STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS AT BROOKSIDE	6311 WEST CR 900 NORTH, MCCORDSVILLE, , 46055

(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 a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00436318. Complaint IN00436318- State deficiencies related to the allegations are cited at R0090. Survey dates: July 1 and 2, 2024 Facility number: 013847 Residential Census: 115 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 3, 2024.	R 0000		
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible	R 0090	Will follow the Indiana State Department reporting guidelines, and report all unusual occurrences. In-serviced all staff on reporting guidelines and reportable	07/03/2024

	for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that		situations Do on-going review observation audits	

	indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on interview and record review, the facility failed to ensure an unusual occurrence involving a fall for 1 of 3 residents reviewed for falls was reported to the Indiana Department of Health's (IDOH) Long Term Care (LTC) Division, once becoming aware of the unusual occurrence. (Resident B) Findings include: The clinical record for Resident B was reviewed on 7-1-24 at 12:12 p.m. His diagnoses included, but were not limited to, dementia and memory loss of unknown cause. His most			

recent Service Plan, dated 12-1-23, indicated he resided on a secured memory care unit and was independently mobile.

In an interview with the Administrator, on 7-1-24 at 1:20 p.m., she indicated the facility was unable to identify the cause of Resident B's facial injuries on 4-25-24, until later in the day, when the facility was able to view the footage of the secured memory care unit of the facility from early that morning, identifying a fall early that morning. The Administrator indicated the facility generally does not file a reportable incident for a fall, unless there was a fracture of some type. She indicated none of the hospital paperwork received made any reference to any type of a fracture. The Administrator added, Resident B's spouse was not sharing any type of paperwork she was receiving when she was taking him out to see any of the specialists. "It wasn't until he moved out that she told us he had a fractured cheekbone or around his eye and a problem with his shoulder. I still have not filed a reportable." The Administrator added Resident B did not return to the facility until four days later, on 4-29-24. The family member did not let the facility know if he had been admitted or that he was at home. "On Monday morning, [4-29-24] she

returned him to the campus without any paperwork or updates at that point, as to any recommendations from the emergency room doctors or anything."

In an interview with Memory Care Unit Manager, on 7-1-24 at 11: 25 a.m., she indicated she was familiar with Resident B and had worked at the facility for over 2 years. She could not recall Resident B having any previous falls. The Memory Care Unit Manager described Resident B as having advanced dementia. She did not recall him having a shuffling gait, but he did occasionally walk with his hands in his pockets. The Memory Care Unit Manager indicated she was not present during the time frame of the fall, around 4:00 a.m. on 4-25-24. Her understanding from the camera views, he was seen on camera in the hall, somewhere between 4:00 a.m. to 4:30 am. "He fell in the hallway walking down the hall with his hands in his pant pockets with a shuffling gate and fell face first onto the floor." She indicated by the time she arrived to the facility, mid-morning, the Director of Nursing had checked on him. "When I got here, his eye was puffy and swollen, but not discolored in any way. It kind of reminded me of a bite." She added she was aware the resident's spouse did take him

to an area hospital to be evaluated.

In an interview, on 7-2-24 at 6:27 a.m., with RN 4, she indicated she had worked at the facility for over five years and was familiar with Resident B. She indicated when she went into the memory care unit, on the morning of 4-25-24, the staff told her there was blood on the floor and it was cleaned up. She found Resident B with blood on his hands and Resident B allowed the RN to help him wash his hands. She indicated she was unable to determine where the blood came from. She was aware Resident B would occasionally wander the halls on night shift. "It was close to shift change time [7:00 a.m.]. He had a small bruise or scratch on his cheek, that was new to me. I let the dayshift ADON [Assistant Director of Nursing] know. I did not see any swelling or edema to his face/eye area [at that time]. He ambulates independently. I helped him to his room. I was going to do a head-to-toe assessment, but he would not allow me to help him get undressed." RN 4 indicated Resident B had an unwitnessed fall, but it was not discovered until later when the management team reviewed the hall cameras.

In an interview, on 7-2-24 at 11:55 a.m., with the Director of

	Nursing (DON), she indicated the hospital emergency room had been told by the spouse not to release any records to the facility, but the hospital had already sent some limited information to the facility, prior to the wife giving the directive. "As you can see, nothing is mentioned about a fracture of any kind. My experience with [name of the hospital] is that if they have a fracture of any kind, they will call us directly. [Name of Resident B's spouse] also would not give us any information from the specialists he was sent to see. So, when he was gone for several days, and returned on that Monday after, she still did not tell us anything about how to treat him. She did not let us know until the day he was discharging that he had a fracture on his cheek." He was discharged on 5-8-24 to a different care facility. In an interview with the Administrator, on 7-2-24 at 2:30 p.m., she indicated there were several discussions if, "this situation should be reported to the State, even [including] with my supervisors. It was decided that since we had no proof of a fracture, we would not report it. We even discussed that with the wife not sharing any information, which was pretty unusual, we wouldn't make it a reportable." On 7-2-24 at 12:23 p.m., the			

Administrator indicated the facility does not have a formal policy or procedure related to filing of reportable incidents or unusual occurrences, but merely follows the State's regulations.

This Residential tag relates to Complaint IN00436318.

2.5-1.3(g)(1)(D)

Based on interview and record review, the facility failed to ensure an unusual occurrence involving a fall for 1 of 3 residents reviewed for falls was reported to the Indiana Department of Health's (IDOH) Long Term Care (LTC) Division, once becoming aware of the unusual occurrence. (Resident B)

Findings include:

The clinical record for Resident B was reviewed on 7-1-24 at 12:12 p.m. His diagnoses included, but were not limited to, dementia and memory loss of unknown cause. His most recent Service Plan, dated 12-1-23, indicated he resided on a secured memory care unit and was independently mobile.

In an interview with the Administrator, on 7-1-24 at 1:20 p.m., she indicated the facility was unable to identify the cause of Resident B's facial injuries on 4-25-24, until later in the day,

	when the facility was able to view the footage of the secured memory care unit of the facility from early that morning, identifying a fall early that morning. The Administrator indicated the facility generally does not file a reportable incident for a fall, unless there was a fracture of some type. She indicated none of the hospital paperwork received made any reference to any type of a fracture. The Administrator added, Resident B's spouse was not sharing any type of paperwork she was receiving when she was taking him out to see any of the specialists. "It wasn't until he moved out that she told us he had a fractured cheekbone or around his eye and a problem with his shoulder. I still have not filed a reportable." The Administrator added Resident B did not return to the facility until four days later, on 4-29-24. The family member did not let the facility know if he had been admitted or that he was at home. "On Monday morning, [4-29-24] she returned him to the campus without any paperwork or updates at that point, as to any recommendations from the emergency room doctors or anything." In an interview with Memory Care Unit Manager, on 7-1-24 at 11: 25 a.m., she indicated she was familiar with Resident B			

	and had worked at the facility for over 2 years. She could not recall Resident B having any previous falls. The Memory Care Unit Manager described Resident B as having advanced dementia. She did not recall him having a shuffling gait, but he did occasionally walk with his hands in his pockets. The Memory Care Unit Manager indicated she was not present during the time frame of the fall, around 4:00 a.m. on 4-25-24. Her understanding from the camera views, he was seen on camera in the hall, somewhere between 4:00 a.m. to 4:30 am. "He fell in the hallway walking down the hall with his hands in his pant pockets with a shuffling gate and fell face first onto the floor." She indicated by the time she arrived to the facility, mid-morning, the Director of Nursing had checked on him. "When I got here, his eye was puffy and swollen, but not discolored in any way. It kind of reminded me of a bite." She added she was aware the resident's spouse did take him to an area hospital to be evaluated. In an interview, on 7-2-24 at 6:27 a.m., with RN 4, she indicated she had worked at the facility for over five years and was familiar with Resident B. She indicated when she went into the memory care unit, on the morning of 4-25-24, the staff			

	told her there was blood on the floor and it was cleaned up. She found Resident B with blood on his hands and Resident B allowed the RN to help him wash his hands. She indicated she was unable to determine where the blood came from. She was aware Resident B would occasionally wander the halls on night shift. "It was close to shift change time [7:00 a.m.]. He had a small bruise or scratch on his cheek, that was new to me. I let the dayshift ADON [Assistant Director of Nursing] know. I did not see any swelling or edema to his face/eye area [at that time]. He ambulates independently. I helped him to his room. I was going to do a head-to-toe assessment, but he would not allow me to help him get undressed." RN 4 indicated Resident B had an unwitnessed fall, but it was not discovered until later when the management team reviewed the hall cameras. In an interview, on 7-2-24 at 11:55 a.m., with the Director of Nursing (DON), she indicated the hospital emergency room had been told by the spouse not to release any records to the facility, but the hospital had already sent some limited information to the facility, prior to the wife giving the directive. "As you can see, nothing is mentioned about a fracture of any kind. My experience with			

	[name of the hospital] is that if they have a fracture of any kind, they will call us directly. [Name of Resident B's spouse] also would not give us any information from the specialists he was sent to see. So, when he was gone for several days, and returned on that Monday after, she still did not tell us anything about how to treat him. She did not let us know until the day he was discharging that he had a fracture on his cheek." He was discharged on 5-8-24 to a different care facility. In an interview with the Administrator, on 7-2-24 at 2:30 p.m., she indicated there were several discussions if, "this situation should be reported to the State, even [including] with my supervisors. It was decided that since we had no proof of a fracture, we would not report it. We even discussed that with the wife not sharing any information, which was pretty unusual, we wouldn't make it a reportable." On 7-2-24 at 12:23 p.m., the Administrator indicated the facility does not have a formal policy or procedure related to filing of reportable incidents or unusual occurrences, but merely follows the State's regulations. This Residential tag relates to Complaint IN00436318.			

	2.5-1.3(g)(1)(D)			
R 0300	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(4) (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation, interview, and record review, the facility failed to ensure the over-the-counter (OTC) medications had appropriate labeling for 1 of 5 residents observed for medication administration during 1 of 2 medication observations with 2 of 2 nursing staff. (Resident R5) Findings include: During a medication pass observation, on 7-2-24 at 8:05 a.m., for Resident R5, with Qualified Medication Aide (QMA) 5, he was scheduled to receive two OTC's, Refresh Gel Drops 1% (percent) and Vitamin B-12. The boxed container for the Refresh Gel Drops 1% orders indicated to "instill 1 drop in both eyes four times daily," according	R 0300	Cart Audits will be done weekly X4 weeks, then bi-weekly for 4 weeks and the monthly after. In-serviced staff on over the counter labels. Updated labels to assure we are capturing the correct information.	07/05/2024

	to the medication administration record. The medication box had the manufacturer's directions for use listed as, "instill 1 or 2 drops in the affected eye(s) as needed." The bottle nor the box had the ordering physician or nurse practitioner identified or the ordered directions for use present. The bottle of Vitamin B-12 did not have the ordering physician or nurse practitioner identified. In an interview with QMA 5, at the time of the observation, she indicated she was unaware of labeling requirements for OTC medications. 2.5-6(c)(4) Based on observation, interview, and record review, the facility failed to ensure the over-the-counter (OTC) medications had appropriate labeling for 1 of 5 residents observed for medication administration during 1 of 2 medication observations with 2 of 2 nursing staff. (Resident R5) Findings include:			

	During a medication pass observation, on 7-2-24 at 8:05 a.m., for Resident R5, with Qualified Medication Aide (QMA) 5, he was scheduled to receive two OTC's, Refresh Gel Drops 1% (percent) and Vitamin B-12. The boxed container for the Refresh Gel Drops 1% orders indicated to "instill 1 drop in both eyes four times daily," according to the medication administration record. The medication box had the manufacturer's directions for use listed as, "instill 1 or 2 drops in the affected eye(s) as needed." The bottle nor the box had the ordering physician or nurse practitioner identified or the ordered directions for use present. The bottle of Vitamin B-12 did not have the ordering physician or nurse practitioner identified. In an interview with QMA 5, at the time of the observation, she indicated she was unaware of labeling requirements for OTC medications. 2.5-6(c)(4)			
R 0302	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(6) (6) Over-the-counter medications must be identified with the	R 0302	Cart Audits will be done weekly X4 weeks, then bi-weekly for 4 weeks and the monthly after. In-serviced staff on over the counter labels. Updated labels to	07/05/2024

following:

(A) Resident name.

(B) Physician name.

(C) Expiration date.

(D) Name of drug.

(E) Strength.

Based on observation, interview, and record review, the facility failed to ensure the over-the-counter (OTC) medications had appropriate labeling for 1 of 5 residents observed for medication administration during 1 of 2 medication observations with 2 of 2 nursing staff. (Resident R5)

Findings include:

During a medication pass observation, on 7-2-24 at 8:05 a.m., for Resident R5, with Qualified Medication Aide (QMA) 5, he was scheduled to receive two OTC's, Refresh Gel Drops 1% (percent) and Vitamin B-12.

The boxed container for the Refresh Gel Drops 1% orders indicated to "instill 1 drop in both eyes four times daily," according to the medication administration record. The medication box had the manufacturer's directions only listed as, "instill 1 or 2 drops in the affected eye(s) as needed." The bottle nor the box

assure we are capturing the correct information.

had the ordering physician or nurse practitioner identified or the ordered directions for use present.

The bottle of Vitamin B-12 did not have the ordering physician or nurse practitioner identified.

In an interview with QMA 5, at the time of the observation, she indicated she was unaware of labeling requirements for OTC medications.

2.5-6(c)(6)(B)

Based on observation, interview, and record review, the facility failed to ensure the over-the-counter (OTC) medications had appropriate labeling for 1 of 5 residents observed for medication administration during 1 of 2 medication observations with 2 of 2 nursing staff. (Resident R5)

Findings include:

During a medication pass observation, on 7-2-24 at 8:05 a.m., for Resident R5, with Qualified Medication Aide (QMA) 5, he was scheduled to receive two OTC's, Refresh Gel Drops 1% (percent) and Vitamin B-12.

The boxed container for the Refresh Gel Drops 1% orders indicated to "instill 1 drop in both eyes four times daily," according to the medication administration

	record. The medication box had the manufacturer's directions only listed as, "instill 1 or 2 drops in the affected eye(s) as needed." The bottle nor the box had the ordering physician or nurse practitioner identified or the ordered directions for use present. The bottle of Vitamin B-12 did not have the ordering physician or nurse practitioner identified. In an interview with QMA 5, at the time of the observation, she indicated she was unaware of labeling requirements for OTC medications. 2.5-6(c)(6)(B)			

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