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 02/01/2024

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 IN00424481. Complaint IN00424481 - Federal/State deficiency related to the allegations is cited a F600. Survey date: February 1, 2024 Facility number: 000563 Provider number: 155766 AIM number: 100267610 Census Bed Type: SNF/NF: 48 Total: 48 Census Payor Type: Medicaid: 32 Other: 16 Total: 48 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 6, 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 treat the resident's medical symptoms.	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	F 600		

§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 immediately responded when a resident (Resident B) fell and a full body assessment completed at the time of the fall for 1 of 3 residents reviewed for neglect.

Past noncompliance: no plan of correction required.

Findings include:

The clinical record for Resident B was reviewed on 2/1/24 at 1:29 p.m. The diagnoses included, but were not limited to, metabolic encephalopathy, osteoarthritis and vascular dementia.

The baseline care plan, dated 12/9/23, indicated the resident was a fall risk and the resident was to have a PSA (personal safety alarm) to her bed and chair at all times.

During an interview on 2/1/24 at 12:20 p.m., CNA (Certified Nursing Aide) 8 indicated on 12/19/23, she was coming up the 200 hallway and heard a loud thump. RN 4 told her Resident B had just put herself on the floor. She went around the nurse's station and saw the resident on the floor. She told RN 4 it looked like the resident had fallen. Resident B was hollering out and she tried to keep her calm. She asked RN 4 to help her with the resident because she could not move her until RN 4 assessed the resident. RN 4 just sat there.

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F 600	Continued From page 2 She heard RN 4 call the DON (Director of Nursing) to let her know Resident B had put herself on the floor. RN 4 finally got up to help assist Resident B back up into her wheelchair. RN 4 told Resident B, "look what that got you." RN 4 did not even assess Resident B for any injury. Resident B asked RN 4 to call her daughters to let them know she had fallen. RN 4 responded "no, you ran them all off as well."CNA 8 looked Resident B over and did not see anything, however she was not allowed to assess the resident since she was a CNA. RN 4 then went outside for a break and she reported the incident to the DON. The progress note from RN 4, dated 12/19/23 at 2:22 p.m., indicated the resident had sat herself down on the floor at the nurse's station. The resident had reported over and over throughout the day that she would put herself on the floor. Her alarm sounded at the nurse's desk and she had put herself on the floor at the foot of her wheelchair. The resident was assessed and no injury found. The progress note, dated 12/19/23 at 5:08 p.m., indicated that upon video review of Resident B's fall at approximately 2:30 p.m., it was observed that the resident was sitting in her wheelchair at the nurse's station. The resident continued to scoot closer and closer to the edge of her wheelchair. The resident fell forward onto the floor and hit the wheel of another resident's wheelchair in front of her. Upon assessment by LPN (Licensed Practical Nurse) 3, there were no injuries or physical concerns observed. Nursing would continue to observe and monitor neurological status.	F 600		

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F 600	Continued From page 3	F 600		

On 2/1/24 at 1:46 p.m., the video of the incident, dated 12/19/23 at 2:18 p.m., was observed with the Executive Director present. The following was observed in the video:

On 12/19/23 at 2:18 p.m., Resident B was observed sitting at the nurse's station. RN 4 was observed sitting at the desk behind the nurse's station. Resident B scooted forward towards the edge of her chair. At 2:19 p.m., RN 4 turned her head towards the direction of Resident B. Resident B then fell forward out of the wheelchair and onto the floor, striking her head on the wheel of another residents' wheelchair. RN 4 remained sitting behind the nurse's station and did not look up. At 2:20 p.m., CNA 8 came around the nurse's station and saw Resident B on the floor at which time RN 4 picked up the facility phone to make a call. CNA 8 went behind Resident B's wheelchair and turned off Resident B's alarm. CNA 8 then moved another resident from out of in front of Resident B and bended over the resident. During this time, RN 4 hung up the facility phone and then pulled out her cell phone to make another call. CNA 8 walked down the hall towards the front doors. At 2:20 p.m., CNA 8 walked back down toward Resident B, at which time RN 4 had gotten up from her seat and walked out from behind the nurse station. RN 4 stared at Resident B while she was on the floor. At 2:21 p.m., RN 4 and CNA 8 assisted Resident B up from the floor and placed her back into the wheelchair. RN 4 did not assess Resident B for injury prior to moving her. RN 4 then went back behind the nurse's station, sat down, and picked up the facility phone where she remained until 2:24 p.m. At 2:24 p.m., RN 4 got up and exited out from behind the nurse's station, walked down the hall and exited out the side door.

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F 600	Continued From page 4 During an interview on 2/1/24 at 1:50 p.m., the Executive Director indicated the nurse in the video was an RN, Resident B's alarm was sounding and RN 4 did not move. RN 4 was no longer employed by the next day. On 2/1/24 at 12:29 p.m., the Director of Nursing provided a current copy of the document titled "Abuse/Neglect/Mistreatment/Exploitation/Misappropriation of Personal Property" dated 1/12/18. It included, but was not limited to, "Abuse...Abuse also includes the deprivation by an individual...of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being...Prevention...The facility strictly prohibits...neglect...by employees......Neglect...the willful failure of the facility...employees...to provide goods and services that are necessary to avoid physical harm, mental anguish, or emotional distress...." The Past noncompliance began on 12/19/23. The deficient practice was corrected by 12/21/23 after the facility implemented a systemic plan that included the following actions: All nurses were educated on the importance of fall assessments to include completing the assessment prior to moving a resident; All licensed staff were educated on abuse and neglect, which included providing services necessary to avoid physical harm, mental anguish and emotional distress. This Citation relates to Complaint IN00424481 3.1-27(a)(3)	F 600		