

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/16/2025	
NAME OF PROVIDER OR SUPPLIER BROOKDALE CARMEL		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Complaints IN00445842 and IN00450524. Complaint IN00445842-State deficiencies related to the allegations are cited at R0052. Complaint IN00450524-State deficiencies related to the allegations are cited at R0052. Survey dates: January 15 and 16, 2025 Facility number: 010416 Residential Census: 54 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on January 24, 2025.	R 0000	The following Plan of Correction for Brookdale Carmel regarding the statement of Deficiencies dated January 28th, 2025. This Plan of Correction is not to be constructed as an admission of our 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 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be	R 0052	R0052 Based on observation, interview and record review, the facility failed to ensure staff used		02/06/2025		

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free from:

- (1) sexual abuse;
- (2) physical abuse;
- (3) mental abuse;
- (4) corporal punishment;
- (5) neglect; and
- (6) involuntary seclusion.

Based on observation, interview and record review, the facility failed to ensure staff used wheelchair foot pedals during a wheelchair transfer through a hallway in accordance with the Indiana State Department of Health Nurse Aide Curriculum to protect a cognitively impaired resident's right to be free from neglect (Resident B) and failed to protect a cognitively impaired resident's right to be free from physical abuse perpetrated by CNA 1 (Resident C) for 2 of 5 residents reviewed for neglect and abuse. This deficient practice resulted in Resident B sustaining bruising to the right eye and eyebrow, swelling underneath the right eye, an abrasion to the corner of the right eye, an abrasion on the nose, a laceration of the lip, and a nosebleed.

Findings include:

- 1. A document, titled "Intake Information," dated 10/22/24,

wheelchair foot pedals during a wheelchair transfer through a hallway in accordance with the Indiana Department of Health Nurse Aide Curriculum to protect a cognitively impaired residents right to be free from neglect (Resident B) and failed to protect a cognitively impaired residents right to be free from physical abuse perpetrated by CNA 1 (Resident C) for 2 of 5 residents reviewed for neglect and abuse.

R0052 1 Resident B

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Resident B passed away
10.17.2024 at 11:15pm

How the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

Health & Wellness Director completed audit to identify residents that utilize wheelchair transport per staff.

What measures will you put in place into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:

Resident`s personal service plan & care profile updated to utilize foot

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indicated CNA 2 was pushing Resident B through a hallway in a wheelchair without foot pedals, on 10/15/24 at 2:20 p.m. CNA 2 stopped suddenly to listen to another CNA, and Resident B fell forward out of the wheelchair onto the floor. The resident had bruising under her right eye and to her right eyebrow, a small abrasion to the corner of her nose and right eye, she bit her lip, and she had a nosebleed. Resident B passed away on 10/17/24.

A facility document, titled "Assisted Living INCIDENT INVESTIGATION Summary," indicated the following:

a. On 10/15/24 at 2:15 p.m., Resident B was being pushed to an activity in her wheelchair by CNA 2. CNA 2 heard CNA 4 say something, so she stopped pushing the resident. CNA 4 told CNA 2 Resident B was going to fall out of her wheelchair. At that time, Resident B fell forward onto the floor. The resident had facial bruising, swelling and a small laceration.

b. On 10/16/24 at 10:00 a.m., the resident's family declined for a hospital visit and wanted the resident to remain at the facility on hospice and kept comfortable.

b. On 10/17/24 at 11:15 p.m., the resident passed away.

pedals during transport by staff.

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: Health & Wellness Director and or designee in-service staff on transfers & transporting residents in wheelchair utilizing foot pedals.

Health & Wellness Director and or designee to observe three (3) associates weekly for transfer and transporting residents in wheelchair utilizing foot pedals for four (4) weeks.

Health & Wellness Director and or designee to observe ten (10) associate per month for five (5) months. Any issues identified will be brought to morning meeting Monday through Friday and addressed per community policy with the individual associate.

By what date the systemic changes will be completed 2.6.2025

R0052 2 Resident C

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

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c. On 10/21/24 at 2:00 p.m., the coroner's office arrived at the facility and wanted information regarding the resident's fall.

The clinical record for Resident B was reviewed on 1/16/25 at 1:21 p.m. The diagnoses included, but were not limited to, Lewy body dementia, generalized anxiety disorder, Alzheimer's disease, type II diabetes mellitus, history of falling, and anemia.

The resident's service plan, dated 5/14/24 at 12:30 p.m., indicated staff were to provide physical assistance to and from the dining room and/or community activities as needed related to the resident's memory impairment and physical impairment. Staff were to ensure the resident was all the way back in her recliner and the resident was to get up in her wheelchair with staff assistance. She leaned forward at times in her wheelchair.

Upon knowledge of the reported incident, associate was immediately suspended and subsequently terminated.

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:

An assessment of the residents on identified associate's assignment were assessed, and no injuries noted.

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 reeducation on abuse, neglect and exploitation was completed by Health & Wellness Director and Designee for current associates 1/3/2025, 1/4/2025 & 1/6/2025.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e.,

Community Executive Director and Health & Wellness Director will continue to audit video monitoring alerts daily times three (3) for four (4) weeks.

By what date the systemic changes will be completed 2.6.2025

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A nursing progress note, dated 10/15/24 at 4:46 p.m., indicated the resident was being pushed in the wheelchair to an activity and fell to the floor. She hit her face on the floor. She had facial bruising and small lacerations to her lip, nose and under her right eye. She was able to move all extremities and had complaints of pain. Tylenol was given for pain.

A nursing progress note, dated 10/16/24 at 2:19 p.m., indicated the resident was resting comfortably with no need for morphine (a pain medication). The resident had facial bruising.

A nursing progress note, dated 10/17/24 at 11:56 a.m., indicated the resident was observed to be in pain and discomfort based on her facial grimacing, moaning and groaning sounds she was making.

A facility document, titled "CORRECTIVE ACTION," dated 10/18/24, indicated CNA 2 was observed pushing a resident in a wheelchair without leg rests and the resident fell out of the wheelchair. This was a violation of policy, as outlined in the handbook. All associates were to adhere to proper operating practices and procedures designed to prevent injuries and illnesses to residents.

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During an interview, on 1/16/25 at 11:45 a.m., the Director of Nursing (DON) indicated CNA 2 did not place footrests on Resident B's wheelchair prior to transporting her to an activity. The CNA got distracted and forgot to put the footrests on her wheelchair.

During an interview, on 1/16/25 at 12:01 p.m., CNA 4 indicated she was sitting on the unit when she observed CNA 2 pushing Resident B in her wheelchair without foot pedals. The resident was about to fall forward out of her wheelchair. Her feet did not touch the floor in the wheelchair, and they were dangling in the air. CNA 2 was not paying attention to the resident, while she was pushing her in the wheelchair. CNA 4 told CNA 2 the resident was going to fall forward, and this was when CNA 2 looked at CNA 4 instead of Resident B. CNA 4 jumped up to go help the resident and observed the resident fall forward out of her wheelchair onto her head on the floor. There was blood on the floor where the resident landed.

During an interview, on 1/16/25 at 12:34 p.m., CNA 5 indicated Resident B was not able to propel herself in her wheelchair. She had footrests for her wheelchair, which needed to be placed on her wheelchair whenever she was being

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pushed by the staff or family.
The resident complained of pain
all over her body after the fall.
Her face was bruised.

The Indiana State Department
of Health Nurse Aide
Curriculum, revised 11/19/15,
indicated "...Resident Care
Procedure (RCP) 26...Transfer
to Wheelchair...11. Align
resident's body and position foot
rests [sic]..."

2. A document, titled "Indiana
State Department of Health
Survey Report System,"
undated, indicated on 1/2/25 at
8:13 p.m., the Director of
Nursing (DON) and Executive
Director (ED) received a call to
watch the Safely You video (a
system of surveillance which
detects falls). They viewed the
video which showed CNA 1
appearing to strike Resident C,
then the resident fell to the floor.

An Incident Investigation
Summary report, dated 1/3/25,
indicated the incident happened
on 1/1/25 at 7:50 a.m. On
1/2/25 at 8:13 p.m., the ED and
DON were notified to watch the
Safely You video. The report
indicated a video showed what
"looked like" CNA 1 striking the
resident and the resident fell to
the floor. The report indicated
Police Officer 3 asked Resident
C about the incident and the
resident indicated he was not
able to remember. The report

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included a typed phone interview, dated 1/4/25 at 9:30 a.m., which indicated CNA 1 was told it appeared he hit Resident C. CNA 1 indicated he did not hit the resident. He was pointing to the bathroom. The ED and DON asked CNA 1 why he did not take the resident to the bathroom. He indicated he helped the resident up from the floor and the resident asked to sit on the bed, so he helped the resident to his bed. They asked CNA 1 what he did after he helped the resident onto the bed and he indicated he went to tell the nurse the resident was holding the door, then put himself onto the floor.

On 1/15/25 at 3:15 p.m., with the ED and DON in attendance, the "Safely You" video showing the incident which occurred on 1/1/25 at 7:50 a.m., between CNA 1 and Resident C was observed. At the start of incident on the video, Resident C was standing at his door, pushing on it, as if he was trying to keep it closed. CNA 1 was observed to open the door and take a step inside the resident's room, while raising his right arm with his right hand up to Resident C's right eye and forehead area. At that time, Resident C placed his hands on his face, and he fell down onto the floor backwards, landing on his buttocks. CNA 1 stepped all the way into the resident's room and picked the

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resident up off the floor by placing his arms under the resident's arms. CNA 1 walked Resident C over to his bed with his arms under the resident's arms and tossed him onto his bed. As the resident was tossed onto his bed, he bounced when he landed. There was no audio with the video. After CNA 1 tossed the resident on the bed, he left the room. The ED indicated they were not able to determine whether CNA 1 made contact with the resident or not, but there was no other way to explain why the resident grabbed his head and fell to the floor after CNA 1 raised his arm.

The record for Resident C was reviewed on 1/16/25 at 1:45 p.m. The diagnoses included, but were not limited to, dementia, anxiety, Alzheimer's disease, and major depressive disorder.

The resident's service plan, dated 7/29/24, included, but was not limited to, the resident was up to the bathroom by himself, but at times he required assistance in the bathroom.

A progress note, dated 1/3/25 at 3:56 p.m., indicated Resident C had a fall, on 1/1/25 at 7:50 a.m., in the resident's room. The resident was pushing on his door trying to close the door and keep an associate out.

There were no progress notes, dated before 1/3/25 at 3:56 p.m., which discussed the resident's fall or the incident between CNA 1 and Resident C.

A facility document, titled "Corrective Action," dated 1/16/25 at 9:15 a.m., indicated CNA 1 was terminated from his position at the facility as a CNA when he was observed to engage in inappropriate conduct which posed a safety concern for a resident. Upon completing the facilities' investigation, it was confirmed he engaged in inappropriate behaviors towards a resident.

A current facility policy, titled "Abuse, Neglect & Exploitation Policy," dated 5/2021 and provided by the DON on 1/15/25 at 12:13 p.m., indicated "...Abuse" is defined in Indiana as a willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, anguish, or deprivation by an individual of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well-being. Abuse may also include sexual abuse and verbal abuse..."Neglect" is defined in Indiana as an act or omission which places a resident in a situation that may endanger the resident's life or health; abandoning or cruelly

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confining a resident; or depriving a resident or necessary support, including food, shelter and medical care...."

A current facility policy, titled "Indiana Resident Rights," dated 8/2012 and provided by the DON on 1/15/25 at 12:18 p.m., indicated "You have a right to the following...Treatment with consideration, respect, and recognition of your dignity and individuality...Freedom from sexual, physical, mental abuse, verbal abuse, corporal punishment, neglect and involuntary seclusion...."

A current facility policy, titled "Falls Management Policy," dated 1/2025 and provided by the DON on 1/15/25 at 12:18 p.m., indicated "...Definition of a Fall: A fall refers to unintentionally coming to rest on the on the ground, floor, or other lower level either witnessed or unwitnessed, with or without injury...."

A current facility policy, titled "Safe Resident Handling Policy," dated 3/2020 and provided by the DON on 1/15/25 at 2:12 p.m., indicated "...This policy is intended to promote the safe handling of residents and help reduce the number and severity of work-related muscles disorders (eg: lower back pain, neck or shoulder injuries) to

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associates in our communities.
This policy must be followed whenever an associate provides assistance to residents with transferring and movement, including, but not limited to resident transfers, transfers using Assistive devices, and assisting residents with mobility...."

This citation relates to Complaints IN00445842 and IN00450524.

Based on observation, interview and record review, the facility failed to ensure staff used wheelchair foot pedals during a wheelchair transfer through a hallway in accordance with the Indiana State Department of Health Nurse Aide Curriculum to protect a cognitively impaired resident's right to be free from neglect (Resident B) and failed to protect a cognitively impaired resident's right to be free from physical abuse perpetrated by CNA 1 (Resident C) for 2 of 5 residents reviewed for neglect and abuse. This deficient practice resulted in Resident B sustaining bruising to the right eye and eyebrow, swelling underneath the right eye, an abrasion to the corner of the right eye, an abrasion on the nose, a laceration of the lip, and a nosebleed.

Findings include:

1. A document, titled "Intake Information," dated 10/22/24, indicated CNA 2 was pushing Resident B through a hallway in a wheelchair without foot pedals, on 10/15/24 at 2:20 p.m. CNA 2 stopped suddenly to listen to another CNA, and Resident B fell forward out of the wheelchair onto the floor. The resident had bruising under her right eye and to her right eyebrow, a small abrasion to the corner of her nose and right eye, she bit her lip, and she had a nosebleed. Resident B passed away on 10/17/24.

A facility document, titled "Assisted Living INCIDENT INVESTIGATION Summary," indicated the following:

a. On 10/15/24 at 2:15 p.m., Resident B was being pushed to an activity in her wheelchair by CNA 2. CNA 2 heard CNA 4 say something, so she stopped pushing the resident. CNA 4 told CNA 2 Resident B was going to fall out of her wheelchair. At that time, Resident B fell forward onto the floor. The resident had facial bruising, swelling and a small laceration.

b. On 10/16/24 at 10:00 a.m., the resident's family declined for a hospital visit and wanted the resident to remain at the facility on hospice and kept comfortable.

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b. On 10/17/24 at 11:15 p.m., the resident passed away.

c. On 10/21/24 at 2:00 p.m., the coroner's office arrived at the facility and wanted information regarding the resident's fall.

The clinical record for Resident B was reviewed on 1/16/25 at 1:21 p.m. The diagnoses included, but were not limited to, Lewy body dementia, generalized anxiety disorder, Alzheimer's disease, type II diabetes mellitus, history of falling, and anemia.

The resident's service plan, dated 5/14/24 at 12:30 p.m., indicated staff were to provide physical assistance to and from the dining room and/or community activities as needed related to the resident's memory impairment and physical impairment. Staff were to ensure the resident was all the way back in her recliner and the resident was to get up in her wheelchair with staff assistance. She leaned forward at times in her wheelchair.

A nursing progress note, dated 10/15/24 at 4:46 p.m., indicated the resident was being pushed in the wheelchair to an activity and fell to the floor. She hit her face on the floor. She had facial bruising and small lacerations to her lip, nose and under her right eye. She was able to move all

extremities and had complaints of pain. Tylenol was given for pain.

A nursing progress note, dated 10/16/24 at 2:19 p.m., indicated the resident was resting comfortably with no need for morphine (a pain medication). The resident had facial bruising.

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A facility document, titled "CORRECTIVE ACTION," dated 10/18/24, indicated CNA 2 was observed pushing a resident in a wheelchair without leg rests and the resident fell out of the wheelchair. This was a violation of policy, as outlined in the handbook. All associates were to adhere to proper operating practices and procedures designed to prevent injuries and illnesses to residents.

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During an interview, on 1/16/25 at 12:01 p.m., CNA 4 indicated she was sitting on the unit when she observed CNA 2 pushing Resident B in her wheelchair without foot pedals. The resident was about to fall forward out of her wheelchair. Her feet did not touch the floor in the wheelchair, and they were dangling in the air. CNA 2 was not paying attention to the resident, while she was pushing her in the wheelchair. CNA 4 told CNA 2 the resident was going to fall forward, and this was when CNA 2 looked at CNA 4 instead of Resident B. CNA 4 jumped up to go help the resident and observed the resident fall forward out of her wheelchair onto her head on the floor. There was blood on the floor where the resident landed.

During an interview, on 1/16/25 at 12:34 p.m., CNA 5 indicated Resident B was not able to propel herself in her wheelchair. She had footrests for her wheelchair, which needed to be placed on her wheelchair whenever she was being pushed by the staff or family. The resident complained of pain all over her body after the fall. Her face was bruised.

The Indiana State Department of Health Nurse Aide Curriculum, revised 11/19/15, indicated "...Resident Care Procedure (RCP) 26...Transfer

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to Wheelchair...11. Align resident's body and position foot rests [sic]..."

2. A document, titled "Indiana State Department of Health Survey Report System," undated, indicated on 1/2/25 at 8:13 p.m., the Director of Nursing (DON) and Executive Director (ED) received a call to watch the Safely You video (a system of surveillance which detects falls). They viewed the video which showed CNA 1 appearing to strike Resident C, then the resident fell to the floor.

An Incident Investigation Summary report, dated 1/3/25, indicated the incident happened on 1/1/25 at 7:50 a.m. On 1/2/25 at 8:13 p.m., the ED and DON were notified to watch the Safely You video. The report indicated a video showed what "looked like" CNA 1 striking the resident and the resident fell to the floor. The report indicated Police Officer 3 asked Resident C about the incident and the resident indicated he was not able to remember. The report included a typed phone interview, dated 1/4/25 at 9:30 a.m., which indicated CNA 1 was told it appeared he hit Resident C. CNA 1 indicated he did not hit the resident. He was pointing to the bathroom. The ED and DON asked CNA 1 why he did not take the resident to the bathroom. He indicated he

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helped the resident up from the floor and the resident asked to sit on the bed, so he helped the resident to his bed. They asked CNA 1 what he did after he helped the resident onto the bed and he indicated he went to tell the nurse the resident was holding the door, then put himself onto the floor.

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tossed the resident on the bed, he left the room. The ED indicated they were not able to determine whether CNA 1 made contact with the resident or not, but there was no other way to explain why the resident grabbed his head and fell to the floor after CNA 1 raised his arm.

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A current facility policy, titled "Abuse, Neglect & Exploitation Policy," dated 5/2021 and provided by the DON on 1/15/25 at 12:13 p.m., indicated "...Abuse" is defined in Indiana as a willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, anguish, or deprivation by an individual of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well-being. Abuse may also include sexual abuse and verbal abuse..."Neglect" is defined in Indiana as an act or omission which places a resident in a situation that may endanger the resident's life or health; abandoning or cruelly confining a resident; or depriving a resident or necessary support, including food, shelter and medical care...."

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