STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	12/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND BROOK MEMORY CARE OF GREENWOOD	2444 SOUTH STATE ROAD 135, GREENWOOD, , 46143

(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 IN00369596. Complaint IN00369596 - Substantiated. State Residential Finding related to the allegation is cited at R0052. Survey dates: December 27 and 28, 2021 Facility number: 014426 Residential Census: 36 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality Review completed on December 29, 2021.	R 0000	This Plan of Correction is submitted as required under Federal and State regulation and statues applicable to assisted living care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.	
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	A head to toe assessment was conducted on all residents to ensure there were no unknown bruising or marks. Residents that were interview able were interviewed about abuse. We	01/31/2022

	(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 a resident was free from abuse by another resident (Resident B) which resulted in a fractured nose and a bruise under the right eye for 1 of 3 residents reviewed for abuse. (Resident C) Findings include: During an initial tour of the facility, on 12/27/2021 at 2:00 p.m., Resident C was observed to be sitting in the television room playing with a balloon. A golf ball sized bruise was observed under his right eye and his nose was crooked. An Investigation Report dated, 12/21/2021 at 7:15 a.m., for Resident C indicated, "... While staff were getting residents up and ready for the day one of the staff members [LPN 1] came out of a resident's room to find [Resident C's name] standing in the living room with a nose bleed. When asked what had		discussed what should happen if they were abused or witnessed someone else being abused. We will continue to train all new hires on the facilities Abuse policies. Audits will be conducted once monthly for 6 months then quarterly 3 months. QAPI team will review to ensure this is being completed. DON or designee will train and in-service staff on how to report abuse and neglect. Audits will be conducted once monthly for 6 months then quarterly 3 months. QAPI team will review to ensure this is being completed. All New employees will be trained upon hire. DON or designee to complete resident rights and resident abuse in-services for all staff members monthly for 6 months then quarterly 3 months. QAPI team will review to ensure this is being completed. New employees will be trained upon hire. We will continue to follow our policy for Abuse Prevention: Our Purpose is: •To ensure that the community is doing all that is within its control to prevent occurrences of	

happened [Resident C's name] pointed to [Resident B's name] and said he hit me. [Resident B's name] was then questioned as to what had happened and [Resident B's name] stated I hit the S-- [curse word] he was in my room and I was defending my room ... Was a witness present ... No ..."

Resident C's clinical record was reviewed on 12/27/2021 at 2:30 p.m. Diagnoses included, but were not limited to dementia and anxiety disorder.

A service plan, dated 12/13/2021 for Resident C indicated, "... Behaviors ... Resident to receive assistance with behaviors as appropriate and necessary, can be verbally aggressive, jiggles door knows [sic] to the point of breaking the handle, lay in other resident's beds ... Staff to assist with other behaviors as appropriate and necessary ..."

The service plan lacked documentation of Resident C having had behaviors of wandering into other resident rooms.

A review of the hospital "After Visit Summary," dated 12/21/2021, for Resident C indicated, "... Today's visit ... Diagnosis ... closed fracture of nasal bone ..."

Observation Notes, dated

abuse, neglect, involuntary seclusion, and misappropriation of property for allcustomers.

·The community will do all that it can within itscontrolto prohibit abuse, neglect, involuntary seclusion, and misappropriation of property for all residents through the implementation of sevencomponents:

a)**Screening**of potential employees

Pre-hire screening is completed before hiring. We perform a state background check, a criminal record database search for all 50 states and a License Litigation Search.

b)**Training**of employees (both new and ongoing training for all employees)

All new employees will be provided training on what constitutes abuse or neglect and the prevention of abuse during their orientation and supervised training within the first 20 hours of a new employee’s training. All employees are provided at least 12 hours of continuing education every year including one hour of continuing education on the prevention of abuse andneglect.

c)**Prevention**ofoccurrences

1. posting the ombudsman

12/27/2021 at 10:10 a.m., indicated upon rising Resident C's nose had "significant swelling to side of nose, however swelling has gone."

Resident B's clinical record was reviewed on 12/27/2021 at 3:00 p.m., Diagnoses included, but were not limited to dementia and diabetes mellitus.

A review of Resident B's observation notes indicated the following:

-7/7/2021 at 4:47 a.m., "Resident was walking around living room and dining room without pants or underwear on. Certified Nursing Assistant [CNA] nicely asked him to put on clothes and he stated that people in here were F------[curse word] with him and if they keep it up he would knock the F---[curse word] out of them ..."

-7/7/2021 at 11:33 a.m., "Staff was outside another resident had sat on table in front of [resident name] and he began cussing at resident saying he was going to knock him upside the head if he didn't move. He then went to get up throwing his hands up while staff intervened."

-7/9/2021 at 1:42 a.m., "Resident is being aggressive, agitated, and combative, seeking exit all night, trying to go other resident room, trying to

contact information in the community, 2. providing families and residents upon admission with information on how and to whom they may report concerns, incidents and grievances without fear of retribution, and provide feedback regarding the concerns that have been expressed, and 3. Identifying, correcting and intervening in situations in which abuse is more likely tooccur.

d)**Identification**of possible incidents or allegations which need investigation

Staff will identify events, such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse or neglect, including resident-to-resident abuse. Staff will also report in accordance with community abuse policy.
Investigationof incidents and allegations.

e)**Protection**of residents during investigation,and

1)Tell the abuser to stop and remove the resident to a safe area.

Remove alleged abuser to a nonresident care area (i.e. the front office orfoyer)

2)Immediately notify the Executive Director. In the absence of the Executive

hit the care staff ..."

-7/12/2021 at 11:42 a.m., "Unwitnessed altercation-patient entered the other patient room. The patient then started to yell at him for him to get out of the room. Patient then punched him in the mouth."

-7/26/2021 at 5:14 a.m., "Patient got aggressive with staff Qualified Medication Aide [QMA] when asked to help care for him.

-8/7/2021 at 12:11 a.m., "Resident being aggressive and banging other residents door, very hard to get in control ..."

-8/7/2021 at 6:27 a.m., "Resident has been aggressive all night, trying to combative[sic[to the resident and the staff ..."

-8/11/2021 at 10:58 p.m., "Resident was being aggressive and combative, banging on other residents door ..."

-9/3/2021 at 1:51 a.m., "Resident is agitated and being aggressive towards other resident and care staff ..."

-9/4/2021 at 10:52 a.m., "Agency aide reported she was speaking on the phone when resident approached her and aggressively tried to grab her arm and phone ..."

-12/21/2021 at 10:43 a.m.,

Director such reports should be made to the employee's direct supervise and to the lead caregiver onduty.

3)In addition, if the director is unavailable, the VP of Operations should benotified.

4)The lead caregiver shall document the said incident on accident/ incident report form.

5)The Executive Director, or designee, shall ensure that the following persons are notified immediately of the allegation of abuse and that an investigation is underway: state agencies as required by state and local law, police if required by law, physician, responsible party, community nurse, Director of Health Care, and VP of Operations.

6)ALL facility personnel/staff/employees who have reasonable cause to suspect that a resident has been subjected to abuse/neglect are required to IMMEDIATELY notify the Executive director or designee.

f)**Reporting**of incidents, investigations, and facility response to the results of their investigations

The Executive Director is responsible for the coordination of the investigation and the maintenance and confidentiality

	"Resident exited his room this a.m. after another male resident also exited the residents room before him with a bloody nose. Writer and CNA asked this resident why other male resident stating that you had hit him. Resident stated, I did hit the S-- [curse word]. I had to defend my room he was in there. Noted on this residents hand he had 2x2 skin tear dried area ..." -12/21/2021 at 5:56 p.m., "Resident transported to [psychiatric hospital name]." A service plan, dated 11/30/2021 for Resident B indicated, "... Behaviors ... Resident to receive assistance with behaviors as appropriate and necessary ... Staff to assist with other behaviors as appropriate and necessary ..." The service plan lacked documentation of Resident B having had agitation and aggressive behaviors. During an interview, on 12/28/2021 at 11:07 a.m., Licensed Practical Nurse 1 (LPN) indicated Resident C would wander the halls but typically would not be aggressive. Resident B would become agitated when up for long periods of time. On 12/21/2021, Resident C wandered into Resident B's		of all records pertaining to the investigation. All phases of the investigation shall be kept confidential. The Executive Director has the authority to delegate coordination of the investigation to other individuals within the community. The preliminary investigation must include thefollowing: 1)If the alleged abuser is an employee, the employee shall be removed from the facility and suspended pending the results of the community’s investigation**.**If the employee is not on duty at the time, the employee shall be contacted and instructed not to return to the community until further notice. If unable to contact the employee by telephone, a certified letter with a return receipt requested should be sent. The suspension shall be documented in the employee personnel file and shall remain in effect until the investigation is completed. 2)If the alleged abuser is a visitor, they shall be denied unsupervised visits pending the results of theinvestigation. 3)If the alleged abuser is another resident, the two residents shall be separated and the alleged resident shall be temporarily separated from other residents and monitored with one-on-one supervision as	

	room while the staff were getting other residents up for the morning. Resident C came out into the hallway with a bloody nose and indicated Resident B had hit him. Resident B confirmed he had hit Resident C because he was in his room. Resident C was sent to the hospital and returned with a broken nose. The altercation was unwitnessed by staff. During an interview, on 12/28/2021 at 11:30 a.m., QMA 1 indicated Resident C would wander the halls but would typically not be aggressive. Resident B would be aggressive if he were tired and had been up for several days in a row. On 12/28/2021 at 1:57 p.m., the Administrator provided the facility policy, "Abuse Prevention Policy" undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "Purpose ... To ensure that the community is doing all that is within its control to prevent occurrences of abuse ... 1. The community will do all that it can within its control to prohibit abuse ..." This State Residential tag relates to Complaint IN00369596. Based on observation, interview, and record review, the		a therapeutic intervention to help lower the agitation, until a plan of care can be developed to meet the needs of the alleged abusive resident. 4)If equipment failure was identified as the cause of resident abuse, mistreatment or neglect, the item will be removed from resident care area and clearly marked for nonuse. 5)Immediate examination of the resident by a licensed nurse, executive director, or lead caregiver. Document the results of the examination on the accident/incident report form and in the resident’s clinical record. 6)The involved employee’s supervisor will obtain if possible, hand written statements from employees, residents and witnesses. Include all staff working at the time that the alleged incident occurred and other residents who may have witnessed the incident or receives care from the alleged abuser. In the case of bruises and/or abrasions of unknown origin, interviews must take place with employees who worked on the previous shift. Document all interviews even if the individual claims to have no knowledge of the incident. Witnesses’ statements are confidential and are notto be	

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A review of Resident B's

9)The Executive Director, or designee, will report conclusions of investigation per state and local requirements via form DMS-742 within 5 business days. The resident and responsible party shall be notified of the investigation results in a general manner. Disciplinary actions toward employees are confidential.

10)The Executive Director, or designee, will report any alleged, suspected, or witnessed occurrences of abuse to the OTLC within 1 business day via fax on form DMS 731.

11)The Executive Director and or designee will analyze all occurrences to determine what changes are needed, if any, to policies and procedures to prevent furtheroccurrences.

12)No written report shall be submitted to state agency without consulting with the corporate legal and corporate management.

13)Follow-up action with employee includes 1. Reinstatement with back pays if unsubstantiated. 2. Termination if substantiated. Review investigation findings with HR prior to termination. 3. Reinstate withawrittenwarningandsetupa monitoringprogram that includes retraining, if warranted. If a monitoring program is

	observation notes indicated the following: -7/7/2021 at 4:47 a.m., "Resident was walking around living room and dining room without pants or underwear on. Certified Nursing Assistant [CNA] nicely asked him to put on clothes and he stated that people in here were F------[curse word] with him and if they keep it up he would knock the F---[curse word] out of them ..." -7/7/2021 at 11:33 a.m., "Staff was outside another resident had sat on table in front of [resident name] and he began cussing at resident saying he was going to knock him upside the head if he didn't move. He then went to get up throwing his hands up while staff intervened." -7/9/2021 at 1:42 a.m., "Resident is being aggressive, agitated, and combative, seeking exit all night, trying to go other resident room, trying to hit the care staff ..." -7/12/2021 at 11:42 a.m., "Unwitnessed altercation-patient entered the other patient room. The patient then started to yell at him for him to get out of the room. Patient then punched him in the mouth." -7/26/2021 at 5:14 a.m., "Patient got aggressive with staff Qualified Medication Aide		established, the employee's supervisor is responsible for communicating behaviors/actions to be monitored to individuals within departments that have supervisory responsibilities. 14)Monitoring Program. Establish for a minimum of 30 days; Identify training needs and list; Identify performance expectation and list; If employee typically works an off shift, the employee must work the day shift, or the designated supervisor works the employee's assigned shift to train an monitor; A weekly review of progress is given to employee and Executive Director by the employee supervisor; Interview residents cared for by employee and document responses; Employee may be reinstated to assigned shift after 2 weeks with ongoing supervisor designated; After 30 days, monthly reviews of progress are provided to employee and director by the assigned supervisor for up to 90 days; Any further misconduct or infraction results in immediate termination. Completion Date for this plan of correction will be 1/31/2022 We are requesting an IDR because we do not agree with the finding of abuse.	

	[QMA] when asked to help care for him. -8/7/2021 at 12:11 a.m., "Resident being aggressive and banging other residents door, very hard to get in control ..." -8/7/2021 at 6:27 a.m., "Resident has been aggressive all night, trying to combative[sic[to the resident and the staff ..." -8/11/2021 at 10:58 p.m., "Resident was being aggressive and combative, banging on other residents door ..." -9/3/2021 at 1:51 a.m., "Resident is agitated and being aggressive towards other resident and care staff ..." -9/4/2021 at 10:52 a.m., "Agency aide reported she was speaking on the phone when resident approached her and aggressively tried to grab her arm and phone ..."		Please see uploaded IDR request.	

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-12/21/2021 at 5:56 p.m., "Resident transported to [psychiatric hospital name]."

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wandered into Resident B's room while the staff were getting other residents up for the morning. Resident C came out into the hallway with a bloody nose and indicated Resident B had hit him. Resident B confirmed he had hit Resident C because he was in his room. Resident C was sent to the hospital and returned with a broken nose. The altercation was unwitnessed by staff.

During an interview, on 12/28/2021 at 11:30 a.m., QMA 1 indicated Resident C would wander the halls but would typically not be aggressive. Resident B would be aggressive if he were tired and had been up for several days in a row.

On 12/28/2021 at 1:57 p.m., the Administrator provided the facility policy, "Abuse Prevention Policy" undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "Purpose ... To ensure that the community is doing all that is within its control to prevent occurrences of abuse ... 1. The community will do all that it can within its control to prohibit abuse ..."

This State Residential tag relates to Complaint IN00369596.

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