STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155829	A. BUILDING _____ B. WING _____	C 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGS AT LAFAYETTE, THE	**2402 SOUTH STREET LAFAYETTE, IN 47904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00435669 and IN004364493. Complaint IN00435669- Federal/State deficiencies related the allegations are cited at F600. Complaint IN00436493- Federal/State deficiencies related the allegations are cited at F600. Survey date: June 18, 2024. Facility number: 013499 Provider number: 155829 AIM number: 201285490 Census Bed Type: SNF/NF: 20 SNF: 13 Residential: 31 Total: 64 Census Payor Type: Medicare: 8 Medicaid: 18 Other: 7 Total: 33 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on June 26, 2024.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and	F 600		

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

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F 600	Continued From page 1 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, 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; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a cognitively impaired resident with a diagnosis of post-traumatic stress disorder was free from verbal and mental abuse for 1 of 2 residents reviewed for abuse. (Resident C) This deficient practice resulted in Resident C experiencing emotional distress. The deficient practice was corrected on 6/5/2024, prior to the start of the survey, and was therefore past noncompliance. Findings includes: An Indiana Department of Health report indicated, on 5/29/24 at 11:00 p.m., Resident C was verbally assaulted by two staff members during resident care. Staff Member 2 and 3 were overheard by staff to verbally insult Resident C. Resident C indicated she had been verbally assaulted by the staff. The clinical record for Resident C was reviewed on 6/17/24 at 12:50 p.m. The diagnoses included,	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2	F 600		

but were not limited to type 2 diabetes mellitus, heart failure, dementia, and post-traumatic stress disorder.

Her Brief Interview for Mental Status (BIMS) score was a 7 which indicated a severe cognitive impairment.

A facility investigation note, dated 5/30/24 at 9:52 a.m., indicated during an interview with Resident C, she indicated she was upset with the way the staff talked to her last evening. They were yelling with raised voices.

A facility investigation note, dated 5/30/24, was written by Staff Member 5. She witnessed Staff Member 3 when giving a report, on 5/29/24, referring to Resident C as "the b*****". The resident was within hearing distance when the comment was made by the staff member.

A facility investigation note, dated 5/30/24, was written by Staff Member 6. She overheard Staff Member 3 while pushing Resident C down the hallway to her room, on 5/29/24 at 11:00 p.m., say "I am f****** tired of taking care of her". When Resident C was in her room, Staff Member 2 was heard to tell the resident, she was tired of cleaning s*** out from under her nails and she was f****** nasty. Staff Member 6 stayed with Resident C, gave her care, and put her to bed after sending the other staff members out of the room. Staff Member 6 then reported the incident to the supervisor.

A facility investigation note, dated 5/30/24, was written by Staff Member 2. She indicated she did not raise her voice to the resident and did not speak inappropriately to her. Staff Member 3

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F 600	Continued From page 3	F 600		

during report referred to Resident C as "This b****".

A facility investigation note, dated 5/30/24, was written by Staff Member 3. She indicated she did not speak inappropriately to Resident C. She may have raised her voice to speak over other noises. She may have referred to the resident as "This B****" during the report and was not aware the resident overheard her comment.

A facility investigation note, dated 5/30/24, was written by Staff Member 7. She indicated she heard Resident C yelling with Staff Member 2 and 3. She overheard Staff Member 2 indicate to the resident she and Staff Member 3 were tired of taking care of her. She separated the resident from Staff Member 2 and 3. She overheard Staff Member 3 say she was tired of taking care of the resident. The resident was able to hear the staff member.

The facility personnel records were reviewed, on 6/17/24 at 3:15 p.m., and indicated Staff Member 2 and 3 were terminated for substantiated resident abuse.

During an interview, on 6/18/24 at 12:51 p.m., Resident C indicated two (2) staff members were mean to her the other day. They said bad things about her. When she was asked to describe what things were said to her the resident started to cry, was very tearful, and could not continue. When the resident was asked if she was afraid to be in the facility, she said not now, the two (2) staff members were gone, and no longer working. She indicated she had good support with the Assistant Director of Nursing (ADON), the Director of Nursing (DON) and other staff members who

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F 600	Continued From page 4	F 600		

were nice to her and listened to her. She indicated she had a rough life and all her family, and friends have died.

During an interview, on 6/18/24 at 4:55 p.m., Staff Member 8 indicated Staff Member 2 and 3 were suspended during the investigation and terminated for verbally abusing the resident. She indicated all staff members were re-educated on abuse and reporting abuse.

A current facility policy, titled "Abuse and Neglect Procedural Guidelines," dated 8/29/19 and received from Staff Member 8 on 6/18/24 at 2:10 p.m., indicated "...ABUSE...It includes verbal abuse, sexual abuse, physical abuse and mental abuse...Willful, is used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm...."

The deficient practice was corrected by 6/5/24, after the facility implemented a systemic plan which included a house wide physical assessment of each resident, house wide interviews with all capable residents on abuse allegations, reporting, and knowledge of abuse, and in servicing of all staff regarding abuse and reporting. Staff Member 2 and 3 were terminated for abuse.

This citation relates to Complaints IN00435669 and IN00436493.

3.1-27(a)
3.1-27(b)