

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155851	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/10/2025
NAME OF PROVIDER OR SUPPLIER  Orchard Pointe Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE  702 Sawyer Road Kendallville, IN 46755	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>46756</p> <p>Based on interview and record review the facility failed to ensure freedom from verbal and physical abuse for 2 of 24 residents reviewed (Resident A, and Resident B).</p> <p>Findings include:</p> <p>In a review of a written complaint on 1/6/25 at 9:24 AM, a Complainant indicated Qualified Medicine Aide (QMA) 7 had been verbally abusive to Resident A in Complaint IN00450607. The Complainant indicated a facility vendor had witnessed and reported the abuse to the Administrator. The Complainant indicated the Administrator and Assistant Director of Nursing (ADON) were aware of the abuse and did not report it to Resident A's family or the State Department of Health. The Complainant indicated QMA 7 had previous occurrences of witnessed abuse and was eligible to be rehired.</p> <p>During an interview on 1/7/25 at 11:27 AM, Facility Vendor 6 indicated they were present in the assisted dining room on 11/15/24 during breakfast. Vendor 6 indicated QMA 7 came into the assisted dining room with an agitated demeanor, verbally indicating displeasure about being assigned to assist in feeding residents. Vendor 6 indicated Resident A made a statement she was unable to hear to QMA 7, who was seated next to Resident A assisting him with his meal. Vendor 6 indicated QMA 7 became upset and raised her voice to Resident A. She told the resident she only disrespected him because he had disrespected her. QMA 7 then abruptly stood up, grabbed Resident A's meal tray and slammed it on the tray cart. Vendor 6 indicated QMA 7's body language appeared angry and escalated as she went over to Resident B. Resident B had been seated at a table with her clothing protector in her mouth. QMA 7 forcibly pulled the clothing protector out of Resident B's mouth verbally indicating she should not be eating laundry detergent. Vendor 6 indicated an unidentified employee came in the room and asked QMA 7 to leave the dining room and finish her medication pass. Vendor 6 indicated they had emailed the Administrator requesting a phone call since she was not present in the building at the time. Vendor 6 indicated they verbally reported the incident as described to the Administrator over the phone on 11/19/24.</p> <p>1. During an interview on 1/7/25 at 3:52 PM, Resident A's Power of Attorney (POA) indicated they were not aware of any occurrences of disrespectful, rude or abusive conduct toward Resident A. The POA indicated Resident A would not have the ability to recall any abusive event that may have occurred.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident A's record was reviewed on 1/8/24 at 11:52 AM. Diagnoses included diffuse traumatic brain injury with loss of consciousness, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and depression.</p> <p>Progress notes between 11/15/24 and 11/19/24 did not include any assessments or interviews with Resident A pertaining to recollection or psychosocial effects from verbal abuse.</p> <p>2. Resident B's record was reviewed on 1/8/25 at 12:59 PM. Diagnoses included dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, personal history of traumatic brain injury, and mild intellectual disabilities. Resident B was unable to be interviewed about abuse.</p> <p>Progress notes between 11/15/24 and 11/19/24 did not include any assessments or interviews with Resident B pertaining to recollection or psychosocial effects from abuse.</p> <p>In an interview, on 1/8/25 at 1:51PM, Certified Nurse Aide (CNA) 11 indicated rude or inappropriate speech toward a resident should be reported to the person in charge of the shift, or the nurse management.</p> <p>In an interview, on 1/8/24 at 1:53 PM, Licensed Practical Nurse (LPN)12 indicated verbal abuse could include derogatory or disrespectful speech and physical abuse could include rough physical touch during care. She indicated a nurse's first action upon witnessing abuse was to call the corporate compliance hotline posted on the wall near the front office. LPN 12 walked to the sign and pointed at the phone number.</p> <p>In an interview, on 1/8/24 at 1:56 PM, Life Enrichment Aide (LEA) 13 indicated rough handling of a resident during care, yelling and using downgrading or derogatory speech toward residents were examples of abuse. LEA 13 indicated any witnessed abuse should be reported to the ADON or the Administrator.</p> <p>In an interview, on 1/8/24 at 2:01 PM, CNA 14 indicated any staff member witnessing abuse should make sure the resident was safe and then immediately report the abuse directly to the Administrator. If the Administrator was not available, staff should report to the nurse manager in charge.</p> <p>In a confidential interview, on 1/9/24 at 9:58 AM, Employee 18 indicated QMA 7 had contacted them and indicated she had been terminated for being verbally inappropriate with a resident and roughly pulling a clothing protector out of a resident's mouth. Employee 18 indicated they were on duty the day of the incident and no person from management had requested a statement from them about any knowledge of the incident.</p> <p>In an interview, on 1/9/25 at 2:49 PM, The Administrator indicated QMA 7 was disciplined on 11/19/24 because she had reportedly slammed a breakfast tray down in front of a student. She indicated this incident had been the final incident for this employee concerning conduct. She indicated she had received a report over the phone from the instructor of the CNA class, who performed clinical work in the building, QMA 7 had slammed a tray down in front of a student. She indicated the instructor did not mention anything to indicate any verbal or physical abuse had occurred. She indicated she had no reason to suspect abuse, so she did not conduct an abuse investigation. She indicated she had no statements or notes describing the incident or behavior regarding rough treatment of residents.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A witness statement given by the Administrator, dated 11/19/24, presented by the ADON on 1/10/25 at 8:53 AM, indicated the CNA instructor had reported QMA 7 having negative interactions in front of residents in the dining room. The note further indicated she would have jumped in if the situation had gotten physical or abusive.</p> <p>A witness statement given by the ADON, dated 11/19/24, presented by the ADON on 1/10/25 at 8:53 AM indicated she interviewed QMA 7 had asked Resident A to show her respect because she showed him respect. She indicated QMA 7 denied slamming a tray down.</p> <p>During an interview, on 1/10/25 at 11:30 AM, Registered Nurse (RN) 19 indicated she was not aware of any inappropriate behavior at any time in the assisted dining room by any staff member. She indicated when a student or instructor noticed any inappropriate behavior, they should report it to her or an administrative staff member immediately.</p> <p>A current policy dated 7/2/24, titled Abuse and Neglect Procedural Guidelines, provided by the Administrator on 1/6/24 at 9:29 AM indicated physical abuse can include corporal punishment, involving physical punishment to control behavior. Mental abuse involves the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation. The policy indicated occurrences of suspected abuse should be reported to the Administrator or the Administrator's designee immediately after resident safety was secured. The policy indicated physicians, consultants, volunteers and other contracted employees and providers should be provided with the Abuse and Neglect Procedural Guidelines for awareness of protocols. The policy indicated the Administrator should identify and interview all involved persons including the alleged victim, perpetrator, witnesses and all others who may have knowledge of the allegation. The Administrator should provide complete, thorough documentation of the investigations.</p> <p>This citation is related to complaint IN00450607.</p> <p>3.1-27(b)</p>		

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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>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>46756</p> <p>Based on interview and record review the facility failed to ensure an allegation of abuse was reported to the Department of Health for 2 of 24 residents reviewed (Resident A, and Resident B).</p> <p>Findings include:</p> <p>In a complaint review, on 1/6/25 at 9:24 AM, a Complainant indicated Qualified Medicine Aide (QMA) 7 had been verbally abusive to Resident A in Complaint IN00450607. The Complainant indicated a facility vendor had witnessed and reported the abuse to the Administrator. The Complainant indicated the Administrator and Assistant Director of Nursing (ADON) were aware of the abuse and did not report it to Resident A's family or the State Department of Health.</p> <p>During an interview, on 1/7/25 at 11:27 AM, Facility Vendor 6 indicated they were present in the assisted dining room on 11/15/24 during breakfast. Vendor 6 indicated QMA 7 came into the assisted dining room with an agitated demeanor, verbally indicating displeasure about being assigned to assist in feeding residents. Vendor 6 indicated Resident A made a statement she was unable to hear to QMA 7, seated next to Resident A assisting him with his meal. Vendor 6 indicated QMA 7 became upset and raised her voice to Resident A. She told Resident A she only disrespected him because he had disrespected her. QMA 7 then abruptly stood up, grabbed Resident A's meal tray and slammed it on the tray cart. Vendor 6 indicated QMA 7's body language appeared angry and escalated as she went over to Resident B. Resident B had been seated at a table with her clothing protector in her mouth. QMA 7 forcibly pulled the clothing protector out of Resident B's mouth. She told Resident B she should not be eating laundry detergent. Vendor 6 indicated an unidentified employee came in the room and asked QMA 7 to leave the dining room and finish her medication pass. Vendor 6 indicated they had emailed the Administrator requesting a phone call since she was not present in the building at the time. Vendor 6 indicated they verbally reported the incident to the Administrator over the phone on 11/19/24.</p> <p>1. During an interview on 1/7/25 at 3:52 PM, Resident A's Power of Attorney (POA) indicated they were not aware of any occurrences of disrespectful, rude or abusive conduct toward Resident A. The POA indicated Resident A would not have the ability to recall any abusive event that may have occurred.</p> <p>Resident A's record was reviewed on 1/8/24 at 11:52 AM. Diagnoses included diffuse traumatic brain injury with loss of consciousness, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and depression.</p> <p>2. Resident B's record was reviewed on 1/8/25 at 12:59 PM. Diagnoses included dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, personal history of traumatic brain injury, and mild intellectual disabilities. Resident B was unable to be interviewed about abuse.</p> <p>(continued on next page)</p>		

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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>In an interview, on 1/9/25 at 2:49 PM, The Administrator indicated QMA 7 was disciplined on 11/19/24 because she had reportedly slammed a breakfast tray down in front of a student. She indicated this incident had been the final incident for this employee concerning conduct. She indicated she had received a report over the phone from the instructor of the CNA class, who performed clinical work in the building, QMA 7 had slammed a tray down in front of a student. She indicated the instructor did not mention anything to indicate any verbal or physical abuse. She indicated she had no reason to suspect abuse, so she did not conduct an abuse investigation, or report the incident. She indicated she had no statements or notes describing the incident or QMA 7's behavior.</p> <p>A current policy dated 7/2/24, titled Abuse and Neglect Procedural Guidelines, provided by the Administrator on 1/6/24 at 9:29 AM indicated the Administrator was accountable for investigating and reporting. The policy indicated the Administrator should identify and interview all involved persons including the alleged victim, perpetrator, witnesses and all others who may have knowledge of the allegation. The Administrator should provide complete, thorough documentation of the investigations. All alleged violations should be reported to the Department of Health within 24 hours of the report.</p> <p>This citation is related to complaint IN00450607.</p> <p>3.1-28 (c)</p>		