PRINTED: 11/10/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	X3) DATE SURVEY COMPLETED 09/27/2022
	PROVIDER OR SUPPLIER	901 S I	ADDRESS, CITY, STATE, ZIP COD HASTINGS DR	
GENTRY	PARK	BLOOK	MINGTON, IN 47401	
(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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
R 0000				
Bldg. 00	This visit was for the Investigation of Complaints IN00389357 and IN00389898. Complaint IN00389357 - Unsubstantiated due to	R 0000		
	lack of evidence. Complaint IN00389898 - Substantiated. State deficiencies related to the allegations are cited at R53.			
	Survey date: September 27, 2022			
	Facility number: 013766			
	Residential Census: 90			
	This State Residential Finding is cited in accordance with 410 IAC 16.2-5.			
	Quality review completed September 29, 2022.			
R 0053 Bldg. 00	410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse.			
	Based on interview and record review, the facility failed to ensure a resident was free from verbal abuse for 1 of 3 residents reviewed for abuse. (Resident B) Finding includes: During an interview on 9/27/22 at 9:13 a.m., the Business Office Manager indicated she was the weekend supervisor on 9/10/22 when she received a phone call from the Memory Care Director. The	R 0053	PRINTED: 10/04/2022 FORM APPROVED Indiana State Department of Health STATEMENT OF DEFICIENC AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 013766 (X2) MULTIPLE CONSTRUCT A. BUILDING:	N CLIA
LABORATOI	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE
Emily Ben	nett	RDO		11/10/2022

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.

State Form Event ID: WGX611 Facility ID: 013766 If continuation sheet Page 1 of 12

PRINTED: 11/10/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 09/27/2022	
NAME OF PROVIDER OR SUPPLIER GENTRY PARK			901 S	ADDRESS, CITY, STATE, ZIP COD HASTINGS DR MINGTON, IN 47401	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
	Memory Care Direct (Certified Nursing a When she was notified and interviewed CN CNA 1 admitted the she had said rude the interview, CNA 1 w CNA 1 did not undeasked to leave since behavior. CNA 1 w Business Office Maverbal abuse. During an interview Memory Care Direct have a fall when CN on the floor and to go The clinical record on 9/27/22 at 9:20 a but were not limited and anxiety disorde cognitively intact. An email sent by the dated 9/10/22 at 1:3 approximately 9:00 care apartment 1020 he overheard CNA Resident B "get you need your stress too had her hands in the flatware was placed he was preparing to said that she would room so he could el B "you need to get cleaned up. You are	A LSC IDENTIFYING INFORMATION etor notified her that CNA Aide) 1 was rude to Resident B. fied, she came to the facility IA 1 regarding the allegation. The allegation was true and sings to Resident B. After the was asked to leave the facility. The erstand why she would be a she had apologized for her torked for an agency. The anager indicated this was worded to she was asked to leave the facility. The anager indicated this was a she		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	E COMPLETION DATE BE N)
	He intentionally did	l not inform CNA 1 of who he		This visit was for the Investiga	ation

State Form Event ID: WGX611 Facility ID: 013766 If continuation sheet Page 2 of 12

PRINTED: 11/10/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u>		COMPLETED		
			B. W	B. WING		09/27/2022	
				CTD FET	ADDRESS OF A STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
OFNITON	(D A D I (HASTINGS DR		
GENTRY	PARK			BLOOM	IINGTON, IN 47401		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	was in an attempt t	to see how she would continue			of Complaints IN00389357 ar	nd	
	to act. At that poin	t, he moved down the hall to			IN00389898.		
	give the resident ti	me to get herself together. As			Complaint IN00389357 -		
	-	eartment 1026 to get it cleaned			Unsubstantiated due to lack o	of	
		1 re-enter apartment 1011 and			evidence.		
	_	on the floor? You need to get			Complaint IN00389898 -		
		at point, he entered the room			Substantiated. State deficience	cies	
		A 1 that we do not speak to our			related to the allegations are o		
		and that we do not allow			at R53.		
		without help and without			Survey date: September 27, 2	022	
		a nurse. CNA 1 said she			Facility number: 013766		
	would never allow	someone to get up or tell them			Residential Census: 90		
		en CNA 1 left the room to get			This State Residential Finding	is	
		The nurse and our care partner			cited in		
		etting Resident B evaluated and			accordance with 410 IAC 16.2	-5.	
		the shower to get her cleaned			Quality review completed		
		d calling personnel to inform			September 29, 2022.		
	_	on and to get CNA 1 dealt with			410 IAC 16.2-5-1.2(w) Reside	nts'	
	accordingly.	_			Rights -		
					Deficiency		
	An email sent by the	he Administrator to the			(w) Residents have the right to	be	
	Regional Director	of the agency CNA 1 worked			free from verbal abuse.		
	for, dated 9/10/22	at 5:15 p.m., indicated she			This RULE is not met as		
	wanted to notify th	ne Regional Director we let CNA			evidenced by:		
	1 go home today d	ue to verbal abuse. CNA 1 will			Based on interview and record	i	
	not be allowed bac	k in our building.			review, the facility failed to en	sure	
					a resident was free from verba	al	
	On 9/27/22 at 8:37	a.m., the Assistant Director of			abuse for 1 of 3 residents revi	ewed	
	Nursing provided	a copy of a facility policy, titled			for abuse. (Resident B)		
	"Abuse and Negleo	ct, Observed or Suspected,"			Finding includes:		
	dated 6/11/20, and	indicated this was the current			During an interview on 9/27/22	2 at	
	policy used by the	facility. A review of the policy			9:13 a.m., the Business Office	Э	
	indicated "it is the	policy that residents will not be			Manager indicated she was th	е	
	abused or neglecte	d by anyone at any time while			weekend supervisor on 9/10/2		
	residing"				when she		
					R 000		
	This State tag relat	tes to Complaint IN00389898.			R 053		
					This plan of correction is		
					submitted as required under S	tate	
					and/or Federal law. The		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
			B. WI	B. WING		09/27/2022	
		1	1	STREET A	ADDRESS, CITY, STATE, ZIP COD	I .	
NAME OF F	PROVIDER OR SUPPLIEF	8			ASTINGS DR		
GENTRY	' PARK				IINGTON, IN 47401		
	Г				- , . 	1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	_	TAG			DATE
					submission of this Plan of		
					Correction does not constitute	an	
					admission on the part of the	- £	
					community as to the accuracy	OT	
					the surveyors' findings or the		
					conclusions drawn therefrom.		
					Submission of this Plan of		
					Correction also does not constitute an admission that the		
					findings constitute a deficiency		
					cited are correctly applied. Ar		
					changes to the community	ıy	
					policies and procedures shoul	d he	
					considered subsequent remed		
					measures as that concept is	iidi	
					employed in Rule 407 of the		
					Federal Rules of Evidence,		
					corresponding state rules of c	vil	
					procedure and should be	• • •	
					inadmissible in any proceeding	a on	
					that basis. The community	5	
					submits this plan of correction		
					with the intention that it be		
					inadmissible by any third party	/ in	
					any civil or criminal action aga		
					the community or any employe		
					agent, officer, director, attorne		
					shareholder of the community	-	
					affiliated companies.		
					Correction of Cited Deficiency		
					Agency Employee is unable to		
					work in the community after th		
					incident on 09/10/22. Residen		
					doing well and has no recall o		
					incident. No injury noted. Fam	ily	
					and Physicians were notified.		
					Community staff was educate		
			1		company policy of abuse, neg	lect.	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	G <u>00</u>	COMPLETED	
			B. WING		09/27/2022	
			STRI	EET ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	8		S HASTINGS DR		
GENTRY	PARK			DOMINGTON, IN 47401		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	ICY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPR	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG			
				and misappropriation on 09/1	12/22	
				by the community Executive		
				Director. Community staff al		
				receive this training annually	•	
				Procedure to ensure on-goin	g	
				compliance: Business Office		
				Director will monitor departm	ent	
				head and staff training on		
				company policy on abuse, neglect, and misappropriation	,	
				monthly for new hires and ar		
				for current staff by examining		
				attendance logs.	'	
				09/10/22		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/27/2022
NAME OF P	ROVIDER OR SUPPLII	ΕR	901 S I	ADDRESS, CITY, STATE, ZIP COD HASTINGS DR MINGTON, IN 47401	•
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE
				9/12/22	
				NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 S HASTINGS DR GENTRY PARK BLOOMINGTON, IN 47401 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST I) PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATIO ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTIO SHOULD BE CROSS-REFERENCED TO TAPPROPRIATE DEFICIENCY)	BE N)
				(X5) COMPLETE DATE R 053 Continued From page 1	

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PRINTED: 11/10/2022 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/27/2022
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD HASTINGS DR	
GENTRY	PARK			MINGTON, IN 47401	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				received a phone call from the Memory Care Director. The Memory Care Director notified that CNA (Certified Nursing A 1 was rude to Resident B. Wishe was notified, she came to facility and interviewed CNA 1 regarding the allegation. CNA admitted that the allegation witrue and she had said rude this to Resident B. After the interviewed CNA 1 was asked to leave the facility. CNA 1 did not underst why she would be asked to leave the facility. CNA 1 did not underst why she would be asked to leave the facility. CNA 1 worked for a agency. The Business Office Manager indicated this was vabuse. During an interview on 9/27/2: 9:20 a.m., the Memory Care Director indicated Resident B have a fall when CNA 1 asked what she was doing on the floand to get herself up. The clinical record for Resider was reviewed on 9/27/22 at 9 a.m. The diagnoses included, were not limited to, major depressive disorder and anxidisorder. Resident B was not cognitively intact. An email sent by the Director Plant Operations, dated 9/10, at 1:35 p.m., indicated at approximately 9:00 a.m. he workeaning memory care aparting 1020. As he exited the apartment, he overheard CNA	d her dide) hen the A 1 as dings view, element deave her note the did did did door the dide dide dide dide dide dide dide di
			1	i e	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/27/2022
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD	
GENTRY				HASTINGS DR MINGTON, IN 47401	
		OT LITER OF DEPLOYMENT		T	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE OVER MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	-	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
PREFIX TAG	-	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ent B " At " At re e was ould m so to out I up. , eed and dse nows ded eeded and
				monthly. Monitoring for Ongoing Compliance: The Executive Director/Business Office Directive will monitor department head staff training on company polition abuse, neglect, and misappropriation upon hire ar annually.	ctor and cy

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	T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/27/2022
NAME OF PE	ROVIDER OR SUPPLIER PARK	901 S H	ADDRESS, CITY, STATE, ZIP COD HASTINGS DR MINGTON, IN 47401	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
			/p> DOW and MCD identified residents with similar risk. Monthly nursing assessment/summary will be completed monthly to monitor psychological well-being of residents residing in the memorare neighborhood. Assessments/summary will be completed monthly by wellnes nurse. DOW and MCD will memonthly to ensure compliance Audit will be conducted month 3 months Agency Representative for Clinotified on date of incident and CNA 1 placed on do not return	nory e ss onitor e. hly X
			Indiana State Department of Health STATE FORM 6899 WGX61* continuation sheet 2 of 3 PRINTED: 10/04/2022 FORM APPROVED Indiana State Department of Health STATEMENT OF DEFICIENC AND PLAN OF CORRECTIO (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER 013766 (X2) MULTIPLE CONSTRUC A. BUILDING:	CIES N CLIA :

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	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 09/27/2022
NAME OF PR	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD HASTINGS DR	
GENTRY	PARK			MINGTON, IN 47401	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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
				B. WING	
				(X3) DATE SURVEY COMPLETED C 09/27/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 S HASTINGS DR GENTRY PARK BLOOMINGTON, IN 47401 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST B PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO T APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE R 053 Continued From page 2	I) N
				He intentionally did not inform	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/27/2022
NAME OF P	ROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD	
GENTRY	PARK			MINGTON, IN 47401	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	CNA 1 of who he was in an	DATE
				attempt to see how she would continue to act. At that point,	
				moved down the hall to give t	
				resident time to get herself together. As he was entering	
				apartment 1026 to get it clean up he heard CNA 1 re-enter	ed
				apartment 1011 and say "why	
				you on the floor? You need to yourself up." At that point, he	get
				entered the room and informe	ed
				CNA 1 that we do not speak to	
				our residents that way and the we do not allow residents to g	
				up without help and without be	
				evaluated by a nurse. CNA 1	
				she would never allow somed to get up or tell them they need	
				to. Then CNA 1 left the room to	
				get the nurse on duty. The nu	
				and our care partner came to	
				assist in getting Resident B evaluated and then getting he	er in
				the shower to get her cleaned	
				He then enacted calling perso	•
				to inform them of the situation	1
				and to get CNA 1 dealt with accordingly.	
				An email sent by the	
				Administrator to the	
				Regional Director of the agend	·
				CNA 1 worked for, dated 9/10 at 5:15 p.m., indicated she	0/22
				wanted to notify the Regional	
				Director we let CNA 1 go hom	ne
				today due to verbal abuse. CN	
				will not be allowed back in ou	r
				building. On 9/27/22 at 8:37 a.m., the	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00 CADDRESS, CITY, STATE, ZIP COD	(X3) DATE SURVEY COMPLETED 09/27/2022
NAME OF P	PROVIDER OR SUPPLIE	R	901 S	HASTINGS DR MINGTON, IN 47401	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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 APPROPRIL DEFICIENCY) Assistant Director of Nursing provided a copy of a facility p titled "Abuse and Neglect, Observed or Suspected," dat 6/11/20, and indicated this was the current policy used by the facility. A review of the policy indicated "it is the policy that residents will not be abused neglected by anyone at any tiwhile residing" This State tag relates to Complaint IN00389898. R 053	olicy, ted as e
				Indiana State Department of Health STATE FORM 6899 WGX61 continuation sheet 3 of 3	1 If

State Form Event ID: WGX611 Facility ID: 013766 If continuation sheet Page 12 of 12