STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CARMEL	301 EXECUTIVE DR, CARMEL, , 46032

(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 Intake IN00463643. Intake IN00463643-State deficiencies related to the allegations are cited at R0052. Survey date: September 8, 2025. Facility number: 010416 Residential Census: 35 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on September 12, 2025.	R 0000		
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse;	R 0052	**• What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** QMA 4 employment was	10/31/2025

	(2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident with cognitive impairment was free from abuse of a staff member for 1 of 3 residents reviewed for abuse. (Resident C) Findings include: The clinical record for Resident C was reviewed on 9/8/25 at 10:48 a.m. The diagnosis included, but were not limited to, dementia, parkinsonism, major depressive disorder, and type 2 diabetes mellitus.		terminated 7/26/2025 **• How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** The Health and Wellness Coordinator (HWC), Clinical Services Specialist (CSS) conducted physicals on all residents ensuring no signs or symptoms of mental or physical abuse The Executive Director, (ED) HWC and CSS conducted hands on training and in-service on Abuse, Residents Rights and Brookdale's Policy on Abuse and residents' rights. and customer service on 7/25/2025 - 7/26/2025 – 8/3/2025. Audits on practice examples of abuse types for AL/MC to ensure compliance. **• What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;**	

	A personal service assessment, dated 8/30/23, indicated Resident C had a memory loss with cognitive impairments. He needed structure, attention or assistance to accomplish or participate in daily routines which included grooming, bathing, bathroom, and resident programs. He needed additional staff involvement due to being verbally or physically reluctant to accept care related to medication assistance. Resident C did not like to be told what to do or when to do it. A nursing progress note, dated 7/25/25 at 9:22 p.m., indicated "The resident was holding a cup, qma holding his hands to prevent from hurting...." A facility investigation report dated 7/25/25-7/26/25, indicated QMA 4 made contact with Resident C when he was being aggressive by holding both of his wrists with his back down across a table. LPN 5 observed QMA 4 holding Resident C down on the counter. CNA 6 observed QMA 4 grab Resident C's hands and hold him down on the table. When questioned by the Executive Director and the Business Office Manager, Resident C indicated he was attacked, he wanted his insulin and QMA 4 would not give it to him. He was upset and hit QMA 4 with a cup. She then grabbed him and held him on the table.		The ED, HWC, CSS will conduct abuse and resident rights training x2 monthly for 2months then monthly thereafter for 4 months. **• How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The ED, HWC and CSS will conduct knowledge-based audits weekly for the next four weeks, with ongoing training completed weekly for the next 4 weeks. All results and trends will be reviewed and discussed monthly in the quality assurance meeting. **• By what date the systemic changes will be completed.** 10/31/2025	

After completing the investigation, the allegation of abuse against QMA 4 was substantiated.

A facility corrective action form, dated 8/1/25, indicated QMA 4 made direct contact with an aggressive resident by holding both of his wrists and pinning him with his back down across the table. This action constituted a form of abuse. The facility maintained a zero-tolerance policy for such conduct. The behaviors described would not be tolerated, and based on the severity of the behaviors, employment was terminated effective immediately.

During a telephone interview, on 9/8/25 at 10:44 a.m., QMA 4 indicated Resident C was upset and threw a cup at her, so she grabbed Resident C's hands to prevent him from grabbing another item.

During an interview, on 9/8/25 at 10:55 a.m., the Executive Director (ED) indicated after the investigation was completed, QMA 4 was terminated for abuse.

During an interview, on 9/8/25 at 10:56 a.m., the Power of Attorney (POA) for Resident C indicated his father would get upset with the facility staff over his medications. His father felt disrespected and restrained

related to the events which occurred during the incident.

A current facility policy, titled "Abuse, Neglect and Exploitation Policy," dated as revised on 5/2021 and received from the ED on 9/8/25 at entrance, indicated "...Abuse is defined in Indiana as a willful infliction of injury, unreasonable confinement, intimidation or punishment...."

A current facility policy, titled "Indiana Resident Rights," dated as revised 3/2003 and received from the ED on 9/8/25 at entrance, indicated "...Freedom from sexual, physical, mental abuse, verbal abuse...."

This citation relates to Intake IN00463643.

Based on interview and record review, the facility failed to ensure a resident with cognitive impairment was free from abuse of a staff member for 1 of 3 residents reviewed for abuse. (Resident C)

Findings include:

The clinical record for Resident C was reviewed on 9/8/25 at 10:48 a.m. The diagnosis included, but were not limited to, dementia, parkinsonism, major depressive disorder, and type 2 diabetes mellitus.

A personal service assessment,

dated 8/30/23, indicated Resident C had a memory loss with cognitive impairments. He needed structure, attention or assistance to accomplish or participate in daily routines which included grooming, bathing, bathroom, and resident programs. He needed additional staff involvement due to being verbally or physically reluctant to accept care related to medication assistance. Resident C did not like to be told what to do or when to do it.

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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