

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155766	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/22/2024
NAME OF PROVIDER OR SUPPLIER  Maple Manor Christian Home Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  643 W Utica St Sellersburg, IN 47172	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>34231</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident (Resident B) was not restrained in place for 1 of 3 residents reviewed for abuse.</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 11/21/24 at 12:16 p.m. The resident's diagnoses included, but were not limited to, dementia, abnormality of the gait and cognitive communication deficit.</p> <p>On 11/21/24 at 12:50 p.m., the resident was observed sitting up on the side of her bed. She was well groomed and pleasantly confused with no signs of any psychosocial distress.</p> <p>On 11/21/24 at 11:45 a.m., the facility video footage, from 10/28/24 between 5:48 a.m. and 5:55 a.m., was observed with the following:</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/28/24 at 5:48 a.m., CNA (Certified Nursing Aide) 5 was observed to propel Resident B across from the nurse's station and backed the wheelchair up against the wall. Resident B had attempted to propel her wheelchair forward. CNA 5 moved the resident's wheelchair back up against the wall, locked the brakes to the wheelchair and leaned over the resident. CNA 5 had turned to walk away from the resident. The resident placed her hands down towards the wheelchair wheels, at which time, CNA 5 turned back around, walked back towards the resident, and then had placed the residents arms and hands across the resident's chest. The resident placed her right arm back down toward the wheelchair wheel and CNA 5 placed the resident's right arm back across the resident's chest. CNA 5 was standing to the right of the resident and the resident then had attempted to scoot forward to move the wheelchair and placed her arms back down on the wheelchair wheels. CNA 5 again, had moved both of the resident's arms back across the resident's chest. CNA 5 then checked to ensure wheelchair brakes were locked. The CNA had turned and looked to the right at which time the resident attempted to move her wheelchair. CNA 5 was bent over the resident which obstructed the view of the resident and then CNA 5 had turned and leaned back against the wall. The resident placed her right arm down toward the wheelchair wheel at which time CNA 5 had placed the resident's right arm back across the resident's chest. The resident moved her legs, put both her arms down and unlocked her wheelchair. CNA 5, again, had placed the residents arms back across the resident's chest and locked both brakes on the wheelchair. The resident placed her right arm down towards the wheelchair wheel and CNA 5 had placed the resident's right arm across the resident's chest. The resident moved her body and legs, at which time, CNA 5 locked the left wheelchair brake and checked the right brake to make sure it was still locked. The resident attempted to propel herself and could not due to the wheelchair brakes had been locked. The resident had continued to try to propel herself multiple times. CNA 5 was observed to place her right hand on the resident's right shoulder area to get the resident to sit back in the wheelchair. At 5:53 a.m., the resident tried to propel herself and could not due to the locked wheelchair brakes. CNA 5, again, placed her left hand on the resident's right shoulder area to sit her back in the wheelchair. CNA 5 had assisted Resident B to put her hearing aides in and walked away from the resident. At 5:55 a.m., the resident unlocked her wheelchair brakes and propelled herself around the nurse's station.</p> <p>During an interview on 11/22/24 at 11:38, the Executive Director indicated Resident B wanted to go back to her room and CNA 5 was trying to keep her from going to her room so she would not fall.</p> <p>During an interview on 11/22/24 at 11:41 a.m., Staff Member 6 indicated it was not appropriate to lock a resident's wheelchair to prevent them from moving.</p> <p>On 11/21/24 at 1:20 p.m., the Director of Nursing provided a current copy of the undated document titled If You See Something Say Something. It included, but was not limited to, employees are required to report .all . occurrences of .unreasonable confinement .What constitutes abuse .Physical .Restraints .It is prohibited to . unnecessarily inhibit a resident's freedom of movement or activity</p> <p>The Past noncompliance began on 10/28/24 at 5:48 a.m. The deficient practice was corrected by 10/29/24 after the facility implemented a systemic plan that included the following actions: All staff were interviewed and educated on abuse and neglect which included involuntary seclusion and physical/chemical restraints (10/29/24); Resident interviews and facility wide skin assessments were conducted with no findings (10/28/24).</p> <p>3.1-3(w)</p> <p>(continued on next page)</p>		

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