility and to other to the State Survey protective services where en for jurisdiction in long-term eccordance with State law					

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Event ID:

E02L11

Facility ID: 000546

If continuation sheet

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	T OF HEALTH AND HU						RM APPROVED
	R MEDICARE & MEDIC	X1) PROVIDER/SUPPLIER/CLIA	(V2) M	III TIDI E C	ONSTRUCTION		IB NO. 0938-039
			r í	ULTIPLE CI JILDING		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155473					00	COMPLETED 11/22/2022	
155473 B. WING						11/22	72022
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD PARKWAY ST		
ENVIVE	OF BERNE			BERNE	E, IN 46711		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	investigations to the her designated re officials in accordation in accordation including to the St 5 working days of alleged violation is corrective action in Based on interview to ensure an allegat the Indiana Department of the allegation. (Refindings include: An incident report, by the Administrator report indicated on notified the facility an incident of sexual A statement was pron 11/22/22 at 2:48 on 9/16/22 the Administrator indicated and inappropriate interatemployee and a fact In an interview on Administrator indicated reported Resident Erelationship. The A interviewed CNA 2 both parties denied	and record review the facility ion of abuse was reported to ment of Health within 24 hours desident B) dated 10/7/22, was provided or on 11/22/22 at 2:48 PM. The 10/7/22 "a third party had a former resident had alleged al assault." ovided by the Administrator PM. The statement indicated ministrator was notified of an action between a facility	F 00	509	F 609 - Reporting of Alleged Violations SS=D "The facility to ensure an allegation of abuse was report to the Indiana Department of Health within 24 hours of the allegation. (Resident B)" 1: What corrective action(s) to be accomplished for those residents found to have affected by the deficient practice? - Resident B no longer resides at the facility Allegation was reported upon notification of the allegation the potential to be affected by the same deficient practice where identified and what corrective action will be take alleged deficient practice.	dions. ng y vill n.	12/07/2022

until 10/7/22.

department indicated Resident B had filed charges

Administrator also indicated he had not reported

the allegation to the Indiana Department of Health

of sexual assault against CNA 2. The

All allegations of abuse

were audited by the ED to ensure

within 24hrs. No allegations were

reporting had occurred to the

Indiana Department of Health

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

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155473	(X2) MULTIPLE C A. BUILDING B. WING	OOSTRUCTION OO	(X3) DATE SURVEY COMPLETED 11/22/2022			
NAME OF PROVIDER OR SUPPLIER ENVIVE OF BERNE			STREET ADDRESS, CITY, STATE, ZIP COD 1065 PARKWAY ST BERNE, IN 46711					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY) noted to be out of complian:	BE COMPLETION DATE			
	Neglect and Exploi was provided by the 3:58 PM. The polic indicated"reporti alleged violations in exploitation or mist unknown source an property, are report than 2 hours after the events that cause the result in serious bothours if the events to involve abuse a bodily injury, to the and to other official agency and adult provides for jur facilities) in accord established procedure.	ng/response: ii: ensure that all avolving abuse, neglect reatment, including injuries of d misappropriation of resident ed immediately, but not later he allegation is made, if the e allegation involve abuse or dily injury, or not later than 24 hat cause the allegations do not do not result in serious e administrator of the facility including the state survey otective services where state is diction in long term care ance with state law through		3: What measures will be into place or what systemichanges will be made to ensure that the deficient practice does not recur? - Executive Director was erviced on: o "Resident Abuse, Negled Exploitation Procedural Guidelines" 4: How the corrective action will be monitored to ensure deficient practice will not include includ	put c as in ct and on e the recur e ace? udit all e nthly all een artment audits shold action e ogram, ke ded for			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
THISTERN	or condition	155473	B. WIN		<u></u>	11/22/2022	
	PROVIDER OR SUPPLIER OF BERNE			1065 PA	ADDRESS, CITY, STATE, ZIP COD ARKWAY ST , IN 46711		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	(X5) COMPLETION DATE
					5. Date of completion: 12/07/2022		

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