STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF NEWBURGH	5311 ROSEBUD LANE, NEWBURGH, , 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the investigation of complaints IN00463987, and IN00463687. Complaint IN00463687: State deficiencies related to the allegation(s) are cited at R0064. Complaint IN00463987: No deficiencies related to the allegation(s) are cited. Survey date: August 20, 2025 Facility number: 016891 Residential Census: 57 This state residential finding is cited in accordance with 410 IAC 16.2-5. Quality review completed September 2, 2025.	R 0000	In lieu of revisit the community would like to request a desk review	
R 0064	Residents' Rights- Noncompliance 410 IAC 16.2-5-1.2(hh) (hh) The facility shall exercise	R 0064	What corrective action(s) will be accomplished for those residents found to have been affected	09/14/2025

	reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on interview and record review, the facility failed to ensure residents were free from misappropriation for 2 of 3 residents reviewed for misappropriation. A resident's checkbook was taken from their room and fraudulently used to make withdraws from residents' checking account. (Resident B, Resident C) Finding includes: During a review of facility reported incidents on 8/20/25 at 1:05 P.M., an incident, dated 7/28/25, indicated that a local police officer notified the facility that QMA 13 had been writing checking using Resident B and Resident C's checkbook and forging the resident's signature for personal gain. Video footage was obtained showing QMA 13 cashing the forged checks. Resident B and Resident C's family contacted police after they became aware of that on 7/25/25. A follow up to the reported incident, dated 8/7/25, indicated that QMA 13 had written checks to herself from Resident B and		by the deficient practice; Resident B and Resident C were affected without adverse consequences. Resident B and Resident C are no longer residents of the community. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected. Education was provided to all staff regarding elder abuse. The community will interview five residents each week regarding the safety and security of their personal property including monetary possessions. The responses will be reviewed by the ED/designee and any negative findings will be addressed immediately. What measures will be put into place or what systemic changes the facility will make to ensure	

	Resident C's account in the amounts of $800.00, $700.00, $1,000.00, and 1,200.00. A car payment of $305.00 was also made. QMA 13 admitted to the wrongdoing after police showed images of her cashing the checks at the bank. Resident B's and Resident C's nurse's progress notes both contained a nurse's note, dated 7/30/25, that included; On 7/28/25 a local police officer came to meet with the Director of Nursing (DON) and informed her that he had been notified of financial exploitation of a resident from the resident's family member. The officer inquired about QMA 13 and the DON confirmed that she worked at the facility. After learning the gravity of QMA 13's actions, QMA 13 was terminated from employment immediately. On 7/29/25 at 2:00 P.M., QMA 13 was met at the facility front door when she reported for work and led to a conference room. Local police officers questioned QMA 13 and she admitted to taking checks from Resident B's top dresser drawer from her apartment without Resident B's consent or knowledge. During an interview on 8/20/25 at 1:45 P.M., the DON indicated she was notified by the local police of QMA 13's actions and she was terminated immediately. The DON indicated		that the deficient practice does not recur; All new hires will be educated on the community's elder abuse policies prior to their first day. The ED/designee will also interview current employees regarding the elder abuse policy to ensure compliance; any negative findings will be addressed immediately. Staff, residents, visitors and families will be encouraged to report any non-compliance with the elder abuse policy to the ED/designee How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Monitoring by the executive or designee will include interviewing five residents and two staff members each week regarding elder abuse weekly x four weeks, then every other week x two months, then monthly x three months. Any findings and recommendations	

	both Resident B and Resident C were confused and were unaware of the missing money from their account. On 8/20/25 at 2:10 P.M., the DON supplied a facility policy titled Abuse, Neglect, and Misappropriation Policy and Procedure, dated 12/31/24. The policy included, "...Residents have the right to be free from... misappropriation of property... Misappropriation of resident is property - the deliberate misplacement, exploitation of wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent..." This citation relates to complaint IN00463687. Based on interview and record review, the facility failed to ensure residents were free from misappropriation for 2 of 3 residents reviewed for misappropriation. A resident's checkbook was taken from their room and fraudulently used to make withdraws from residents' checking account. (Resident B, Resident C) Finding includes: During a review of facility reported incidents on 8/20/25 at 1:05 P.M., an incident, dated 7/28/25, indicated that a local police officer notified the facility that QMA 13 had been writing		will be reviewed monthly during the QA meeting	

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This citation relates to complaint IN00463687.

PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		