STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155746	A. BUILDING 00 B. WING	12/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PARKVIEW HAVEN	101 CONSTITUTION DR FRANCESVILLE, IN 47946

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F 0000 Bldg. 00	This visit was for Investigation of Complaints IN00423481 and IN00424317. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00423481 - Federal/State deficiencies related to the allegations are cited at F600 and F609. Complaint IN00424317 - No deficiencies related to the allegations are cited. Survey dates: December 27 & 28, 2023 Facility number: 000539 Provider number: 155746 AIM number: 100267280 Census Bed Type: SNF/NF: 30 Residential: 21 Total: 51 Census Payor Type: Medicare: 2 Medicaid: 11 Other: 17 Total: 30 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/4/23.	F 0000	Parkview Haven respectfully requests a desk review for compliance based on the low scope and severity.	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation			

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

Max Wayern Jones | Administrator | 01/17/2024

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	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, 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, record review, and interview, the facility failed to ensure a resident was free from verbal and physical abuse, related to a staff member's forceful attempts to pry a resident's hand open, pressing their fingers into the resident's neck, and yelling foul language at the resident, for 1 of 2 residents reviewed for abuse. (Resident B and Terminated Employee 1) Finding includes: Resident B was interviewed on 12/27/23 at 9:13 a.m. She indicated an Employee had given her medications and she had not wanted to take them. The Employee kept "pushing me to take them" and I wanted to know what they were. The Employee cussed at her and said they were going to make me take them. She had a glass of water in her hand and threw it at the Employee so they would leave her alone. They then put their thumb up to her neck and pressed hard into her neck. She demonstrated what was done. The observation indicated the Employee's thumb and forefinger was in the front/left middle area of the neck and was pressing into the skin. She indicated	F 0600	**TAG # F600 – Freedom from Abuse, Neglect, and Exploitation** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a Resident B was immediately separated from Terminated Employee #1 by direct care giver to ensure safety. Family/POA, attending physician, executive director, and director of nursing were notified. Resident B assessment was conducted, no injuries noted at that time. Resident B stated she feels safe in the facility. b Terminated Employee #1 was immediately notified via phone by executive director and director of nursing that they were immediately suspended for an allegation of abuse.	01/18/2024

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	they had pressed hard and it hurt. She then, "got away from" them and reported the incident. The Police come in and the Employee can no longer come into the building. An Indiana Department of Health (IDOH) reported incident, dated 12/6/23 at 12 p.m., indicated on 12/6/23 at 5:01 a.m., Resident B was treated inappropriately by Terminated Employee 1. The Terminated Employee 1 was immediately suspended and the incident was under investigation. The follow-up to the IDOH reported incident, dated 12/11/23, indicated the Resident alleged that the staff member made contact with her neck and arm after she had refused her medications and she had tossed water in the employee's face. Terminated Employee 1 was interviewed and indicated they had grabbed the front of the resident's clothing, and not her neck area, and had held her arm to keep her from falling. Staff members working at the time were interviewed and one staff member indicated she heard yelling though did not know what had happened. Another staff member stated she immediately separated the employee and the resident. Several residents were interviewed and indicated they heard loud speaking though were unable to hear what was being said. The local police were notified. There had been no evidence of injury to the resident. The allegation of abuse was substantiated and the Employee was terminated. Resident B's record was reviewed on 12/27/23 at 11:33 a.m. The diagnoses included, but were not limited to, Alzheimer's disease. A Quarterly Minimum Data Set assessment, dated 11/21/23, indicated a moderately impaired		**2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a All residents have the potential to be affected by this deficient practice. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a Education provided regarding F-Tag #600- all residents will be free from abuse, neglect, & exploitation. **4 How the correct action(s) will be monitored to ensure the deficient practice will not recur; i.e.; what quality assurance program will be put into place;** a Director of Nursing/Social Services/Designee will provide in-services to all team members on abuse, neglect, & exploitation monthly x 3 months, quarterly thereafter x 3 quarters, PRN as needed and upon hire to ensure compliance. b Results will be reported to the monthly QAPI meeting for review. After reviewing results, an action plan may be developed, if needed, to ensure compliance.	

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	cognitive status, had no behaviors, and was independent for ambulation. A Nurse's Progress Note, dated 12/6/23 at 12:44 p.m., indicated she had made an allegation of being treated inappropriately by a staff member. An assessment was completed and there was no redness or discoloration of the skin not completed and there was no redness or discoloration of the skin noted and there was no acute distress noted. A Nurse's Progress note, dated 12/6/23 at 4:40 p.m., indicated she was calm and was in no distress. A signed statement from the Assistant Director of Nursing (ADON), dated 12/6/23 and not time documented, indicated Employee 3 asked her to talk to Resident B. The resident had been talking to Employee 3 about an incident that occurred. The resident indicated Terminated Employee 1 had gotten mad at her for not taking her medications and they had argued back and forth for a while, then she threw a glass of water in his face. She indicated he then pressed his thumb into her neck and she asked him if he was trying to kill her. She then started screaming and he walked away. There were no marks on the resident's neck or any signs of injury. She was calm during the interview. The Administrator was then alerted. Terminated Employee 1 was interviewed by the facility on 12/7/23 at approximately 2:30 p.m. per telephone and he indicated the resident's medications were placed on her walker seat and he then walked away from the resident. She then refused to take the medication and he attempted to get the medications back to destroy them. She refused to give the medications back and "eventually" threw a cup of water in his face. He		**5 By what date the systemic changes for each deficient will be completed.** a January 18, 2024	

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	then grabbed the resident by the shirt and yelled at her. She no longer had her hands on the walker and he held her arm to get her to hold onto the walker. Employee 2 then intervened and he walked away. Employee 2's written, non-dated and non-signed statement, indicated around 4:30 a.m., Terminated Employee 1 had started the medication pass. Resident B had exited her room with her walker and indicated the resident was not in a good mood. Employee 4 had attempted to have a conversation with the resident and Terminated Employee 1 set a small plastic cup of water and a medication cup with medications on her walker and walked away. Employee 4 then walked away from the resident. The resident had started to ambulate towards her room and she stopped by the medication cart where Terminated Employee 1 was standing. Employee 2 was unsure what the resident had said, then Terminated Employee 1 asked for the medications back from the resident if she was not going to take them. He then yelled, "give me the f****** meds...." He was attempting to pry her hand open because she had the medications clenched in her hand. She then grabbed the cup of water and threw it at him. He then pushed her against the wall and had one hand up under her chin. He was yelling at her to, "stop being so f****** mean and hateful." Employee 2 then jumped up and said, "hey" and the he let go of the resident. The resident was rubbing her neck and said, "you hurt me, you stupid idiot". The two were separated. They continued yelling at each other. Terminated Employee 1 was walking away and yelling, "F*** you" repeatedly. The resident was assisted back to her room and then took the medications. She then got dressed. When the Day Shift staff came in, the resident started talking to Employee 3.			

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Employee 4 was interviewed on 12/6/23 at approximately 10:30 a.m. by telephone, and indicated around 5:30 a.m. she had heard yelling. She was in another resident's room assisting them to the bathroom. After she completed the care, she noticed water on the floor by the Nurses' Station.

Residents G, H, and J, who resided on the hallway close to where the incident occurred, were interviewed on 12/6/23. They indicated they heard yelling in the hallway. They were unsure what was being said.

During a telephone interview on 12/27/23 at 6:20 p.m., Employee 2 indicated Resident B had not been in a good mood the morning of 12/6/23. Terminated Employee 1 brought a medication cup with medications in it and a glass of water and sat them on the seat of the walker. The resident was ambulating toward her room and she stopped and asked the him what was in her medication cup and she was informed it was her medications. The medication cup was in her hand. Employee 2 then looked up and observed him attempting to "pry" the medication out of the resident hands and was saying "f****** give them back", the resident threw a glass of water on him. He then grabbed the resident's neck and had her back against the wall. The resident started yelling, "you hurt my throat" and he yelled back, "f*** you". Employee 2 was attempting to separate the resident and the employee. Employee 2 was trying to talk to the resident and Terminated Employee 1 was yelling at her in the hall, "f*** you".

During an interview on 12/28/23 at 11:02 a.m., Employee 4 indicated Resident B had not been in a good mood on 12/6/23. She had been talking to

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	the resident when Terminated Employee 1 placed the medications on the resident's walker. A call light was then activated down the hall. She responded to the call light and assisted that resident into the bathroom. She was unable to hear what was being said but could hear yelling in the hallway. After the care had been completed, she observed water on the floor and was told by Terminated Employee 1 that Resident B had thrown water at him. During an interview on 12/28/23 at 11:08 a.m., the ADON indicated Employee 3 had asked her to talk to Resident B on 12/6/23 around 6:35 a.m. She had been told the resident was making some "weird" remarks. The resident had informed her she had words with Terminated Employee 1 and had thrown water in his face. He had gotten mad and put his hands around her throat. The Administrator had been notified by text around 8:45 a.m. on 12/6/23. A facility Abuse Policy, received from the DON as current, and dated 2017, indicated the resident has the right to be from verbal and physical abuse and must not be subjected to abuse by anyone. This citation relates to Complaint IN00423481. 3.1-27(a)(1) 3.1-27(b)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect,			

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	exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to report an allegation of abuse to the Administrator of the facility, in a timely manner, related to a staff to resident abuse allegation, for 1 of 2 residents reviewed for abuse. (Resident B and Terminated Employee 1) Finding includes: An Indiana Department of Health (IDOH) reported incident, dated 12/6/23 at 12 p.m., indicated on 12/6/23 at 5:01 a.m., Resident B was treated inappropriately by Terminated Employee 1. The Terminated Employee 1 was immediately suspended and the incident was under	F 0609	**TAG # F609 – Reporting of Alleged Violations** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a Resident B was immediately separated from Terminated Employee #1 by direct care giver to ensure safety. Family/POA, attending physician, executive director, and director of nursing were notified. Resident B assessment was conducted, no	01/18/2024

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	investigation. The follow-up to the IDOH reported incident, dated 12/11/23, indicated the Resident alleged that the staff member made contact with her neck and arm after she had refused her medications and she had tossed water in the employee's face. Terminated Employee 1 was interviewed and indicated they had grabbed the front of the resident's clothing, and not her neck area and had held her arm to keep her from falling. Staff members working at the time were interviewed and one staff member indicated she heard yelling though did not know what had happened. Another staff member stated she immediately separated the employee and the resident. Several residents were interviewed and indicated they heard loud speaking though were unable to hear what was being said. The local police were notified. There had been no evidence of injury to the resident. The allegation of abuse was substantiated and the Employee was terminated. Cross reference F600. Employee 2's written, non-dated and non-signed statement, indicated around 4:30 a.m., Terminated Employee 1 had started the medication pass. Resident B had exited her room with her walker and indicated the resident was not in a good mood. Employee 4 had attempted to have a conversation with the resident and Terminated Employee 1 set a small plastic cup of water and a medication cup with medications on her walker and walked away. Employee 4 then walked away from the resident. The resident had started to ambulate towards her room and she stopped by the medication cart where Terminated Employee 1 was standing. Employee 2 was unsure what the resident had said, then Terminated Employee 1		injuries noted at that time. Resident B stated she feels safe in the facility. b Terminated Employee #1 was immediately notified via phone by executive director and director of nursing that they were immediately suspended for an allegation of abuse. **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a All residents have the potential to be affected by this deficient practice. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a Education provided regarding F-Tag #609- Timely reporting of alleged violations. **4 How the correct action(s) will be monitored to ensure the deficient practice will not recur; i.e.; what quality assurance program will be put into place;** a Director of Nursing/Social Services/Designee will provide in-services to all team members on reporting of alleged violations monthly x 3 months, quarterly	

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	asked for the medications back from the resident if she was not going to take them. He then yelled, "give me the f****** meds...." He was attempting to pry her hand open because she had the medications clenched in her hand. She then grabbed the cup of water and threw it at him. He then pushed her against the wall and had one hand up under her chin. He was yelling at her to, "stop being so f****** mean and hateful." Employee 2 then jumped up and said, "hey" and he let go of the resident. The resident was rubbing her neck and said, "you hurt me, you stupid idiot". The two were separated. They continued yelling at each other. Terminated Employee 1 was walking away and yelling, "F*** you" repeatedly. The resident was assisted back to her room and then took the medications. She then got dressed. When the Day Shift staff came in, the resident started talking to Employee 3. Employee 2 was interviewed by telephone on 12/27/23 at 6:20 p.m. and indicated Resident B had not been in a good mood the morning of 12/6/23. Terminated Employee 1 brought a medication cup with medications in it and a glass of water and sat them on the seat of the walker. The resident was ambulating toward her room and she stopped and asked the him what was in her medication cup and she was informed it was her medications. The medication cup was in her hand. Employee 2 then looked up and observed him attempting to "pry" the medication out of the resident hands and was saying "f****** give them back", the resident threw a glass of water on him. He then grabbed the resident's neck and had her back against the wall. The resident started yelling, "you hurt my throat" and he yelled back, "f*** you". Employee 2 was attempting to separate the resident and the employee. Employee 2 was trying to talk to the resident and Terminated Employee 1 was yelling		thereafter x 3 quarters, PRN as needed and upon hire to ensure compliance. b Results will be reported to the monthly QAPI meeting for review. After reviewing results, an action plan may be developed, if needed, to ensure compliance. **5 By what date the systemic changes for each deficient will be completed.** **a** January 18, 2024	

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	at her in the hall, "f*** you". She indicated she had not notified the Administrator or the Director of Nursing after the incident had occurred. During an interview on 12/28/23 at 10:31 a.m., the Administrator indicated he was not made aware of the allegation in a timely manner and he should have been called by Employee 2. He indicated he telephone number is posted at the Nurses' Desk. During an interview on 12/28/23 at 11:08 a.m., the ADON (Assistant Director of Nursing) indicated Employee 3 had asked her to talk to Resident B on 12/6/23 around 6:35 a.m. She had been told the resident was making some "weird" remarks. The resident had informed her she had words with Terminated Employee 1 and had thrown water in his face. He had gotten mad and put his hands around her throat. The Administrator was then notified by text around 8:45 a.m. on 12/6/23. The facility Abuse Policy, received from the DON as current, and dated 2017, indicated abuse allegations were to be reported immediately to the Administrator. This citation relates to Complaint IN00423481. 3.1-28(c)			