STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155160	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebrooke Rehabilitation Center	990 N 16th St New Castle, IN 47362

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review, the facility failed to provide dignified incontinent care for 1 of 3 residents reviewed for dignity (Resident D). Finding include:During an interview with Resident D on 10/22/25 at 1:00 p.m., the resident indicated the facility staff treated her with dignity except CNA 3. CNA 3 was rough during incontinence care and it made her sore. The resident had told CNA 3 to go easy and he would say ok, but did not. CNA 3 was rushing with care and the resident felt it was disrespectful to her. Resident D indicated other than CNA 3 rushing, he was a good guy. The resident had reported this to a nurse and some of the other CNA's about Resident 3 being rough and rushing during care, but did not know their name. The staff have not fill out a grievance for her related to this matter. Review of the clinical record of Resident D on 10/23/25 at 11:31 a.m., indicated the resident's diagnoses included, but were not limited to, acute and chronic diastolic (congestive) heart failure, acute respiratory failure with hypoxia, Chronic obstructive pulmonary disease with (acute) exacerbation, paroxysmal atrial fibrillation, atherosclerotic heart disease of native coronary artery without angina pectoris, iron deficiency anemia, unspecified, Essential (primary) hypertension, type 2 diabetes mellitus with hyperglycemia, mixed hyperlipidemia, pulmonary hypertension, generalized anxiety disorder, major depressive disorder, recurrent, unspecified, obstructive sleep apnea (adult) (pediatric), morbid (severe) obesity due to excess calories, difficulty in walking, not elsewhere classified and Pleural effusion. The admission Minimum Data Set (MDS) assessment for Resident D, dated 10/1/25, indicated the resident was cognitively intact for daily decision making. The resident was reasonable and consistent. The resident had no behavior. The resident was frequently incontinent of urine and always incontinent of bowels. The resident right policy provided by the Executive Director on 10/22/25 at 2:20 p.m., indicated the resident had the right to be treated with dignity and respect. Each resident shall be treated with consideration, respect and full recognition of dignity and individuality, including care of personal needs. The resident had the right to a dignified existence. This citation relates to Intake 2646099.3.1-3(t)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to protect the residents' right to be free of verbal abuse for 2 of 4 residents reviewed for abuse. (Resident C and Resident F). Findings include:1. During an interview with Resident C on 10/22/25 at 1:05 p.m., they indicated Certified Nursing Assistant (CNA) 9 had come onto shift one morning to assist CNA 2 with incontinence care. Resident C indicated CNA 9 was upset with her upon entering the room and asked rudely, didn't they change you already?, and indicated she apologized for being wet and she couldn't control her bladder and CNA 9 kept saying hush it and using hand gestures for her to shut her mouth when she was trying to speak. The clinical record for Resident C was reviewed on 10/22/25 at 1:45 p.m. The diagnoses included, but were not limited to, lymphedema (swelling in the body's tissues due to blockage in the lymphatic system), hypertensive heart disease, and post-traumatic stress disorder. An admission Minimum Data Set (MDS) assessment, dated 9/25/25, indicated Resident C was cognitively intact, dependent with toileting hygiene, required substantial/maximal assistance with rolling right/left, and was frequently incontinent of bowels and bladder. An incident report was provided by the Executive Director (ED) on 10/22/25 at 1:30 p.m. It indicated Resident C reported concerns with care on 10/16/25. During an interview with CNA 2 on 10/23/25 at 11:30 a.m., they indicated on the morning of 10/15/25 around shift change (5:55 a.m.) Resident C had called out indicating she was dirty and needed cleaned up. CNA 2 indicated CNA 9 had just come onto shift when CNA 2 asked for CNA 9's help to get Resident C cleaned up. CNA 2 indicated CNA 9 entered Resident C's room to assist with incontinence care with CNA 9 told the resident to be quiet, this was not how she wanted to start her day, hushing the resident when she was speaking and made hand gestures for her to shut her mouth. CNA 2 indicated CNA 9 then said, great, now I'm covered in piss. CNA 2 indicated Resident C was crying after the incident. During an interview with the Occupational Therapist (OT) on 10/23/25 at 10:26 a.m., they indicated Resident C was tearful during therapy on 10/15/25 and informed her that CNA 9 had rushed in and out of her room and hushed her during care that morning. During an interview with the Social Service Director (SSD) on 10/23/25 at 11:00 a.m. she indicated Resident C told her on 10/16/25 that on 10/15/25 CNA 9 had hushed her during care and made hand gestures for her to shut her mouth and stop talking. The SSD indicated Resident C was tearful during the conversation. 2. Review of the record of Resident F on 10/23/25 at 2:15 p.m., indicated the resident's diagnoses included, but were not limited to, bipolar disorder, behavioral disturbance, major depressive disorder, anxiety, traumatic brain injury, muscle weakness and hemiplegia affecting the left and right side. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The annual Minimum Data Set (MDS) assessment for Resident F, dated 8/29/25, indicated the resident was moderately impaired for daily decision making. The resident had no behaviors. The resident utilized a wheelchair for mobility. The resident was dependent on staff for toileting needs and transfers. The progress note for Resident F, dated 7/18/25 at 10:52 a.m., indicated the resident was resting in bed with no signs of distress noted. The resident was pleasant and smiling, talkative with this writer. Denied any concerns. Skin assessment completed with no abnormal findings. Denied any pain or psychosocial distress/changes. The physician and Executive Director made aware of the alleged incident with a staff member this morning. The incident report and investigation for Resident F, dated 7/18/25, indicated CNA 4 used a harsh tone with speaking with Resident F. CNA 4 was suspended during the investigation. An interview with CNA 5 indicated on 7/18/25 Resident F became upset because there was not a mechanical lift to assist him out of bed and started cussing at the CNA 4 and CNA 5. CNA 4 was cursing at Resident F, but was unsure exactly what was said. CNA 5 heard CNA 4 use the words F--- and S---. CNA 5 reported the incident to the nurse. The employee communication form for CNA 4, dated 7/23/25, indicated the CNA was terminated for resident abuse or neglect or intentional violation of resident rights. The abuse policy provided by the Executive Director on 10/22/25 at 2:20 p.m., indicated each resident would be provided with an environment free of abuse. Abuse included, but were not limited to, verbal abuse and mental abuse. Verbal abuse was the use of oral, written, and/or gestured language that willfully included disparaging and derogatory terms to residents. Mental abuse included, but were not limited to, mocking, insulting, ridiculing and yelling. This citation relates to Intake 2646099. 3.1-27(b)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to timely report an incident of alleged verbal abuse to the Executive Director for 1 of 1 resident reviewed for reporting abuse. (Resident C) Findings include:The clinical record for Resident C was reviewed on 10/22/25 at 1:45 p.m. The diagnoses included, but were not limited to, chronic pain syndrome, major depressive disorder, and hypertension.The annual Minimum Data Set (MDS) assessment, dated 9/25/25, indicated Resident C was cognitively intact.During an interview with Certified Nursing Assistant (CNA) 2 on 10/23/25 at 11:30 a.m., they indicated Resident C was upset and tearful on 10/15/25 after receiving incontinent care from CNA 9. CNA 2 indicated CNA 9 had hushed Resident C when she was apologizing for being wet, making hand gestures for her to shut her mouth and stop talking, and throwing dirty linens on the floor and saying in front of Resident C, great, now I'm covered in piss. CNA 2 indicated she wrote out a statement of the incident and placed it under every director's door the night of 10/15/25, so they received the report on 10/16/25. CNA 2 indicated she should have notified the Executive Director (ED) sooner.During an interview with the Occupational Therapist (OT) on 10/23/25 at 10:26 a.m., they indicated they did a therapy treatment in Resident C's room on 10/15/25 and Resident C was tearful and indicated CNA 9 had rushed in and out of her room earlier that day, hushed her during care and made hand gestures for her to shut her mouth when she was apologizing for being wet. The OT indicated she told the Social Service Director (SSD) that Resident C had some care concerns, and she needed to talk to someone. The OT indicated the Social Service Director (SSD) was in a family meeting at the time and told the OT she would notify the ED once she was done.During an interview with the SSD on 10/23/25 at 11:00 a.m., they indicated the OT informed her on 10/15/25 that Resident C had been crying and to check in on her. The SSD indicated during an interview with Resident C on 10/15/25, she had not indicated to her what had happened that morning with CNA 9. The SSD indicated Resident C did not tell her about CNA 9's care until 10/16/25.During an interview with the Director of Nursing (DON) on 10/23/25 at 1:40 p.m., she indicated she did not know anything about this incident until she came to work the morning of 10/16/25 and there was a statement under her door from CNA 2 explaining the care concerns for Resident C from 10/15/25. The DON indicated once she read CNA 2's statement, she notified the ED who was off of work, who then reported the incident to IDOH (Indiana Department of Health) reporting care concerns.During an interview with the ED on 10/23/25 at 1:30 p.m., she indicated she was not at work when this concern came in and did not know it was an alleged abuse allegation until she began investigating the incident and spoke with Resident C.The Abuse policy was provided by the ED on 10/22/25 at 2:20 p.m. It indicated,. Resident Abuse-Staff member:.2. Any individual who witnesses abuse, or has suspicion of abuse, shall immediately notify the charge nurse of the unit, which the resident resides and to the Executive Director.3. 1-28(c)