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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/15/2024 |
| NAME OF PROVIDER OR SUPPLIER Aperion Care Greenfield | | STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 Greenfield, IN 46140 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>30344</p> <p>Based on interview and record review, the facility failed to report an allegation of abuse to the Indiana Department of Health (IDOH) timely for 1 of 3 residents reviewed for abuse. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 10/15/24 at 10:14 a.m. Her diagnoses included, but were not limited to, anxiety and depression.</p> <p>An interview was conducted with Resident B on 10/11/24 at 12:20 p.m. She indicated on Sunday, 10/6/24, Certified Nursing Assistant (CNA) 3 grabbed her left arm and shook her, telling her 'you don't talk to me like that,' and called her a crazy b**** along with other names. CNA 3 ran out of the room when one of the nurses came in. CNA 3 was screaming she was never going in that 'damn b*****s' room again. Resident B reported this to the night shift nurse, who was right outside the door when CNA 3 was still screaming.</p> <p>On 10/11/24 at 1:11 p.m., the Business Office Manager (BOM) provided a copy of an email sent to her from Resident B on Monday, 10/7/24 at 6:14 a.m., with Serious complaint in the subject line. The email indicated CNA 3 grabbed Resident B's left arm and forcefully shook her repeatedly; that CNA 3 refused to leave her room; that CNA 3 left her hanging over the bed in the Hoyer lift; that CNA 3 refused to reposition her in the bed, telling her to 'figure that out yourself;' that her call light wasn't answered for 11 hours the night of 10/5/24; along with several other allegations. The email read, All of [name of CNA 3's] actions this weekend have been either neglect or abusive.</p> <p>An interview was conducted with the BOM on 10/11/24 at 1:01 p.m. She indicated she received the email from Resident B the morning of 10/7/24. She responded to Resident B via email the same day that an investigation was started. Resident B replied, thanking her for the quick response, and they began to investigate. The Administrator was on vacation, on 10/7/24, and currently still was, as she left for vacation on 10/3/24. This allegation of abuse by Resident B was not reported to the IDOH. The BOM assumed it was the Assistant Director of Nursing (ADON) who was responsible for reporting it. They just reported it today, 10/11/24.</p> <p>On 10/11/24 at 1:03 p.m., the Regional Nurse Consultant (RNC) provided a copy of a reportable, dated 10/11/24, regarding Resident B's allegations of abuse against CNA 3.</p> <p>(continued on next page)</p> |

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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 10/15/24 at 12:45 p.m., an interview was conducted with the Administrator. She indicated the BOM and ADON were responsible for reporting to IDOH in her absence.</p> <p>The Abuse Prevention and Reporting policy was provided by the BOM on 10/11/24 at 1:21 p.m. It read, Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Department of Public Health immediately, but not more than two hours after the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours.</p> <p>This citation relates to Complaint IN00444277.</p> <p>3.1-28(c)</p> | | |