STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155205	A. BUILDING _____ B. WING _____	**05/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GREENCROFT HEALTHCARE	**1225 GREENCROFT DR GOSHEN, IN 46527**

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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based in record review and interview, the facility failed to ensure residents were free from staff to resident verbal abuse. (Resident B) Finding includes: An incident report, dated 5/7/2020, indicated CNA (Certified Nurses Aide) 4 had was allegedly heard yelling at Resident B and a housekeeper had witnessed her hit him on the hand and tell him she was of him. The record for Resident B was reviewed on 5/11/2020 at 2:00 P.M The [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Status) assessment, dated 2/6/2020, indicated Resident B had a BIMS (Brief Interview of Mental Status) of 15, cognitive impairments. A written statement, dated 5/8/2020, indicated Housekeeper 2 and Housekeeper 3 had overheard yelling in Resident B's room. Housekeeper 2 heard CNA (certified nursing assistant) 4 telling Resident B she was sick of him. Housekeeper 2 reported the incident to the nurse, who went down to Resident B's room. The nurse exited the room, CNA 4 remained in room with Resident B. Resident B's door was open and CNA 4 was heard screaming at resident. Housekeeper 2 indicated she witnessed CNA 4 hit Resident B on his hand. Housekeeper 2 told CNA 4 to leave Resident B's room, CNA 4 said Resident B was out of control. The housekeeper told the nurse about the ongoing situation. During an interview, on 5/11/2020 at 2:20 P.M., Resident B indicated CNA 4 did not hit him on 5/7/2020, but they have a relationship, in which, they have words often and this has been going on for a while. He indicated he had pseudobulbar affect from [MEDICAL CONDITION] and that he giggles uncontrollably. CNA 4 thinks he is laughing at her and she gets mad. He indicated on the night the incidence occurred, he was hot and so was the CNA. He indicated he does not like the relationship and that it makes him feel uncomfortable at times. He stated he spoke with ADON (Assistant Director of Nursing) indicating CNA 4 did not hit him, but he was upset about the way she talked to him and he wanted the nurse to explain his disease. He indicated CNA 4 had told him she had never heard of pseudobulbar affect. During an interview, on 5/11/2020 at 2:30 P.M., CNA 5 indicated CNA 4 was easily worked up and she was more intense with Resident B than any other resident. She indicated she would not treat someone the way CNA 4 treated Resident B. She indicated she had not reported it to anyone else, but she had said something to CNA 4 herself. She indicated this has been going on for a long time between the two. During an interview, on 5/11/2020 at 3:00 P.M., the ADON indicated Resident B had reported to her on 5/8/2020 that CNA 4 did not hit him. He had indicated that CNA 4 and him had words but that wasn't any different than any other day. He indicated that he had pseusobulbar affect and that frustrates her. She indicated CNA 4 had previous verbal and physical altercations with other staff but no behavioral issues with other residents. She indicated no investigation had been completed on the allegation of verbal abuse. During an interview, on 5/11/2020 at 3:49 P.M., the ED (Executive Director) indicated he did not do a follow up on the allegation of verbal abuse. He indicated the housekeeper that reported the incidence is like the boy that cried wolf. He indicated CNA 4 was suspended at time of allegation but returned to work on Saturday. He indicated the allegation was unsubstantiated. During an interview, on 5/11/2020 at 4:02 P.M., Housekeeper 2 indicated that her and another housekeeper had heard a lot of hollering coming from Resident B's room. She indicated she observed CNA 7 walked out of Resident B's room and did not shut the door. She heard CNA 4 was yelling at him, stating she was sick of him and that she had a lot of work to do. She went and got the nurse, who went into Resident B's room but wasn't in the room very long. She indicated, she again heard CNA 4 screaming at Resident B and when she walked past the door she witnessed CNA 4 hit Resident B on the hand. During an interview, on 5/11/2020 at 4:58 P.M., CNA 7 indicated she was present in Resident B's room and witnessed CNA 4 yelling at Resident B. She indicated CNA 4 was frustrated and her frustration was coming out at Resident B. She indicated no one from the facility had asked her about the incident. During an interview, on 5/12/2020 at 12:00 P.M., the ED indicated he had filed an abuse allegation for Resident B reporting he did not like how CNA 4 talked to him. He indicated that CNA 4's employment would be terminated follow this allegation. On 5/12/2020 at 12:19 P.M., the ED provided the Abuse-Identification of Abuse policy, revised 10/2016, and indicated this was the policy currently being used by the facility. The policy indicated it's purpose was to ensure all employees were aware that mistreatment, neglect and abuse of residents was strictly forbidden by the instituition. The Federal tag is related to complaint IN 105. 3.1-27(a) 3.1-27(b)
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** Based on record review and interview, the facility failed to complete a thorough investigation for staff to resident verbal and physical abuse in 3 of 3 residents reviewed for abuse allegations. (Resident B, C and D) Findings include: 1. An incident report, dated 5/7/2020, indicated CNA 4 had was allegedly heard yelling at Resident B and a housekeeper had witnessed her hit him on the hand and tell him she was sick of him. During an interview, on 5/11/2020 at 3:00 P.M., the ADON indicated no investigation had been completed on the allegation of verbal abuse. During an interview, on 5/11/2020 at 3:49 P.M., the ED (Executive Director) indicated he did not do a follow up on the allegation of verbal abuse. He indicated the housekeeper that reported the incidence is like the boy that cried wolf. He indicated CNA 4 was suspended at time of allegation but returned to work on Saturday. 2. An incident report, dated 3/30/2020, indicated Housekeeper 2 had reported CNA 8 had grabbed Resident C by the arm and took his walker away from him and CNA 4 was heard telling Resident D to go sit down and shut up. A written statement, no date, indicated Housekeeper 2 witnessed CNA 8 grab Resident C by the arm and take his walker away. She indicated Resident C was upset and she had sat with him to calm him down. She indicated she then witnessed CNA 8 tell Resident D to sit down and shut up. There was no investigation present for the allegation of verbal and physical abuse, there was only a statement from CNA 8 and Housekeeper 2 present in file provided. On 5/12/2020 at 12:19 P.M., the ED provided the Abuse- Investigation of Abuse and Protection of the Resident policy, dated 10/2016, and indicated this was the policy currently being used by the facility. The policy indicated will assure that upon the allegation or identification of abuse, neglect or misappropriation of resident property, the administrator or designee would immediately undertake an investigation of the allegation or event. This Federal tag relates to Complaint IN 105. 3.1-28(d)

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.