STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING _____ B. WING _____	C 06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(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 Complaint IN00434474. Complaint IN00434474 - Federal/State deficiency related to the allegation is cited a F600. Survey date: June 3, 2024 Facility number: 000563 Provider number: 155766 AIM number: 100267610 Census Bed Type: SNF/NF: 51 Total: 51 Census Payor Type: Medicare: 2 Medicaid: 38 Other: 11 Total: 51 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 7, 2024.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §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	F 600		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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F 600	Continued From page 1 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 observation, interview and record review, the facility failed to ensure staff to resident abuse did not occur for 1 of 3 residents reviewed for abuse. (Resident B) Findings include: The clinical record for Resident B was reviewed on 6/3/24 at 9:48 a.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbance and mood disorder. The care plan, dated 1/24/24, indicated the resident was at risk for mood changes and verbal aggression. The interventions included, but were not limited to, allow the resident to vent feelings and frustrations, change care givers, ensure the resident's safety and observe from a distance and to leave resident alone to calm down. During an interview on 6/3/24 at 9:13 a.m., LPN (Licensed Practical Nurse) 3 indicated on 5/12/24, CNA (Certified Nursing Aide) 5 reported to her that CNA 9 had spoken inappropriately to Resident B and pointed her finger at him. She did not witness the incident but immediately reported to the Director of Nursing. During an interview on 6/3/24 at 10:25 a.m., the Director of Nursing (DON) indicated after she	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2	F 600		

watched the video, you could tell CNA 9 pointed her finger at the resident and poked him in the chest. The staff member was terminated.

The progress note, dated 5/12/24 at 8:45 p.m., indicated it was reported that CNA 9 and Resident B had an altercation in the hallway around 6:00 p.m. after Resident B was removed from another resident's room. Resident B called CNA 9 a bitch and told her to go to hell. CNA 9 responded verbally with her finger pointed at the resident. The resident sat in the hallway for a few minutes and then wheeled himself back to his room. The resident did not display any adverse effects from the interaction. All notifications had been made.

On 6/3/24 at 10:45 a.m. , during a video of the incident on 5/12/24 at 6:04 p.m., with the Director of Nursing present, the following was observed:

On 5/12/24 at 6:04 p.m., CNA 9 was observed to wheel Resident B out of a resident's room on the left of the hallway. CNA 9 was observed to walk up to the nurse's station and then abruptly stopped, turned around and walked back down the hall towards Resident B. CNA 9 was standing next to Resident B, in conversation and then poked Resident B in the chest area with her finger and then walked back up towards the nurse's station. A conversation was exchanged between CNA 9 and CNA 5 and then CNA 9 exited the camera view.

The written statement from CNA 5, dated 5/12/24 and untimed, indicated she was headed to the dining room but then remembered something and turned around and went back towards the nurse's station. CNA 5 heard Resident B yell "you can go to hell", she looked down the hall. CNA 9 had

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F 600	Continued From page 3	F 600		

walked past Resident B, immediately turned around and approached him. CNA 9 pointed her finger at Resident B and said in a deep, harsh voice, "you don't talk to me like that". Resident B asked CNA 9 , "what did I say". CNA 9, had her finger pointed at Resident B and scolding him by saying "you told me to go down there".

On 6/3/24 at 9:18 a.m., a current copy of the document titled "Abuse/Neglect/Mistreatment/Exploitation/Misappropriation of Personal Property" dated 1/12/18 was provided. It included, but was not limited to, "Policy...The facility strictly prohibits resident abuse...physical abuse...includes, but is not limited to, hitting slapping, pinching...mistreatment...inappropriate treatment...."

The Past noncompliance began on 5/12/24 at 6:04 p.m. The deficient practice was corrected by 5/30/24 after the facility implemented a systemic plan that included the following actions: All staff were interview, educated on abuse and neglect and post tests on abuse completed (5/30/24); Resident interviews/assessments were conducted with no findings (5/13/24).

This Citation relates to Complaint IN00434474

3.1-27(a)(1)