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	06/17/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 ensure a resident was free from mental abuse by a staff member obtaining a photograph of the resident's genitalia without the resident's permission and showing other staff members resulting in unauthorized photographs taken for 1 of 4 residents reviewed for abuse. (Resident B) Using the reasonable person concept, it is likely this would lead to humiliation, confusion, anxiety, and embarrassment for Resident B. Findings include:The clinical record for Resident B was reviewed on 6/12/26 at 10:26 a.m. The diagnoses included, but were not limited to, morbid (severe) obesity, Alzheimer's disease (progressive, irreversible brain disorder that slowly destroys memory and thinking skills) with late onset, major depressive disorder, and anxiety. A physician's order, dated, 2/3/26, indicated Resident B had Dakin's Solution (a diluted hospital-grade bleach formula used as an antiseptic to cleanse wounds) with special instructions to cleanse scrotal abscess with NS (Normal Saline), pat dry, pack open area with Dakin's Solution, and cover with pad. A Facility reported incident, dated 2/8/26 at 8:55 a.m. indicated staff member took unauthorized photo of a resident. A phone interview with Certified Nursing Assistant (CNA) 2, dated 2/8/26 at 10:23 a.m., indicated she did take a picture of Resident B's wound earlier in the week of 2/2/26. CNA 2 indicated she was unsure what day she took the picture or what nurse she showed it to and was unsure if she had shown any other staff members as well. During an interview with Qualified Medical Assistant (QMA) 5/Family Member on 6/12/26 at 1:20 p.m., indicated CNA 6 called her the morning of 2/8/26, and told her she needed to tell her something about her father. CNA 6 indicated CNA 2 had walked up to her at work and took out her cell phone and said, here, look at Junior's balls. QMA 5/Family Member indicated she did not tell her father or any family members that a photo had been taken of his genital area because of how upset they would have been. QMA 5/Family Member indicated she never wanted to see any photographs of Resident B's wound let alone his genitalia. During an interview with CNA 3 on 6/12/26 at 5:30 p.m., indicated on 2/2/26 she and CNA 2 were providing incontinent care to Resident B after a bowel movement. CNA 3 indicated Resident B had an extensive wound to his scrotal area and she had asked CNA 2 to take out her flashlight on her phone so that she could make sure that she got all of the stool off of Resident B. CNA 3 indicated CNA 2 stated, we should take a picture to show QMA 5/Family Member. CNA 3 indicated she told CNA 2 not to take a photo and that QMA 5/Family Member did not want to see a picture of the wound and she did not know that she did take a picture until she was later questioned by the facility. CNA 3 instructed CNA 2 that if she thought Resident B's wound needed to be looked at, then she should have Licensed Practical Nurse (LPN) 4 look at it. During an interview with LPN 4 on 6/15/26 at 8:14 a.m. indicated back in February, CNA 2 had come up to her on shift and indicated she had taken a photograph of Resident B's wound if she wanted to look at it. LPN 4 informed CNA 2 that she did not want to see a photo of Resident B's wound and would see the wound when she did her assessment. LPN 4 indicated she explained HIPPA (Health Insurance Portability and Accountability Act) laws to CNA 2 and explained there was a very thin line between that and abuse. LPN 4 encouraged CNA 2 to delete the photograph and to her knowledge she did, until she was later questioned by staff about it. During an interview with CNA 6 on 6/16/26 at 10:59 a.m., indicated they (continued on next page)

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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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	were working with CNA 2 on 2/3/26, when CNA 2 pulled out her cell phone and said, hey, look at this.look at what was on his balls? CNA 6 questioned CNA 2 why she had the photograph, and she indicated to show the nurse his wound. CNA 6 then asked why CNA 2 still had the photograph, and she indicated she did not know, she just thought it was weird. CNA 6 indicated the picture was of Resident B's genitalia and wound. CNA 6 indicated she told QMA 5/Family Member because it was bothering her and she did not feel right about it. A written statement interview, completed by the Social Services Director (SSD) on 2/11/26, indicated Resident B was unaware of anyone taking photos of him and when asked he said, not that I know of. The Abuse Prohibition, Reporting, and Investigation policy was provided by Executive Director 8 on 6/10/26 at 4:34 p.m. It indicated .Policy:.Will prohibit employees from taking pictures or recordings in any manner which would demean or humiliate a resident(s) and/or from taking unauthorized photos.Definitions:.Mental abuse includes what is facilitated or caused by staff taking or using photographs or recordings in any manner that would demean, humiliate, or dehumanize a resident(s). This includes any type of equipment (cameras, smart phones, or any other electronic device) to take, keep, or distribute photographs or recordings.Demeaning or humiliating photographs or videos include nudity.exposed body parts.provision of incontinent care exposing perineal/rectal areas and/or fecal matter on body parts. This Citation relates to intake 2737919410 IAC (Indiana Administrative Code) 16.2-3.1-27(a)(1)

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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 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 report an allegation of mental abuse of a resident by a staff member taking a picture of the resident's genitalia in a timely manner to the Indiana Department of Health (IDOH) for 1 of 4 residents reviewed for abuse. (Resident B) Finding include: The clinical record for Resident B was reviewed on 6/12/26 at 10:34 a.m. The diagnoses included, but were not limited to, muscle weakness, Alzheimer's disease (progressive, irreversible brain disorder that slowly destroys memory and thinking skills) with late onset, and anxiety. A facility reported incident, dated 2/8/26 at 8:55 a.m., indicated a staff member took unauthorized photo of resident. A phone interview with Certified Nursing Assistant (CNA) 2, dated 2/8/26 at 10:23 a.m., indicated she did take a picture of Resident B's wound earlier in the week of 2/2/26. CNA 2 indicated she was unsure what day she took the picture or what nurse she showed it to and was unsure if she had shown any other staff members as well. During an interview with Qualified Medical Assistant (QMA) 5/Family Member on 6/12/26 at 1:20 p.m., indicated CNA 6 called her the morning of 2/8/26, and told her she needed to tell her something about her father. CNA 6 indicated CNA 2 had walked up to her at work and took out her cell phone and said, look at Resident B's balls. QMA 5/Family Member indicated she did not tell her father or any family members that a photo had been taken of his genital area because of how upset they would have been. QMA 5/Family Member indicated she never wanted to see any photographs of Resident B's wound let alone his genitalia. QMA 5/Family Member indicated she notified Executive Director (ED) 8 the morning of 2/8/26 to inform her of what she was told and indicated ED 8 did not think it was a reportable event at that time. During an interview with CNA 3 on 6/12/26 at 5:30 p.m., indicated on 2/2/26 she and CNA 2 were providing incontinent care to Resident B after a bowel movement. CNA 3 indicated Resident B had an extensive wound to his scrotal area and she had asked CNA 2 to take out her flashlight on her phone so that she could make sure that she got all of the stool off of Resident B. CNA 3 indicated CNA 2 stated, we should take a picture to show QMA 5/Family Member. CNA 3 indicated she told CNA 2 not to take a photo and that QMA 5/Family Member did not want to see a picture of the wound and she did not know that she did take a picture until she was later questioned by the facility. CNA 3 instructed CNA 2 that if she thought Resident B's wound needed to be looked at, then she should have Licensed Practical Nurse (LPN) 4 look at it. During an interview with LPN 4 on 6/15/26 at 8:14 a.m. indicated back in February, CNA 2 had come up to her on shift and indicated she had taken a photograph of Resident B's wound if she wanted to look at it. LPN 4 informed CNA 2 that she did not want to see a photo of Resident B's wound and would see the wound when she did her assessment. LPN 4 indicated she explained HIPPA (Health Insurance Portability and Accountability Act) laws to CNA 2 and explained there was a very thin line between that and abuse. LPN 4 encouraged CNA 2 to delete the photograph and to her knowledge she did, which is why she did not report anything to the facility, until she was later questioned by staff about it. During an interview with CNA 6 on 6/16/26 at 10:59 a.m., indicated they were working with CNA 2 on 2/3/26, when CNA 2 pulled out her cell phone and said, hey, look at this.look at what was on his balls? CNA 6 questioned CNA 2 why she had the photograph, and she indicated to show the nurse his wound. CNA 6 then asked why CNA 2 still had the photograph, and she indicated she did not know, she just thought it was weird. CNA 6 indicated the picture was of Resident B's genitalia and wound. CNA 6 indicated she did not know how to report it, so she did not report the photo right away. CNA 6 indicated she was written up by the facility for reporting knowledge of the photograph late. During an interview with the Director of Nursing (DON) on 6/16/26 at 1:16 p.m., indicated anyone who knew about the photo should have notified the (ED) immediately so that it could be investigated. The Indiana Department of Health Long-Term Care and Incident Reporting policy, effective 12/8/22, indicated .Procedures and responsibilities: Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment are reported immediately, but not (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	later than two hours after the allegation is made, if the events that cause the allegation involve abuse. Staff treatment of residents.(c) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, are reported immediately to the administrator of the facility. This Citation relates to intake 2737919410 IAC (Indiana Administrative Code) 16.2-3.1-28(c)