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	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Manor Christian Home Inc	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)
F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). Based on observation, interview and record review, the facility failed to ensure a resident (Resident B) was not isolated in her room for 1 of 3 residents reviewed for abuse. Findings include:The clinical record for Resident B was reviewed on 6/8/26 at 9:43 a.m. The resident's diagnoses included, but were not limited to, anxiety disorder (mental health conditions characterized by excessive, persistent, and disproportionate fear or worry about everyday situations) and vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, depriving it of oxygen and nutrients) with other behavioral disturbance.The incident report, dated 5/15/26, indicated an anonymous visitor notified the Administrator with concerns on how a resident was treated on 5/14/26. It was reported that between approximately 5:30 p.m. and 6:45 p.m., on 5/14/26, the visitor could hear a resident yelling out in the hallway, repeatedly, I need to go, I'm going to s*it my pants, I'm going to s*it my pants if I don't go. The visitor overheard the staff tell the resident she would have to wait because they were bringing other residents back from the dining room. The visitor reported that, after a while, the yelling had become muffled. The visitor walked out into the hallway and realized that the staff had taken the resident into her room and shut the door with no staff members present. The visitor could hear yelling coming from the resident's room which continued for quite some time.On 6/8/26, at 11:22 a.m., the facility video footage was reviewed from 5/14/26 and included the following:-At 6:21 p.m., Resident B was observed sitting up in her high back specialized medical chair across from the nurses' station,-At 6:22 p.m., Certified Nursing Assistant (CNA) 6 (day shift aide) came out from behind the nurse's station and took Resident B into her room,-At 6:23 p.m., CNA 6 exited the room, shut the door to Resident B's room, and went back behind the nurse's station to sit down, and-At 6:44 p.m. CNA 8 (on-coming night shift aide) entered Resident B's room.The video timeline footage from 5/14/26, between 5:41 p.m. and 6:56 p.m., included, but was not limited to, the following:- At 5:50 p.m., Resident B was brought back to the nurse's station from the dining room,- At 5:52 p.m., Licensed Practical Nurse (LPN) 5 moved Resident B next to the medication cart across from the nurse's station,- At 5:54 p.m., CNA 6 and CNA 8 were talking at the nurse's station,- At 5:58 p.m., CNA 8 started checking the residents due to coming on the shift,- At 6:15 p.m., CNA 6 sat down behind the desk at the nurse's station,- At 6:22 p.m., CNA 6 came out from behind the nurse's station and took Resident B into her room,-At 6:23 p.m., CNA 6 exited the room, shut the door to Resident B's room, and went back behind the nurse's station and sat down,-At 6:44 p.m., CNA 8 entered Resident B's room,-At 6:45 p.m., CNA 6 entered Resident B's room,-At 6:47 p.m., CNA 6 exited Resident B's room,-At 6:52 p.m., CNA 6 entered Resident B's room with a bedpan, and-At 6:56 p.m., CNA 6 exited Resident B's room followed by CNA 8 who had bagged linens and trash.The written statement from CNA 6, dated 5/18/26, indicated that shift change was in progress, CNA 6 had given report to CNA 8. All residents were being removed from the dining room during this time. Resident B started yelling that she needed to use the bathroom. The on-coming nurse (LPN 11) told Resident B she would be toileted soon because it was change of shift. CNA 6 told CNA 8 that she would assist with toileting Resident B and needed a bedpan. CNA 6 told CNA 8 that she would be taking Resident B back to her room as CNA 6 went to get a bedpan because Resident B's yelling was a little disruptive during shift (continued on next page)

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

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	change. When CNA 6 returned with the bedpan, CNA 8 was already in the room with Resident B and both CNAs assisted with toileting Resident B.The written statement from LPN 11, dated 5/18/26, indicated on 5/14/26 at approximately 6:00 p.m., Resident B was sitting in the hallway and yelled out that she needed to use the toilet. LPN 11 had never heard Resident B make that request before. LPN 11 was informed by LPN 5 and CNA 6 that Resident B had been fixated on that statement all day and had repeated the statement after being toileted. LPN 11 then engaged in conversation with Resident B, who, at that time, stopped yelling. LPN 11 informed Resident B that it was shift change and someone would toilet her soon. LPN 11 walked away and Resident B began to yell again. Shortly after, CNA 6 stated she was going to take Resident B to her room to avoid disturbing all the other residents with loud yelling. CNA 6 reported she would toilet the resident when the other CNA became available. Resident B was toileted, placed in bed with no other behaviors observed.On 6/9/26 at 1:09 p.m., during a phone interview with CNA 8 they indicated, when CNA 8 had gotten to work on 5/14/26, CNA 6 had talked about putting Resident B on the bed pan. CNA 6 took Resident B to her room. CNA 8 indicated she did not feel that CNA 6 meant to shut the door all the way. Resident B had been screaming and she screamed loudly. Resident B said she needed to go to the bathroom. It took CNA 8 a while to get to Resident B after she received report because she had gotten distracted with other residents. On 6/8/26 at 9:51 a.m., the Quality Assurance Nurse provided a current copy of the document titled Abuse/Neglect/Mistreatment/Exploitation/Misappropriation of Personal Property dated 1/12/2018. It included, but was not limited to, Definitions/Background.Unreasonable Confinement.the separation of a resident from other residents.confinement to his/her room.Policy.The facility strictly prohibits.unreasonable confinement.by employees.The facility will do all that is within its control to assure that resident a free from.unreasonable confinement.This deficient practice was corrected on 5/26/26, prior to the start of the survey and was therefore Past Noncompliance. The facility implemented a systemic plan which included the following: All staff were educated on resident abuse and resident rights with an emphasis on dignity, neglect, toileting and involuntary seclusion (5/26/26); All alert and oriented residents were interviewed with no negative responses (5/15/26); Skin sweeps were completed on all non-alert residents with no negative findings (5/15/26); Care plans were reviewed and updated on all residents with the potential to be affected (5/15/26). This citation relates to Intake 3016292.410 IAC (Indiana Authorization Code) 16.2-3.1-27(a)(4)