STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155727	A. BUILDING 00 B. WING	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STONEBRIDGE HEALTH CAMPUS	3100 SHAWNEE DR S BEDFORD, IN 47421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 Complaint IN00405456. Complaint IN00405456 - State deficiencies related to the allegations are cited at R0052. Survey date: April 12, 2023 Facility number: 003924 Residential Census: 29 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed April 14, 2023.	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey conducted April 12, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of April 29, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to protect the resident's right to be free from	R 0052	R052 1. What corrective action(s) will be accomplished for those	04/29/2023

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

Megan Alldredge 04/27/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	mental abuse by an employee for 2 of 3 residents reviewed for abuse. A staff member mentally abused 2 residents that resided on the secured memory care unit. Using the reasonable person concept, it is likely this would lead to chronic or recurrent fear, anxiety, and depression. (Resident B, Resident C, RCA 2) Finding includes: During an interview on 4/12/23 at 8:41 a.m., Family member 1 indicated she received a phone call, from the facility, over a week ago informing her that that a staff member used foul language in front of the residents and the staff member was reprimanded. During an interview on 4/12/23 at 9:13 a.m., RCA 1 (Resident Care Associate) indicated she was working on the secure memory care unit, at the end of March of 2023, when she witnessed RCA 2 verbally abuse 2 female residents. On evening shift at approximately 9:00 p.m., RCA 1 and RCA 2 were taking Resident B to get a shower. When RCA 1 and RCA 2 were in the shower room with Resident B, Resident B got her own saliva on her arm, so RCA 2 called her "f****** disgusting." Then, as we were showering Resident B, RCA 2 indicated to RCA 1 that he "couldn't handle old lady breast" and then gagged in front of Resident B. After that, RCA 1 and RCA 2 went to Resident C's room. As we entered, Resident C woke up. Resident C fell asleep with her mouth open, so RCA 2 said to Resident C "what's wrong with you, you must be messed up in the head." The clinical record for Resident B was reviewed, on 4/12/23 at 9:30 a.m. The diagnoses included, but were not limited to, Alzheimer's disease and anxiety disorder.		residents found to have been affected by the deficient practice? -- Residents 1 and 2 were assessed with no injury or psychosocial issues noted. --Like residents were assessed with no findings. --Employee was immediately suspended and subsequently terminated. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. --All residents have the potential to be affected by the alleged deficient practice. --Abuse education was provided to staff by the Executive Director/Director of Health Services. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? --As a measure of ongoing compliance, The Director of Health Services of designee will monitor to ensure that no further allegations of abuse have occurred on 3 residents weekly x 4 weeks, every other week x 2 months then monthly x3 months. 4. How the corrective action will be monitored to ensure the deficient practice will not recur	

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	A service plan, dated 12/2/22, indicated Resident B was severely cognitively impaired and was able to see and hear without any assistance from staff. A progress note, dated 4/1/23 at 9:34 a.m., indicated Resident is awake this am, is calm and cooperative and voices no concerns. No psychosocial concerns at this time. The clinical record for Resident C was reviewed, on 4/12/23 at 9:39 a.m. The diagnoses included, but were not limited to, dementia and delusional disorder. A service plan, dated 12/1/22, indicated Resident C was severely cognitively impaired and was able to see and hear without any assistance from staff. A progress note, dated 4/1/23 at 9:39 a.m., indicated Resident is awake this morning, resident is calm and cooperative and voices no complaints. No psychosocial concerns at this time. On 4/12/23 at 9:35 a.m., the DON (Director of Nursing) provided a copy of a document, titled Investigation Summary, dated 3/31/23, and indicated this was the investigation regarding the allegation of verbal abuse against RCA 2. A review of the document indicated a staff member (RCA 2) was witnessed cursing at assisted living memory care residents during care. RCA 2 was suspended and subsequently terminated. On 4/12/23 at 8:27 a.m., the DON provided a copy of a facility policy, titled Abuse and Neglect procedural Guidelines, dated 12/31/22, and indicated this was the current policy used by the facility. A review of the policy indicated the facility has developed and implemented		i.e., what quality assurance program will be put into place? --As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. 5. Date of Compliance: 4/29/23	

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	processes, which strive to ensure the prevention of resident abuse. This State tag relates to Complaint IN00405456.			