STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155807	A. BUILDING 00 B. WING	10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RURAL HEALTH CARE CENTER	1747 N RURAL ST INDIANAPOLIS, IN 46218

(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 IN00418450 and IN00419246. This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00414456 completed on 8/17/2023. This visit was in conjunction with a PSR to the Investigation of Complaint IN00417488 completed on 9/18/2023. Complaint IN00418450 - Federal/state deficiencies related to the allegations are cited at F600. Complaint IN00419246 - Federal/state deficiencies related to the allegations are cited at F600. Complaint IN00417488 - Corrected. Complaint IN00414456 - Not corrected. Survey date: October 12, 2023 Facility number: 000388 Provider number: 155807 AIM number: 100454140 Census Bed Type: SNF/NF: 31 Total: 31 Census Payor Type: Medicaid: 29 Other: 2 Total: 31	F 0000	The creation and submission of this Plan of Correction (POC) does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this *CMS-2567 Plan of Correction* be considered the *Letter of Credible Allegation of Compliance* and requests a desk review in lieu of a post-survey review on, or after 10/31/2023.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dena Kerschner	RDO	10/31/2023

Any defiencystatement 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 disclo days 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.

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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 19, 2023			
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 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 interview and record review, the facility failed to ensure a resident remained free from verbal and physical abuse by Qualified Medication Assistant (QMA) 2 cursing at Resident B and making physical contact during an argument at smoking time. This led to recurrent fear, anxiety, nervousness, and decreased socialization. Findings include: An incident reported to the Indiana State Department of Health Survey Report System, dated 9/22/23 at 6:45 p.m., indicated the following, "...Residents were outside for afternoon smoke break. ED [Executive Director] was notified that	F 0600	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The facility does ensure, to the best of its ability, that residents remain free of abuse. QMA 2 no longer works at the facility. All staff have been in-serviced on Abuse & Neglect. Abuse and Neglect policy/education is an ongoing part of new hire orientation. SSD met with resident B to ensure psychosocial needs are being met and will continue to meet with resident weekly and as	10/31/2023

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	during smoke break there was an exchange between resident [name of Resident B] and staff member [Name of QMA 2]...Type of Injury...Resident states pain in the facial area...." The clinical record for Resident B was reviewed on 10/12/23 at 3:35 p.m. The diagnoses included, but were not limited to, anxiety disorder, congestive heart failure, major depressive disorder, schizoaffective disorder, bipolar disorder, and post-traumatic stress disorder. A quarterly minimum data set (MDS) assessment, dated 7/14/23, indicated Resident B was cognitively intact. A progress note, dated 9/22/23, indicated the following, "...Resident was going out to smoke at 3:30, resident stated she had cuss words [sic] between her and staff member and staff member hit her across her nose with phone and it her Lt5 [sic, left] cheek, red area noted on nose and sm [small] bump on Lt [left] cheek noted activities was outside when incident occurred...." A written statement, dated 9/22/23, indicated Resident B commented that she came at QMA 2 and smacked the glasses off of QMA 2's face. Resident B did not like the way QMA 2 was speaking to Resident H, her roommate. A written statement by QMA 2, undated, indicated the following, "...At 3:25 pm [name of Resident B] came out behind [name of Resident H]. I told [name of Resident H] to pull her shirt down cause [sic] her breast was hanging out. [Name of Resident B] said B***h you need to check your attitude. I told her that I was talking to [name of Resident H] and she called me another B***h and walked up on me. I told her don't call		needed. 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; All Residents have the potential to be affected by the alleged deficient practice. All interviewable Residents completed an abuse questionnaire to identify any other potential abuse incidents. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff in serviced by 10/31/23. Staff will have ongoing abuse education. Residents will be randomly interviewed by Admin/designee to ensure compliance. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Admin/designee will perform random abuse interviews with residents to ensure ongoing compliance and will review in	

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	me a b***h and got up out the chair to come in a she called me another b***h and knocked my glasses off. I grabbed her hand and pushed it into her head and told her I was pregnant. She started saying she didn't know I was pregnant and she was sorry I told her she was going to jail she said I hit her in her face and scratched her face but I didn't and I've never taken care of [Name of Resident B][sic]...." A written statement by Activities Assistant 4, undated, indicated the following, ""...I was taking the residents out to smoke at 3:30 when I heard an argument start to break out. [Name of a resident] then started to yell there was about to be a fight and I heard the Q [QMA 2] say for [Name of Resident B] to get her a** under the shed and mind her business. I proceeded to run up by the back door when I seen the Q's [QMA 2] hand in [Name of Resident B's] face and [Resident B] smacked her. After [Resident B] smacked her she [QMA 2] grabbed [Resident B] by her hair and hit her in the face with her phone and fist. I broke them up and proceeded to take [Resident B] away from her and under the shed. The resident [name of another resident] told her she was wrong and she proceeded to say "I don't give a f**k if any of you m****r f*****s hit me I'ma [sic] smak yall [sic] a** back". She [QMA 2] then went back into the building and when they told her to leave she would not and continued to be loud and scream and [Resident B]...." A written statement by Social Services Director (SSD), dated 9/25/23, indicated the following, "...Writer spoke with resident [name of Resident B] about incident and Resident stated she felt the QMA was talking rude to another resident. So she said something to her. Resident stated after that the QMA started hitting her".		QA/QAPI committee monthly for a minimum of 6 months. After 6 months, the committee will decide the need for further monitoring and/or frequency. Resident interviews will occur every working day x 1 month, then weekly x4 weeks, and then semi-monthly x 4 months. - by what date the systemic changes for each deficiency will be completed. -October 31, 2023	

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	A termination report, dated 9/27/23, indicated QMA 2 was terminated due to unprofessional behavior and violation of facility policy. An interview conducted with the roommate to Resident B (Resident H), on 10/12/23 at 12:45 p.m., and denied concerns with facility staff and treatment of residents. An interview conducted with Activities Assistant 4, on 10/12/23 at 12:21 p.m., indicated she heard a resident commenting "a fight about to happen". She went over to get it under control. The QMA, QMA 2, was talking at Resident B and "kinda side swiped her nose" with having her hand in her face and got physical before she could get to them. QMA 2 continued to say she was pregnant, but she kept hitting Resident B with an open palm and cell phone in her hand. Resident B had a small knot on her cheek, right under her eye. The knot was still present the following day after the incident along with a "little bit of bruising" around the knot. Resident B liked to come up and watch television, have coffee, socials, watch movies and popcorn. She does like to stay in her room but since the incident Resident B had stayed more in her room that previously. She has only come out to 2 social events since the incident. Resident B cried for the first couple of days after the incident and Activities Assistant 4 took her outside to get some air when that happened. Resident B commented on how the incident had "messed with her anxiety". An interview conducted with Resident B, on 10/12/23 at 2:05 p.m., indicated she went outside to smoke and QMA 2 was giving another resident in front of her "fits about something". Resident B said, "please don't talk to us like that". QMA 2			

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	looked at her and said, "don't get in my business". QMA 2 scratched her nose and got in her face, and she pushed her back. She could feel QMA 2's breath on her. QMA 2 proceeded to hit her "everywhere" and started pulling her hair. Someone came outside and broke up the fight "thank God". It was "like hell" carrying on like that. She doesn't recall the name of QMA 2, but she was a bossy person. Resident B indicated she used to participate in activities, but she doesn't do it much anymore. She prefers to stay in her room because she "doesn't want to get into any problems". Ever since the incident with QMA 2 she doesn't want to be around others because it makes her "nervous or upset". There were no other concerns with staff or other residents prior to this incident with QMA 2. An interview conducted with the Director of Nursing (DON), on 10/12/23 at 3:50 p.m., indicated QMA 2 was terminated due to the incident with Resident B and that was not appropriate action with QMA 2's approach. A policy titled "Abuse & Neglect", revised 8/1/23, indicated the following, "...Each resident has the right to be free from abuse, neglect, and misappropriation of resident property. All allegations will be reported according to State and Federal Law and investigated. Each nursing home must provide care and services in a person-centered environment in which all individuals are treated as human beings...." This Federal tag relates to Complaints IN00418450 and IN00419246. 3.1-27(a)(1) 3.1-27(b)			