STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE GRANGER	430 CLEVELAND RD, GRANGER, , 46530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00374113. Complaint IN00374113 - Substantiated. State Residential Findings related to the allegations are cited at R0091. Survey date: March 8 & 9, 2022 Facility number: 002656 Residential Census: 10 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/17/22.	R 0000	The following is the Plan of Correction for Brookdale Granger regarding the Statement of Deficiencies dated March 9, 2022. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.	
R 0091	Administration and Management - Noncompliance	R 0091	Employee 2 received coaching and education on Brookdale’s	03/26/2022

	410 IAC 16.2-5-1.3(h)(1-4) (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on record review and interview, the facility failed to implement their policy related to investigating and reporting abuse for 1 of 5 residents reviewed for abuse. (Resident D). Finding includes: During an interview on 3/8/22 at 9:53 A.M., Qualified Medication Aide (QMA)1, indicated she witnessed Employee 2 verbally abuse Resident D when the resident wanted to use the phone to call home. QMA1 stated Employee (E) 2 yelled at Resident D saying, "I told you, you are not using the MF phone! Stop asking!" QMA1 indicated she notified the Director of Nursing by phone		abuse policy and residents rights on 3/15/2022. All residents have the potential to be affected. All residents were interviewed and none report any allegations of abuse, neglect or exploitation. The District Director of Clinical Services re-inserviced the Executive Director on Brookdale’s Abuse Policy, Brookdale’s power point on how to conduct an internal investigation and the incident investigation report form and Brookdale’s reportable events grid on 3/23/2022 via zoom call. Associates to be re-inserviced on Brookdale’s abuse policy, Brookdale’s reportable events grid and resident rights on 3/24/2022. The Executive Director and/or designee will verify the reportable events grid and investigation on all allegations of abuse are complete.	

	and the Director of Nursing indicated she would notify the Administrator. During an interview on 3/8/22 at 12:04 P.M., the Administrator indicated the facility had not reported and incidents of abuse to the State Agency any time during the month of February. During a second interview on 3/8/22 at 1:05 P.M., the Administrator indicated QMA1 notified her by phone that she didn't like the way Employee 2 was talking to Resident D, and that she was talking to her in a loud voice. The Administrator indicated she did not know what Employee 2 was upset about and why she was speaking in a loud voice to the resident, but thought his may have been because Resident D obsesses over calling her daughter the daughter did not want her to have phone access to call all the time. The Administrator indicated she talked to Employee 2 when the Employee worked next, which was on 2/8/22, and Employee 2 denied saying anything derogatory to the resident. The Administrator indicated she spoke with Resident D at that time and the resident seemed fine. The Administrator indicated she did not document the interviews with Employee 2 or Resident D, did not perform any other interviews with staff or		ED or designee to complete abuse questionnaire with 20% of residents daily for 5 days, then weekly for 4 weeks, then monthly for 3 months. District Director of Clinical or designee to review questionnaires to ensure any abuse allegations are investigated. Completed by 3/26/2022	

	residents, and did not file a report to the State Agency. The Administrator indicated that she should have reported the allegation of verbal abuse and done more of an investigation. On 3/8/22 at 10:49 A.M., the policy entitled, "Abuse, Neglect & Exploitation Policy IN-1," dated 10/2021 and last revised on 5/2021, was provided by the Administrator and reviewed at that time. The policy indicated, "...Definitions: "Abuse" is defined in Indiana as a willful infliction...Abuse may also include..verbal abuse...5. Investigation: Upon receipt of an allegation of abuse...The Administrator and or Executive Director, or their designee, should conduct a confidential internal investigation of the incident...(1) The investigation should include interviews with potential witnesses which may include the alleged perpetrator, the alleged victim, associates, other residents and visitors to the community...The Administrator...should maintain a written record of the investigation. c. The Administrator...should contact the Indiana State Department of Health...within 24-hours of determining a situation exists, or existed..."			

This state residential tag is related to complaint IN00374113.

Based on record review and interview, the facility failed to implement their policy related to investigating and reporting abuse for 1 of 5 residents reviewed for abuse. (Resident D).

Finding includes:

During an interview on 3/8/22 at 9:53 A.M., Qualified Medication Aide (QMA)1, indicated she witnessed Employee 2 verbally abuse Resident D when the resident wanted to use the phone to call home. QMA1 stated Employee (E) 2 yelled at Resident D saying, "I told you, you are not using the MF phone! Stop asking!" QMA1 indicated she notified the Director of Nursing by phone and the Director of Nursing indicated she would notify the Administrator.

During an interview on 3/8/22 at 12:04 P.M., the Administrator indicated the facility had not reported and incidents of abuse to the State Agency any time during the month of February.

During a second interview on 3/8/22 at 1:05 P.M., the Administrator indicated QMA1 notified her by phone that she didn't like the way Employee 2 was talking to Resident D, and

that she was talking to her in a loud voice. The Administrator indicated she did not know what Employee 2 was upset about and why she was speaking in a loud voice to the resident, but thought his may have been because Resident D obsesses over calling her daughter the daughter did not want her to have phone access to call all the time. The Administrator indicated she talked to Employee 2 when the Employee worked next, which was on 2/8/22, and Employee 2 denied saying anything derogatory to the resident. The Administrator indicated she spoke with Resident D at that time and the resident seemed fine. The Administrator indicated she did not document the interviews with Employee 2 or Resident D, did not perform any other interviews with staff or residents, and did not file a report to the State Agency. The Administrator indicated that she should have reported the allegation of verbal abuse and done more of an investigation.

On 3/8/22 at 10:49 A.M., the policy entitled, "Abuse, Neglect & Exploitation Policy IN-1," dated 10/2021 and last revised on 5/2021, was provided by the Administrator and reviewed at that time. The policy indicated, "...Definitions: "Abuse" is defined in Indiana as a willful infliction...Abuse may also

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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