

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/03/2026	
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 Intake 471226. Intake 471226-No deficiencies related to the allegations are cited. Unrelated deficiencies were cited. Survey date: September 2 and 3, 2026. Facility number: 010416 Residential Census: 32 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on September 8, 2026.	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:	R 0052	The following is the Plan of Correction for Brookdale Carmel regarding the Statement of Deficiencies dated September 3, 2026. This Plan of Correction			09/10/2026	

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FORM APPROVED

OMB NO. 0938-0391

- (1) sexual abuse;
- (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 a diagnosis of dementia was free from verbal and physical abuse from a staff member for 1 of 4 residents reviewed for abuse. (Resident B) This deficient practice resulted in Resident B being verbally and physically abused by CNA 1.

Findings include:

A facility document, titled "EVENT INVESTIGATION", dated 8/17/26, indicated the Executive Director (ED) and the Corporate Clinical Specialist learned of possible verbal and physical abuse from CNA 1 and an investigation had begun. The actions taken included, but were not limited to, CNA 1 was suspended.

The clinical record for Resident B was reviewed on 9/2/26 at 9:48 a.m. The diagnoses included, but were not limited to, Alzheimer's dementia,

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 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.

- Termination of employment for CNA Regina Ben, was effective on 8/28/2026.
- The Executive Director (ED) or designee provided re-education to all staff members on Abuse and Resident Rights and the importance of reporting. The ED or designee is providing re-education to residents and their legal representatives on Residents Rights, on 9/23/2026 during family night.

hypertension, and vitamin B-12 deficiency.

There was no documentation in the nursing progress notes found related to the incident.

A service plan, dated 4/15/26, indicated Resident B was not always oriented to person, place or time. She required physical assistance from staff for mobility, grooming, dressing, bathing and toileting. She was unable to stand independently during bathroom tasks and was incontinent with bowel and bladder.

A facility statement, dated 8/17/26, indicated CNA 3 was asked by CNA 1 to come and assist her with Resident B. Resident B was telling CNA 1 "don't hurt me". When they stood Resident B up to transfer her to a wheelchair, the resident moved in the opposite direction. CNA 1 told Resident B she was a "wicked person" and "You know this isn't right". CNA 1 then made a fist and placed it on Resident B's chin and "grinded it" in her jaw from one side to the other. Resident B was yelling at CNA 1 to stop and was crying.

A facility statement, dated 8/17/26, indicated CNA 2 was asked by CNA 1 to assist with Resident B. In the resident's room, CNA 1 was yanking on

- All residents have the potential to be affected. There were no additional allegations or complaints received during ED interviews of residents.
- To assist with ongoing compliance, the Health and Wellness Director (HWD) or designee will conduct additional associate retraining on Abuse, Neglect, and Exploitation, Reporting, and Resident Rights. This retraining will be conducted monthly at the monthly staff meeting, for three (3) months.
- The ED or designee will verify associate completion of the monthly retraining.

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Resident B's arm, and Resident B was yelling "stop, stop, don't hurt me". CNA 2 was not comfortable with CNA 1 grabbing the resident in that manner. Resident B was brought to the common area and was observed sliding down in her chair. CNA 1 indicated "Let's pull her up in the chair." CNA 1 then grabbed Resident B by her arm, hair and back of her neck to pull her up in the chair. Resident B screamed out. CNA 1 made a comment "the resident knew what she was doing".

A facility document, titled "CORRECTIVE ACTION", dated 8/26/26, indicated CNA 1 was responsible for being a positive member of the team and providing quality customer service to the residents. Behaviors described would not be tolerated. Accordingly, employment was terminated effective immediately.

During an interview, on 9/2/26 at 9:11 a.m., CNA 2 indicated CNA 1 needed assistance to change Resident B. Resident B was in bed, had a bowel movement, and was digging at herself. CNA 1 slapped the resident's hand and told the resident she could not do that. The CNAs got Resident B up and into her wheelchair. She suggested placing Resident B in the

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common area where there was a camera. The resident was crying. Resident B continued to slide down in the wheelchair. She indicated CNA 1 was rough with Resident B. She observed CNA 1 grab Resident B's neck and hair and yank her head back. She reported the incident.

During an interview, on 9/2/26 at 9:24 a.m., Resident B was alert, but unable to stay on topic or answer any questions appropriately.

During a telephone interview, on 9/3/26 at 9:54 a.m., CNA 3 indicated CNA 1 had asked her for assistance to get Resident B changed and up from bed. When she went to assist the resident, she was crying. While they were transferring the resident, she was bearing some weight, but her body was moving in the opposite direction of the staff's movements for the transfer. CNA 1 told Resident B she was "going to throw out their backs and why are you doing this?" CNA 1 called the resident "wicked". Once the resident was up in the wheelchair, CNA 1 used a closed fist and put it under each side of the resident's chin and moved the resident's head side to side. She did not punch or hit her but used a forceful movement.

A current facility policy, titled,

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"Indiana Resident Rights", dated 8/2012 and received from the Corporate Clinical on 9/3/26 at 10:38 a.m., indicated "...You have a right to the following ...Freedom from ...physical, mental abuse, verbal abuse, corporal punishment"

A current facility policy, titled "Abuse, Neglect & Exploitation Policy-IN-1", dated 5/2021 and received from the Corporate Clinical on 9/3/26 at 10:38 a.m., indicated "...Abuse is defined...as willful infliction of injury...intimidation or punishment with resulting physical harm or pain, anguish...Abuse may also include...verbal abuse..."

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
SIGNATUREBradley Miller

TITLEExecutive Director

(X6) DATE09/21/2026