STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155760	B. WING		02/22/2023
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
WATERF	ORD CROSSING			/ATERFORD CIR EN, IN 46526	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
F 0000					
Bldg. 00	This visit was for th IN00398501.	e Investigation of Complaint	F 0000	/p>	
	Complaint IN00398	501 - Substantiated.			
	Federal/State deficie				
	allegations are cited at F550, F609, and F610.				
	Survey dates: 2/22/2	23			
	Facility number: 01	1150			
	Provider number: 15				
	AIM number: 200831020				
	Census Bed Type:				
	SNF/NF: 65				
	SNF: 43				
	NF: 22				
	Total: 130				
	Census Payor Type: Medicare: 18				
	Medicaid: 22				
	Other: 90 Total: 130				
	194411 120				
	These deficiencies r accordance with 410	eflect State Findings cited in IAC 16.2-3.1.			
	Quality review com	pleted 3/1/23.			
F 0550	483.10(a)(1)(2)(b)	(1)(2)			
SS=D	Resident Rights/E				
Bldg. 00	§483.10(a) Reside				
	- , ,	a right to a dignified			
	existence, self-det	ermination, and			
		th and access to persons			
	and services inside	e and outside the facility,			
LABORATOR'	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	I TITLE	(X6) DATE
Cassie			Dunlap	*****	03/10/2023

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.

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155760	B. WI	NG		02/22/	/2023
	PROVIDER OR SUPPLIEF	<u> </u>	1	1332 W	ADDRESS, CITY, STATE, ZIP COD ATERFORD CIR EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG			DATE
	including those sp	ecified in this section.					
	resident with resp each resident in a environment that enhancement of h recognizing each	acility must treat each ect and dignity and care for manner and in an promotes maintenance or is or her quality of life, resident's individuality. The ct and promote the rights of					
	access to quality of diagnosis, severity source. A facility remaintain identical regarding transfer provision of service	e facility must provide equal care regardless of y of condition, or payment must establish and policies and practices, discharge, and the ces under the State plan for dless of payment source.					
	- ' '	the right to exercise his or					
		ident of the facility and as					
	_	nt of the United States.					
	the resident can e	e facility must ensure that xercise his or her rights be, coercion, discrimination, e facility.					
	free of interference and reprisal from or her rights and the facility in the exercipative dunder this Based on record record failed to protect a record record to protect a record recor	view and interview, the facility esidents' right to participate in in the privacy of their own	F 05	550	1-What corrective action(s) will accomplished for those reside found to have been affected by deficient practice	nts	03/10/2023

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Event ID:

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	ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155760	(X2) MULTIPLE A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 02/22/2023
	PROVIDER OR SUPPLIER		1332	T ADDRESS, CITY, STATE, ZIP COD WATERFORD CIR HEN, IN 46526	•
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODES OF THE PROPERTY	
PREFIX TAG	Findings include: On 2/22/23 at 10:30 (ED) provided an er 11/30/22 at 11:34 A received from Reside Emergency Contact 11/20/22 at approximember and a famile B in his room and, for [Resident B]ir time [Registered Not said that [family frishe needed to quiet out to the nurse's stagain closed the doc quieter. A couple medoor again. She said religious ceremonie rooms" On 2/22/23 at 10:13 Resident B was reveal admitted on 10/26/2 but were not limited pneumonitis, sepsis dementia. The most recent Mit 10/12/22, was an accommodity in the most recent Mit 10/12/22, was an accommodity i	CY MUST BE PRECEDED BY FULL ALSC IDENTIFYING INFORMATION O A.M., the Executive Director mail communication dated a.M., and indicated it was dent B's family member and at 2. The email indicated, on mately 4:00 P.M., the family by friend were visiting Resident '[family friend] began praying an elevated tone. After some area (RN) 2] came back in and down as she could be heard ation (the door was closed). I for and [family friend] got ainutes later, [RN 2] was at the did that we had to leave as as were not allowed in the did to, metabolic encephalopathy, bipolar disorder, and the diminimum Data Set (MDS) dated diminimum Data Set (MDS) dated diminimum Data Set (MDS) dated diminimum difficulty in the hearing aids, was usually able as, had moderate cognitive and felt depressed and the ent demonstrated behaviors of 1-3 days in the previous 7 day the staff assessment of daily indicated Resident B	PREFIX TAG	Resident B no longer resid the facility and had necess care provided while in the other facility. Resident B experienced no negative or related to this alleged deficipractice. 2-How other residents having potential to be affected by same deficient practice will identified and what corrective action(s) will be taken. All residents had the potent be affected. A copy of resirights was distributed to all residents on Health Center 3-What measures will be place or what systemic chawill be made to ensure that deficient practice does not The Director of health serv (DHS) or designee will comin-services with nursing staresident rights. SSD and/or designee will interview 3 resident rights 3x's and for 4 weeks, then weekly for weeks, then monthly for 3 in 4-How the corrective action be monitored to ensure the deficient practice will not resident practice.	es at ary care of utcomes cient ing the the libe cive tial to dent ut into anges the recur; ices aplete aff on or esidents oring week or 4 months. In(s) will eccur, eccice; OHS or
i .	I preterred to have to	mily or significant other	I	and corrective action at lea	et I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155760		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/22/2023	
	PROVIDER OR SUPPLIER		1332 V	ADDRESS, CITY, STATE, ZIP COD VATERFORD CIR EN, IN 46526	•
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION
	REGULATORY OR involved in his care planting to Activities indicated, "While in that I have the oppose and opportunities the interests include reafaith is important to continue to engage practices" 2/22/23 at 9:45 A.M. Executive Director, heard loud noises in concerned. The Executive Director, heard loud noises in concerned. The Executive Director, heard loud noises in concerned and becresident was not able was going on becaute the resident and becresident B did not be conducted with RN gone to Resident B' the resident's son was going on becaute the resident B' the resident B' the resident B' the resident B' the resident's son was going on becaute to Resident B' the resident's son was going on becaute the room, the family fri RN 2 indicated whe exited the room, sho raised voice from the to the room, knocket	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY) quarterly and ongoing until campus achieves one hundre percent compliance in the call Quality Assurance Performar Improvement meetings. The will be reviewed and updated warranted. Ongoing monitoring continue past 6 months if warranted until 100% complianmet.	ed mpus ace polan as as ang will
	being loud after I le the room and heard her say, 'I rebuke yo	ove that hereshe continued ft the room so I went back to ou.' [Resident B's] hands were etting upset and I said [the			

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155760	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/22/2023
	PROVIDER OR SUPPLIER		1332 W	ADDRESS, CITY, STATE, ZIP COD VATERFORD CIR EN, IN 46526	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	BE COMPLETION
TAG		LSC IDENTIFYING INFORMATION and had to leave the facility	TAG	DEFICIENCY)	DATE
	1	e was on his chestI told them			
		est" RN 2 indicated the			
	resident was not asking for help or telling the				
	family friend to stop praying, but that she felt the resident was agitated. RN 2 indicated Resident B's son was not happy with her when she had them leave. RN 2 indicated no other residents complained about the noise level in Resident B's room. RN 2 indicated Resident B was not wearing				
his hearing aids that evening.					
	RN 2 indicated she did not document the events of the evening, her concerns, the resident's				
	reactions, and she did not report the incident because,"I thought I nipped it in the bud."				
	On 2/22/23 at 10:30	A.M., the Executive Director			
		tled, Resident Rights			
	· · · · · · · · · · · · · · · · · · ·	effective date of 11/21 with a			
		/17 and indicated it was the			
	current facility police	cy. The policy nts shall not leave their			
	· ·	ities or basic human rights			
	_	nove to a health campusOur			
		ight toExercise choice in			
		ipating in activities, including			
	religious services'	1			
	This Federal tag rel	ated to complaint IN00398501.			
	3.1-3(m)				
F 0609	483.12(b)(5)(i)(A)((B)(c)(1)(4)			
SS=D	Reporting of Alleg	ed Violations			
Bldg. 00	, , ,	onse to allegations of			
	_	cploitation, or mistreatment,			
	the facility must:				
	§483.12(c)(1) Ens	ure that all alleged g abuse, neglect,			

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155760	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/22/2023	
	PROVIDER OR SUPPLIEF	2	1332	r address, city, state, zip cod WATERFORD CIR IEN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	exploitation or misinjuries of unknown misappropriation or reported immediate hours after the allegation to result in serious than 24 hours if the allegation do not it result in serious be administrator of the officials (including Agency and adult state law provides care facilities) in a through established sate in accordation in the designated resulting to the State of 3 residents review failed to assure that reported to the State of 3 residents review failed to assure that reported to the State of 3 residents review failed to assure that reported to the State of 3 residents review failed to assure that reported to the State of 3 residents review failed to assure that reported to the State of 3 residents review failed to assure that reported to the State of 3 residents review failed to assure that reported to the State of 11/30/22 at 11:34 Areceived from Residents review Contact 11/20/22 at approximate the state of 3 residents review failed to assure that reported to the State of 3 residents review Findings include:	streatment, including on source and of resident property, are tely, but not later than 2 egation is made, if the the allegation involve abuse is bodily injury, or not later the events that cause the involve abuse and do not odily injury, to the lefacility and to other to the State Survey protective services where is for jurisdiction in long-term accordance with State law led procedures. For the results of all the administrator or his or presentative and to other ance with State law, that is survey Agency, within the incident, and if the is verified appropriate	F 0609	1-What corrective action(s) will accomplished for those reside found to have been affected by deficient practice Resident B no longer resides athe facility and had necessary care provided while in the care the facility. Resident B experienced no negative outcorelated to this alleged deficient practice. 2-How other residents having potential to be affected by the	Il be nts y the at e of omes t	

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B in his room and, "...[family friend] began praying

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same deficient practice will be

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155760	B. WI	NG		02/22/2	2023
				CTDEET A	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
\A/A TEDE	ODD ODOOOINO				ATERFORD CIR		
WATERF	ORD CROSSING			GOSHE	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	for [Resident B]. Sh	ne was still holding hands with			identified and what corrective		
	him as he did not le	t go of her hands. [Family			action(s) will be taken.		
	friend] was praying	in an elevated tone. After			All residents had the potential	to	
	some time [Register	red Nurse (RN) 2] came back in			be affected. Inservice's were		
	and said that [family	y friend] was being too loud			completed regarding types of		
	and she needed to quiet down as she could be				abuse and reporting procedure	es.	
	heard out to the nur	se's station (the door was			. 5.		
		sed the door and [family friend]			3-What measures will be put i	nto	
	got quieter. A couple minutes later, [RN 2] was at				place or what systemic change		
		said that we had to leave as			will be made to ensure that the		
	religious ceremonies were not allowed in the				deficient practice does not rec	1	
	rooms. She said, 'What you are doing is				DHS or designee will continue		
		friend tried to leave and let go			education on types of abuse a		
	of [Resident B's] hands go, he held on to her				reporting procedures 3x's a w		
	hands and [RN 2] had to separate herself from his				at huddles for 4 weeks, then		
		e walking out, she said, 'This is			weekly for 4 weeks, then mon	thlv	
		ed her, 'what is inappropriate?'			for 3 months.		
		is abusive, struggling with a			-		
	patient,' she said"	, 65 6			4-How the corrective action(s)	will	
	•				be monitored to ensure the		
	On 2/22/23 at 10:13	3: A.M., the clinical record for			deficient practice will not recu	r.	
	Resident B was revi	iewed. Resident B was			i.e., what quality assurance	·	
	admitted on 10/26/2	22 with diagnoses that included			program will be put into place;		
		I to, metabolic encephalopathy,			As a quality measure, the DHS		
		, bipolar disorder, and			designee will review any findir		
	dementia.	•			and corrective action at least		
					quarterly and ongoing until		
	The most recent Mi	nimum Data Set (MDS) dated			campus achieves one hundre	d l	
		lmission assessment that			percent compliance in the can	I	
	indicated Resident I	B had moderate cognitive			Quality Assurance Performan		
		ntly felt depressed and			Improvement meetings. The p		
		ent demonstrated behaviors of			will be reviewed and updated	I	
	_	1-3 days in the previous 7 day			warranted. Ongoing monitorin		
	look back period.				continue past 6 months if	·	
	•				warranted until 100% complia	nce	
	2/22/23 at 9:45 A.M	I., during an interview with the			met.		
		she indicated on 11/20/22 RN 2					
		Resident B's room and was					
		ecutive Director indicated RN 2					
		s room and a family friend and					
			1				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155760	r í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 02/22 /	ETED
	PROVIDER OR SUPPLIEF	3		1332 W	DDRESS, CITY, STATE, ZIP COD ATERFORD CIR N, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	the resident and bed resident was not ab	ere praying the demons out of came concerned because the le to give his consent to what use he had a diagnosis of					
	On 2/22/23 at 10:30 conducted with RN gone to Resident B's room to resident's son was a entry, the family fri RN 2 indicated who exited the room, shoraised voice from the tothe room, knocked "said I could still and we could not have being loud after I lethe room and heard her say, 'I rebuke you raised and he was goon and family friet facilityRN 2 indicasking for help or to praying, but that sh	ou.' [Resident B's] hands were etting upset and I said [the					
	happy with her whe indicated she did no evening, her concer	on she had them leave. RN 2 but document the events of the rns, the resident's reactions, but the incident because,"I					
	with the Executive not believe the ema family member was not initiate an inves	M. during a second interview Director, she indicated she did ail received from Resident B's s an allegation of abuse and did stigation in response to the eport the allegation of abuse to					

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

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155760	r í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 02/22/	ETED
	PROVIDER OR SUPPLIER			1332 W	DDRESS, CITY, STATE, ZIP COD ATERFORD CIR N, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	provided a policy tir Procedural Guidelir 8/29/19 with a revisindicated it was the policy indicated,"" Director of Health Simplementation and standards and proce Abuse-Mental abusinonverbal conduct who potential to cause the experienceagitatic Executive Director and reportingEnsuinvolving abusear not later than 2 hour if the events that car abuseto the admin other officials (included) Agencyin accordates a policy in the experience	onInvestigationthe is accountable for investigating are that all alleged violations the reported immediately, but as after the allegation is made, ase the allegation involve istrator of the facility and to adding to the State Survey ance with State law through					
F 0610 SS=D Bldg. 00	§483.12(c) In resp abuse, neglect, ex the facility must: §483.12(c)(2) Hav violations are thore §483.12(c)(3) Pres	nt/Correct Alleged Violation onse to allegations of ploitation, or mistreatment, e evidence that all alleged oughly investigated. Vent further potential abuse, on, or mistreatment while in progress.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3			(X3) DATE	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155760	B. W	ING		02/22/2023	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD /ATERFORD CIR		
\ \ /\TEDE	CODD CDOSSING						
WAIER	FORD CROSSING			GUSHE	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY 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
	§483.12(c)(4) Rep	oort the results of all					
	investigations to tl	he administrator or his or					
	her designated representative and to other						
	officials in accorda	ance with State law,					
	including to the St	ate Survey Agency, within					
	5 working days of	the incident, and if the					
	alleged violation is	s verified appropriate					
	corrective action r						
	Based on interview and record review, the facility failed to ensure a thorough investigation was completed for an allegation of abuse for 1 of 3		F 0	610	1-What corrective action(s) will	ll be	03/10/2023
					accomplished for those reside	nts	
					found to have been affected b	y the	
	residents reviewed	for abuse, (Resident B).		deficient practice Resident B no longer resides at			
	Findings include:				the facility and had necessary		
					care provided while in the care	e of	
		A.M., the Executive Director			the facility. Resident B		
		mail communication dated			experienced no negative outco		
		A.M., and indicated it was			related to this alleged deficient		
		dent B's family member and			practice.		
		t 2. The email indicated, on					
		mately 4:00 P.M., the family			2-How other residents having		
		ly friend were visiting Resident			potential to be affected by the		
		"[family friend] began praying			same deficient practice will be		
		ne was still holding hands with			identified and what corrective		
		et go of her hands. [Family			action(s) will be taken.		
		in an elevated tone. After			All residents had the potential	to	
		red Nurse (RN) 2] came back in			be affected. Inservice's were		
		y friend] was being too loud			completed regarding reporting		
		uiet down as she could be			procedures and investigations		
		se's station (the door was					
		sed the door and [family friend]			3-What measures will be put in		
		le minutes later, [RN 2] was at			place or what systemic change		
	_	said that we had to leave as			will be made to ensure that the	-	
	_	es were not allowed in the			deficient practice does not rec		
		hat you are doing is			ED and/or designee will contin		
		friend tried to leave and let go			education on types of abuse a		
		ands go, he held on to her			reporting procedures with time	-	
		ad to separate herself from his			reporting 3x's a week at huddl		
		e walking out, she said, 'This is			for 4 weeks, then weekly for 4		
	inappropriate.' I ask	ted her, 'what is inappropriate?'			weeks, then monthly for 3		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155760	B. WI	NG		02/22	/2023
		<u> </u>	_	CTDEET 4	ADDRESS CITY STATE ZIR COR		
NAME OF F	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD ATERFORD CIR		
\A/A TEDE	CODD CDOCCING						
WATERF	FORD CROSSING			GOSHE	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY 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
	'what you are doing	is abusive, struggling with a			months. Audits will		
	patient,' she said"						
					4-How the corrective action(s)	will	
	On 2/22/23 at 10:13: A.M., the clinical record for				be monitored to ensure the		
	Resident B was rev	iewed. Resident B was			deficient practice will not recur	۲,	
	admitted on 10/26/2	22 with diagnoses that included			i.e., what quality assurance		
	but were not limited	l to, metabolic encephalopathy,			program will be put into place;		
	pneumonitis, sepsis	, bipolar disorder, and			As a quality measure, the DHS	S or	
	dementia.				designee will review any findir	ngs	
					and corrective action at least		
	The most recent Minimum Data Set (MDS) dated				quarterly and ongoing until		
	10/12/22, was an admission assessment that				campus achieves one hundred	d	
	indicated Resident B had minimal difficulty in				percent compliance in the can	npus	
	_	hearing aids, was usually able			Quality Assurance Performand	ce	
		s, had moderate cognitive			Improvement meetings. The p	lan	
		ntly felt depressed and			will be reviewed and updated	as	
	_	ent demonstrated behaviors of			warranted. Ongoing monitoring	g will	
		1-3 days in the previous 7 day			continue past 6 months if		
	_	he staff assessment of daily			warranted until 100% complia	nce	
		indicated Resident B			met.		
	1 -	mily or significant other					
	involved in his care	discussions.					
	_	ans included but were not					
		s, dated 10/13/22. The care plan					
		n this campus, it is important					
		ortunity to engage in activities					
		nat are meaningful to me. My					
		nding, music, and churchMy					
		me, and it is important that I					
		in religious services or					
	practices"						
		I., during an interview with the					
		she indicated on 11/20/22 RN 2					
		n Resident B's room and was					
		ecutive Director indicated RN 2					
		s room and a family friend and					
		ere praying the demons out of					
	the resident and bed	came concerned because the					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155760	(X2) MULTIPLE C A. BUILDING B. WING	OO		SURVEY LETED 1/2023
	PROVIDER OR SUPPLIER		1332 \	ADDRESS, CITY, STATE, ZIP COD WATERFORD CIR IEN, IN 46526	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION D BE OPRIATE	(X5) COMPLETION DATE
	was going on becaudementia. The Exect Resident B did not a conducted with RN gone to Resident B's room to resident's son was a entry, the family frit RN 2 indicated where exited the room, show the raised voice from the could not have a could not have could not report thought I nipped it is could	ou.' [Resident B's] hands were etting upset and I said [the and] had to leave the cated the resident was not celling the family friend to stop to felt the resident was cated Resident B's son was not can she had them leave. RN 2 out document the events of the ms, the resident's reactions, out the incident because,"I				

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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) MULTIPLE CON		ONSTRUCTION	(X3) DATI	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		00	COMPLETED 02/22/2023		
		155760	B. WING					
		1		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER				1332 WATERFORD CIR				
WATERFORD CROSSING				GOSHEN, IN 46526				
(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 APPROPRIATE		COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	JINAIL	DATE	
	provided a policy titled, Abuse and Neglect							
	Procedural Guidelines, with an effective date of							
	8/29/19 with a revised date of 8/29/19 and							
	indicated it was the current facility policy. The							
	policy indicated,"The Executive Director and							
	Director of Health Services are responsible for the							
	implementation and ongoing monitoring of abuse							
	standards and proceduresMental/Emotional							
	Abuse-Mental abuse is the use of verbal or							
	nonverbal conduct which causes or has the							
	potential to cause the resident to							
	experienceagitationInvestigationthe							
	Executive Director is accountable for investigating							
	and reportingIdentifying and interviewing all							
	involved persons, including the alleged victim,							
	alleged perpetrator, witnesses, and others who might have knowledge of the allegationsFocusing the investigation on							
	determining if abusehas occurred, the extent,							
	and cause"							
		lated to complaint IN00398501.						
	3.1- 28(d)							

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