STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHAPMAN PLACE	3110 E COLISEUM BLVD FORT WAYNE, IN 46805

(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
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00395043. Complaint IN00395043 - Substantiated. State deficiencies related to the allegations are cited at R0053 Survey date: December 1, 2022 Facility number: 010235 Residential Census: 40 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed December 2, 2022	R 0000	*Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.*	
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 protect the resident's right to be free from verbal abuse for 1 of 3 residents reviewed. (Resident B) Findings include: A list of residents was provided by the Executive Director (ED) on 12/1/22 at 2 PM. The list indicated Resident B was not interviewable. An incident report, dated 11/16/22, was reviewed.	R 0053	**R 053 Residents' Rights – Deficiency** /b> Resident B was assessed for physical and psycho-social injuries on 11/17/2022 by Care Services Manager with none noted. Effective 12/16/2022, QMA 2 is no longer employed by the community.	12/30/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda harlow	Executive Director	12/16/2022

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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	The report indicated on 11/17/22 a staff reported QMA 2 was "roughly handling Resident B and speaking to him disrespectfully." The report indicated QMA 2 was put on leave during the investigation. The resident was assessed with no injuries noted and the resident's family and physician were notified. The report indicated the investigation was completed and found to be verbal abuse. QMA 2 was re-educated on abuse and resident rights upon return. A progress note, dated 11/22/22 indicated Resident B had a diagnosis of dementia. Investigation interviews were provided by the ED on 12/1/22 at 2:55 PM. The documentation indicated: QMA 2 was interviewed on 11/17/22 at 2:10 PM, QMA 2 indicated she was watching Resident B and other residents who are fall risks. QMA 2 indicated she "kept telling him to sit down, she got frustrated and said to him "I am done with you" but she was frustrated." CNA 5 was interviewed on 11/17/22 at 1:30 PM, CNA 5 indicated "QMA 2 was rough handling Resident B and speaking very angry towards him. QMA 2 was saying things like: "stop trying to get up, you need to sit down." CNA 5 indicated QMA 2's tone was mean. She also indicated "Resident B called QMA 2 dumb and QMA 2 responded back "you are the dumb one." CNA 6 was interviewed on 11/17/22 at 3:30 PM. CNA 6 indicated she "heard QMA 2 say things like "give me that, sit down and I told you to sit down," not so nicely to Resident B." The Memory Care Manager was interviewed on		**2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** An observational audit of the memory care unit, interviews with current staff, and interviews with AL residents without cognitive impairment was completed on 12/16/2022 by the Executive Director (ED) and CSM to ensure resident rights are upheld and residents are free from verbal abuse. An audit of care plans for memory care residents will be complete by 12/22/2022 by the CSM to ensure interventions to manage behaviors are reflected in the plan of care. **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Executive Director and Care Services Manager were re-educated on 12/9/2022 by the Regional Director of Care Services (RDCS) on the abuse policy and resident rights. Current Staff will be re-educated on 12/21/2022 by the Executive Director on resident rights and the abuse policy. New employees will be educated on abuse and resident rights during orientation.	

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	11/17/22 at 3:30 PM. The Memory Care Manager indicated she "heard some yelling at Resident B, something like "sit down and stay in your seat." The Memory Care Manager indicated she went to see what was going on but when she got there someone with sitting with Resident B and it was not the same voice she had heard. In a confidential interview on 12/1/22, a staff member indicated QMA 2 had called Resident B dumb and told him in a mean tone to learn his vocabulary. In an interview on 12/1/22 at 2 PM, the ED indicated a staff member reported on 11/17/22 that QMA 2 had got short and raised her voice, like "you need to sit down" to Resident B on 11/16/22. The ED indicated the facility completed an investigation and it was found QMA 2 was short with Resident B, raised her voice and told Resident B that he needed to sit down. The ED indicated through the investigation the facility was unable to prove QMA 2 rough handled Resident B. In an interview on 12/1/22 at 1:41 PM, CNA 2 indicated abuse consisted of neglect, physical hitting, stealing, verbally mean and not properly taking care of a resident. In an interview on 12/1/22 at 1:34 PM, Maintenance Tech 3 indicated abuse consisted of verbal disrespectfulness to a person, physical forcefulness or roughness and neglect of care to a resident. In an interview on 12/1/22 at 1:37 PM, Assistant Cook 4 indicated abuse consisted of not treating a resident with respect.		**4 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:** Effective 12/19/2022, the ED or designee will complete 5 observational audits on the memory care unit, interview 2 residents, and interview 2 staff members to ensure resident rights are upheld and residents are free from verbal abuse. The plan of care for new memory care residents will be reviewed to ensure interventions to manage behaviors are reflected in the plan of care. The observational audits, interviews, and plan of care reviews will occur weekly for four weeks, biweekly for four weeks, then monthly for one month. Interviews and audits will be reviewed at monthly QI meeting. The QI Committee will determine if continued interviews are necessary based on 3 consecutive months of compliance. Monitoring will be on-going **5 By what date the systemic changes will be completed** Completion date: 12/30/2022	

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	A policy, dated 3/1/2022, titled "Abuse, Neglect and Exploitation policy" was provided by the ED on 12/1/22 at 2 PM. The policy did not indicate the resident's rights to be free from verbal abuse. This State citation is related to IN00395043.			