STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155100	A. BUILDING 00 B. WING	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GARDEN VILLA - BEDFORD	2111 NORTON LN 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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00401242. Complaint IN00401242 - Substantiated. Federal/State deficiencies related to the allegations are cited at F609. Survey date: February 16, 2023 Facility number: 000040 Provider number: 155100 AIM number: 100274460 Census Bed Type: SNF/NF: 71 SNF: 9 Total: 80 Census Payor Type: Medicare: 9 Medicaid: 67 Other: 4 Total: 80 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 21, 2023.	F 0000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. 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 a Complaint Survey with exit on 2/16/2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of March 17, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christy Fougerousse	Administrator	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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	exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to immediately report verbal abuse to the administrator for 2 of 2 residents reviewed for abuse. (Resident B, Resident C, CNA 1, RN 1) Finding includes: During an interview on 2/16/23 at 9:00 a.m., the DON (Director of Nursing) indicated she was out of the facility, but was made aware of an allegation that CNA 1 (Certified Nursing Aide) cursed and yelled at Resident B. During an interview on 2/16/23 at 9:37 a.m., RN 1 (Registered Nurse) indicated on 2/7/23 at	F 0609	1. Employee that failed to report allegation in a timely manner was educated and received disciplinary action as well. 2. Up to 7 residents had the potential to be affected by being within earshot of allegation, but 0 residents were per investigation and interviews. 3. Education to be provided to all staff on Abuse policy and reporting, as well as on Elder Justice Act. Staff Development nurse to continue education at least quarterly x 12 months, and	03/17/2023

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	approximately 8:00 p.m., she witnessed CNA 1 exit Resident B's room and yell "I've been in there 3 f****** times. You are dry and don't need to be changed." At that time, Resident B's roommate, Resident C, wheeled out of their room and into the common area. Resident C asked for help for Resident B. CNA 1 told Resident C "I've already been in there 3 f****** times, go tell Resident B to shut the f*** up." RN 1 finished her charting and went home. She reported the incident the next morning, on 2/8/23 around 10:30 a.m., to the Administrator. During an interview on 2/16/23 at 11:55 a.m., the Administrator indicated, on 2/8/23 around 10:30 a.m., RN 1 reported that CNA 1 yelled and told Resident B to stop "f****** yelling". She told RN 1 that she should have been reported to her immediately. On 2/16/23 at 9:45 a.m., the DON provided a copy of an undated policy, titled Abuse Policy and Reporting, and indicated this was the current policy used by the facility. A review of the policy indicated staff must report abuse immediately. Staff are required to contact the Administrator immediately. This Federal tag relates to Complaint IN00401242. 3.1-28(c)		with any identified incident. Interviews to be completed by DON or designee with at least 5 random staff and residents on all shifts weekly x 4 weeks, and then monthly x 3 months to inquire if anyone has witnessed or been a victim of abuse. Will then re-evaluate and make changes as needed and to decide if there is a need to continue. 4. ED or designee to ensure Staff Development nurse completes education with staff as required, along with resident and staff interviews being completed by DON or designee, and will review at least quarterly in QA.	