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	02/13/2023

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 Complaint IN00400483. Complaint IN00400483 - Substantiated. State deficiencies related to the allegations are cited at R0053. Survey date: February 13, 2023 Facility number: 001121 Residential Census: 78 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed February 15, 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 residents right to be free from verbal abuse from an employee for 3 of 3 residents reviewed. (Resident B, Resident C, Resident D) Finding includes: On 2/13/23 at 2:30 p.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, PTSD (post traumatic stress disorder) and major depressive disorder. On 2/13/23 at 2:50 p.m., Resident C's clinical record was reviewed. The diagnoses included, but were not limited to, tear of lateral meniscus and panic	R 0053	What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice? Employee immediately resigned and left the property following the incident. Education provided to staff on Abuse and Resident Rights. 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. All residents involved in the incident	03/14/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gary Griffin	Executive Director	03/02/2023

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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	attacks On 2/13/23 at 10:00 a.m., a self reported abuse allegation related to Residents B, Resident C, and Resident D, dated 1/27/23, was reviewed. The report indicated numerous residents began yelling at the bus driver after his erratic driving and the bus driver responded with derogatory names to all the residents on the bus. A statement from AD (Activity Director), dated 1/27/23, indicated the bus driver had some erratic driving on an outing to a local store. The bus driver attempted to put the bus in reverse with the doors open almost striking Resident C while she was waiting to board the bus. The bus driver pulled forward while another resident was standing in the middle aisle and also attempted again to move forward with the wheelchair gate opened on the back. The driver braked hard at a red light, just down from the facility near a local university. Resident D said "s***!", to which the bus driver indicated the residents were a bunch of "wimps". Resident D got upset indicated to Bus driver "no!", to which the bus driver called them "p******" and "wimps" again. Resident D unbuckled and yelled a superlatives and the AD and another resident told him to sit down and be calm. The bus driver hit a curb and the brakes abruptly again and re-enraged Resident D. The bus driver instructed the residents to "go in and not say anything" to the the RD (Resident Director). The Receptionist statement, dated 1/27/23, indicated she was at the front desk when Resident D came in very upset. The Receptionist asked the AD what happened and the AD indicated the bus driver called Resident D names and it upset him. The AD also indicated how the Bus Driver was driving and scared the residents.		were interviewed. 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 3/13/23 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 3/13/23 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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	A review of Resident B's statement, dated 1/27/23, indicated the bus driver hit the brakes hard and scared Resident D and Resident D started yelling. She indicated the bus driver called them all "wimps" and "p******", which made a lot of the residents upset. She indicated the AD tried to calm many of them down and Resident B started to have a panic attack due to the bus drivers reckless driving. A review of Resident C's statement, dated 1/27/23, indicated during an outing to a local thrift store the bus driver just missed hitting her with the bus doors open while attempting to back up without looking. Then the bus driver started to move the bus with a resident still standing up. On the way back the bus driver hit the brakes so hard, scaring the residents and then the bus driver yelled at them that they were all "p******" and "wimps". The bus driver repeated it numerous times. He was driving reckless and causing panic attacks to the residents. On 2/13/23 at 2:40 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 tag relates to Complaint IN00400483.			