STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE PLACE	2770 S ADAMS RD BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00186591 and IN00188974. Complaint IN00186591-Unsubstantiated due to lack of evidence. Complaint IN00188974 - Substantiated. State deficiencies related to the allegations are cited at R029. Survey date: December 17, 2015 Facility number: 004016 Provider number: 004016 AIM number: N/A Census bed type: Residential: 49 Total: 49 Sample: 04 This State finding is cited in accordance with 410 IAC 16.2-5. Q.R. completed by 14466 on December 18, 2015.	R 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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R 0029 Bldg. 00	410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on interview and record review, the facility failed to ensure residents were treated with respect and consideration in that a Certified Nursing Assistant (CNA) would enter a resident's room and refused to leave upon being asked for 3 of 4 residents reviewed for residents rights. (Resident #A, #C, and #D) Findings include: 1). On 12/17/15 at 9.21 a.m., an interview with a family member of Resident #A indicated, Certified Nursing Assistant (CNA) #1 would go into several residents' rooms, not requested by the resident, and then would not leave upon the resident's request. Resident #A's clinical record was reviewed on 12/17/15 at 1:40 p.m.. Diagnoses included, but were not limited to: bipolar, tremors, diabetes and hypertension. Resident #A was interviewable and cognitively intact. On 12/17/15 at 10:15 a.m., an interview	R 0029	R029 1. CNA #1 is no longer employed at the community. 2. Current residents have the potential to be affected by the alleged deficient practice. 3. An In-service on Resident Rights was conducted for staff members on 12/21/15 by the Area Executive Director (AED) and Care Service Manager (CSM). 4. The Executive Director is responsible for sustained compliance. The ED and/or designee will conduct random discussions with residents to ensure resident rights are being maintained, including staff members entering resident apartments without reason. Residents will be encouraged to report potential violations without fear of retribution to the ED or CSM. Reports of alleged violations of resident rights will be immediately investigated by the ED. Monitoring will be ongoing. 5. Completion Date: 1/1/16	01/01/2016

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	with Resident #A indicated CNA #1 would go into Resident #C and Resident D's rooms at times and would not leave upon request by the residents. Resident #A indicated CNA #1 would also enter her room uninvited and would not leave upon being requested to do so. Resident #A felt uncomfortable and did not want CNA #1 to enter her room anymore. "She [CNA #1] made my skin crawl." 2). Resident #C's clinical record was reviewed on 12/17/15 at 2:00 p.m. Diagnoses included, but were not limited to: acute cerebral vascular accident (stroke). On 12/17/15 at 9:45 a.m., an interview with Resident #C indicated a night shift CNA (CNA #1) would come into Resident #C's room, not requested and not providing care. "I was changing clothes one day getting ready to get up." CNA #1 came into the room, because of " 'being bored with nothing do.' " CNA #1 wanted to, " 'kill time.' " Resident #C indicated CNA #1 was asked to leave, but refused. Resident #C indicated this had happened twice. "I told the CNA not to come back." 3). Resident #D's clinical record was reviewed on 12/17/15 at 2:20 p.m. Diagnoses included, but were not limited			

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	to: lumbar spine stenosis (narrowing of the spine), chronic back pain and debility (weakness). On 12/17/15 at 11:50 a.m., an interview with Resident #D indicated, on December 13, 2015, Resident #D needed assistance with putting on an item. "I used the call light and a Certified Nursing Assistant (CNA) whom I had never seen before came to help me." Resident #D indicated the CNA (CNA #1) was very talkative and sat down in a chair in the room. CNA #1 would not leave Resident #D's room, but continued to talk. "I don't want that CNA to come in my room again. Makes me uncomfortable." On 12/17/15 at 2:46 p.m., the interim Administrator provided the policy "RESIDENT RIGHTS" dated 7/1/14, and indicated the policy was the one currently used by the facility. The policy indicated, "...II. Employees will honor each resident as an individual , treating them with respect and dignity at all times....3. Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality."			