STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE HAVEN HEALTH CARE CENTER	505 N GAVIN ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 IN00193498. Complaint IN00193498 - Substantiated. Federal/State deficiencies related to the allegations are cited at F225 and F226. Survey date: February 16, 2016 Facility number: 000311 Provider number: 15E064 AIM number: 100285520 Census bed type: NF: 41 Total: 41 Census payor type: Medicaid: 40 Other: 1 Total: 41 Sample: 4 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. QR completed by 11474 on February 17, 2016.	F 0000	This Plan of Correction is prepared and executed because it is required by the provisions of the State and Federal regulations, and not because Brookside Haven Care Center agrees with the allegations and citations listed on this statement of deficiencies. This Plan of Correction shall operate as Brookside Haven's written credible allegations of compliance. Brookside Haven respectfully request paper compliance on the attached Plan of Correction.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15E064		02/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE HAVEN HEALTH CARE CENTER	505 N GAVIN ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0225 SS=D Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/16/2016
NAME OF PROVIDER OR SUPPLIER BROOKSIDE HAVEN HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 505 N GAVIN ST MUNCIE, IN 47303	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to report a resident to resident physical altercation (Resident B and Resident D). This deficient practice had the potential to effect 2 of 2 residents reviewed for abuse. (Resident B and Resident D) Findings include: On 11/16/15 Resident B's right hand was bruised after being shut in the door of Resident D's room by Resident D. Review of a nursing note, dated 11/16/15 at 1:15 p.m., indicated Resident D was in her room and was not aware that Resident B had a hold of the door frame and the door shut on Resident B's right hand. Resident B sustained dark purple bruises to her fingers and hand as a result. Review of an x-ray of Resident B's right wrist, dated 11/16/15, indicated "mild degenerative joint disease, otherwise, no fracture seen". Review of an x-ray of Resident B's right hand, dated 12/17/15, indicated "no fracture or dislocation. Degenerative changes noted at the wrist and fingers".	F 0225	F-225 – 1.) The facility administrator and Director of Nursing immediately reviewed Indiana State Reporting Guidelines on reporting allegations of abuse. In addition, Administrator and Director of nursing also reviewed facility Abuse and Prevention Policy. 2) Any resident has the potential to be affected. 3) The HFA and DON will follow Indiana State Guidelines on reporting allegations of abuse to ensure that each resident is free of physical, mental, verbal and sexual abuse, corporal	03/01/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE HAVEN HEALTH CARE CENTER	505 N GAVIN ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	Review of the investigation, dated 11/16/15, provided an employee statement, from a CNA who witnessed the incident. The statement was as follows: "I was walking down the hallway when I saw (Resident B's name) hand was in (Resident D's name) door. (Resident D's name) was slamming the door in an attempt to close it with (Resident B's name) hand in it. I put my foot in front of the door to stop her from hurting (Resident B's name). I told (Resident D's name) she was hurting (Resident B's name), she responded with "Let her put her hand in someone else's f****** door." I witnessed (Resident D's name) slam (Resident B's name) hand four times before I was able to remove (Resident B's name) hand." During an interview on 2/16/15 at 9:51 a.m., QMA (Qualified Medication Aide) #16 indicated the following: "About 2 months ago one of the residents had her hand inside another resident's room and she shut the door on her hand because she didn't want her in her room." QMA #16 indicated she did not know if the incident had been reported. During an interview on 2/15/16 at 12:25 p.m., the Director of Nursing indicated she had been working at the time of the		punishment, mental and physical neglect and involuntary seclusion. An internal investigation will be completed within a twenty-four hour time frame and will be reported to the appropriate officials. 4) RN Consultants will monitor upon regular scheduled visits. Facility Administrator will report to the QAA Committee during regular scheduled meetings and follow any recommendations as deemed necessary. 5.) Date Completed: 2/29/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE HAVEN HEALTH CARE CENTER	505 N GAVIN ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	incident and that the desk nurse working at that time was no longer employed at the facility. "They said (Resident B's name) got her fingers caught in the door. (Resident B's name) was assessed and (Resident D's name) was spoken to. (CNA who witnessed incident name and no longer employed at the facility) report wasn't clear. (Resident D's name) was re-educated not to shut the door without seeing if anyone was around." During an interview on 2/15/16 at 2:25 p.m., the Administrator indicated the incident should have been reported. "Yes, this should have been reported." Review of a current undated policy titled "Abuse and Prevention Policy" indicated the following: "...Incidents or Alleged Abuse ...Purpose: To ensure that each resident is free of physical, mental, verbal and sexual abuse, corporal punishment, mental and physical neglect and involuntary seclusion. Policy: ...Physical Abuse includes, but is not limited to, hitting, slapping, punching, kicking, etc. It also includes controlling behavior through corporal punishment. ... Special Note: Any suspicion of abuse must be reported immediately to the administrator or his/her designee. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15E064		02/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE HAVEN HEALTH CARE CENTER	505 N GAVIN ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	Administrator of [sic] his/her designee will be responsible to coordinate the abuse investigation process. Procedure: Should any type of abuse or alleged abuse occur, the following procedure is to be followed: ... 10. All incidents of resident abuse will be reported to the Indiana State Department of health [sic] and any other necessary agencies, as required by the Unusual Occurrence Reporting Policy. Notification will be completed by the Administrator or his/her designee. ..." This policy was provided by the Administrator on 2/15/16 at 2:00 p.m. This federal tag relates to Complaint IN00193498. 3.1-28(c)			
F 0226 SS=D Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure facility policy was implemented for reporting	F 0226	F-226 1.) The facility administrator and	03/01/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE HAVEN HEALTH CARE CENTER	505 N GAVIN ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	allegations of abuse (Resident B and Resident D). This deficient practice had the potential to effect 2 of 2 residents reviewed for abuse policies. Findings include: On 11/16/15 Resident B's right hand was bruised after being shut in the door of Resident D's room by Resident D. Review of a nursing note, dated 11/16/15 at 1:15 p.m., indicated Resident D was in her room and was not aware that Resident B had hold on the door frame and the door shut on Resident B's right hand. Resident B sustained dark purple bruises to her fingers and hand as a result. Review of the facility investigation, dated 11/16/15, provided an employee statement, from a CNA who witnessed the incident. The statement was as follows: "I was walking down the hallway when I saw (Resident B's name) had was in (Resident D's name) door. (Resident D's name) was slamming the door in an attempt to close it with (Resident B's name) hand in it. I put my foot in front of the door to stop her from hurting (Resident B's name). I told (Resident D's name) she was hurting (Resident B's name), she responded with		Director of Nursing immediately reviewed Indiana State Reporting Guidelines on reporting allegations of abuse. In addition, Administrator and Director of nursing also reviewed facility Abuse and Prevention Policy. 2) Any resident has the potential to be affected. 3) The HFA and DON will follow Indiana State Guidelines on reporting allegations of abuse to ensure that each resident is free of physical, mental, verbal and sexual abuse, corporal punishment, mental and physical neglect and involuntary seclusion. An internal investigation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15E064		02/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE HAVEN HEALTH CARE CENTER	505 N GAVIN ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	"Let her put her hand in someone else's f****** door." I witnessed (Resident D's name) slam (Resident B's name) hand four times before I was able to remove (Resident B's name) hand." During an interview on 2/16/15 at 9:51 a.m., QMA (Qualified Medication Aide) #16 indicated the following: "About 2 months ago one of the residents had her hand inside another resident's room and she shut the door on her hand because she didn't want her in her room." QMA #16 indicated she did not know if the incident had been reported. During an interview on 2/16/16 at 12:25 p.m., the Director of Nursing indicated she had been working at the time of the incident and that the desk nurse working at that time was not longer employed at the facility. "They said (Resident B's name) got her fingers caught in the door. (Resident B's name) was assessed and (Resident D's name) was spoken to. (CNA who witnessed incident name and no longer employed at the facility) report wasn't clear. (Resident D's name) was re-educated not to shut the door without seeing if anyone was around." During an interview on 2/16/16 at 2:25 p.m., the Administrator indicated the incident should have been reported.		will be completed within a twenty-four hour time frame and will be reported to the appropriate officials. 4) RN Consultants will monitor upon regular scheduled visits. Facility Administrator will report to the QAA Committee during regular scheduled meetings and follow any recommendations as deemed necessary. 5.) Date Completed: 2/29/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE HAVEN HEALTH CARE CENTER	505 N GAVIN ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	"Yes, this should have been reported." The Administrator indicated the policy for reporting abuse had not been followed. Review of a current undated policy titled "Abuse and Prevention Policy" indicated the following: "...Incidents or Alleged Abuse ...Purpose: To ensure that each resident is free of physical, mental, verbal and sexual abuse, corporal punishment, mental and physical neglect and involuntary seclusion. Policy: ...Physical Abuse includes, but is not limited to, hitting, slapping, punching, kicking, etc. It also includes controlling behavior through corporal punishment. ... Special Note: Any suspicion of abuse must be reported immediately to the administrator or his/her designee. The Administrator of [sic] his/her designee will be responsible to coordinate the abuse investigation process. Procedure: Should any type of abuse or alleged abuse occur, the following procedure is to be followed: ... 10. All incidents of resident abuse will be reported to the Indiana State Department of health [sic] and any other necessary agencies, as required by the Unusual Occurrence Reporting Policy. Notification will be completed by the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE HAVEN HEALTH CARE CENTER	505 N GAVIN ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	Administrator or his/her designee...." This policy was provided by the Administrator on 2/16/16 at 2:00 p.m. This federal tag relates to Complaint IN 00193498. 3.1-28(a)			