STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BETHANY VILLAGE ASSISTED LIVING	3530 S SHELBY ST INDIANAPOLIS, IN 46227

(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 Complaints IN00397622 and IN00397753. Complaint IN00397622 - Substantiated. State deficiencies related to the allegations are cited at R0053. Complaint IN00397753 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: January 17 and 18, 2023 Facility number: 001121 Residential Census: 80 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed January 20, 2023.	R 0000		
R 0053 Bldg. 00	410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse. Based on interview and record review, the facility failed to protect the residents right to be free from verbal abuse from an employee for 1 of 1 residents reviewed. (Resident B). Finding includes: On 1/18/22 at 1:00 p.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, history of traumatic brain injury without psychotic features.	R 0053	What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice? Employee was immediately suspended following incident and employment terminated following investigation. Education provided to staff on Abuse and Resident Rights. How the facility will identify other Residents having the potential to	02/22/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gary Griffin	Executive Director	02/09/2023

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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	On 1/18/23 at 2:34 p.m., an abuse allegation related to Resident B was reviewed. The investigation statement from Resident B, dated 12/22/22 (no time given), indicated he "didn't remember all the details he should not have said something like that to her, and didn't have any hard feeling against her she works in dietary and there are 2 girls who looked similar and gets them mixed up I said something about one of the being a big girl and she got mad at me very upset and yelled at me, but I don't recall exactly what she said to me". A text from Dietary Aide 1 to a fellow employee was shown to the ED (Executive Director) and indicated on 12-11-22 at 1:17 p.m., Dietary Aide 1 indicated by text "this guy haere [sic] p***** me off so bed [sic] telling me I am fat I told him don't ever talk to me like that again, and take your a** back to your seat". A statement from DM (Dietary Manager), dated 12/22/22, indicated the Dietary Aide 2 indicated to the DM "yes it was a resident and I looked him dead at his face and told him you're not going to disrespect me like that I'm a female and you respect females no you can take your butt back to your room so I guess when I was walking out one of the " ...." family heard him mumble some more stuff so she [Dietary Aide 1] is speaking to the social worker and them today and then when I walked back in he tries to talk to me again and I said just go back to you room this resident has never been like this he probably had something going on but you do not talk to your workers like that that is here taking care of you making sure you are fat making sure you have clean dishes so I hope he understood that when I sent him back to his room". Dietary Aide 1 was terminated from employment		be affected by the same deficient practice and what corrective action will be taken? All Residents have the potential to be affected. No additional Residents reported any additional allegations during investigation. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? All staff will be re-educated by 2/21/23 on Resident Rights and abuse policies, including but not limited to verbal abuse and abuse reporting. New hires will receive education on Resident Rights and abuse policy on orientation. 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? All staff will be re-educated by 2/21/23 on Resident Rights and abuse policies, including but not limited to verbal abuse and abuse reporting. New hires will receive education on Resident Rights and abuse policy on orientation. An abuse policy training CQI tool will be used weekly x 4 weeks then monthly x 3 months. If 100% threshold not met, disciplinary action and new action plan will be completed. The monitoring tool will be completed by Executive Director/designee.	

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	following the investigation. On 12/18/23 at 12:20 p.m., the ED provided the facility policy "Unusual Occurrences for Residents" revised, 12/2017, and the ED indicated this policy was the one used by the facility. A review of the document indicated under verbal abuse ..."language that includes disparaging and derogatory remarks to resident or their families, or within their hearing, regardless of their age, ability to comprehend or disability...scolding and/or speaking to them in harsh voice tones". This State Residential Finding relates to Complaint IN00397622.			