STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/30/2023	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD	
BROOK	SIDE CARE STRA	TEGIES		SAVIN ST E, IN 47303	
(X4) ID		Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE COMITEE TION
TAG F 0000	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
F 0000					
Bldg. 00	This visit was for IN00404302.	the Investigation of Complaint	F 0000		
	Complaint IN00404302 - Federal/State deficiencies related to the allegations are cited at F600, F609 and F610. Survey dates: March 29 and 30, 2023 Facility number: 000311 Provider number: 15E064 AIM number: 100285520				
	Census Bed Type: NF: 37 Total: 37				
	Census Payor Typ Medicaid: 36 Other: 1 Total: 37	e:			
	These deficiencies accordance with 4	s reflect State Findings cited in 10 IAC 16.2-3.1.			
	Quality review co	mpleted April 4, 2023.			
F 0600 SS=G Bldg. 00	Exploitation The resident has abuse, neglect, r property, and ex subpart. This incomplete the subpart of the su	e and Neglect on from Abuse, Neglect, and the right to be free from misappropriation of resident ploitation as defined in this cludes but is not limited to rporal punishment, usion and any physical or			
LABORATO	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S	SIGNATURE	TITLE	(X6) DATE
Derrek Ke	Derrek Keith				04/22/2023

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPL	ETED
		15E064	B. WI	NG		03/30/	/2023
NAME OF B	ADOLUDED OD CLUDDI IED		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	<u>C</u>		505 N G	GAVIN ST		
	SIDE CARE STRATI	EGIES		MUNCI	E, IN 47303		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DLI ICILACTI		DATE
	resident's medical	not required to treat the symptoms.					
	§483.12(a) The fa	cility must-					
	§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, record review and						
	Based on observation interview the facility abuse of a depender another resident (Refereviewed for abuse, resulted in Resident for evaluation of pasafety and ridicule valuation interview Resident B indicate room and sat on her		F 06	500	The filing of the plan of correct does not constitute an admiss that the alleged deficiency did fact exist. This plan of correcti is filed as evidence of the facil desire to comply with the requirements and continue to provide quality care. The facility respectfully reques paper review for compliance. It is the policy of this provider the each resident has the right to free from abuse, neglect, misappropriation of resident	ion in on ity's sts	04/28/2023
	caused significant p "loved on" her breas several times to call	ain. Resident E had also st. She had blown a whistle for help during the incident d Resident E to leave. The			property, and exploitation. What corrective action(s) will be accomplished for those reside found to have been affected be	nts	
	resident was holding	g a whistle in her right hand vand indicated she kept it with			deficient practice? 1. Resident B was assessed to psychosocial distress, none not and is free from abuse.	or	
	Resident C, roomma Resident E entered to leave. Resident E d Resident B's side of indicated she could Resident E get on the feet. Resident C income	on 3/29/2023 at 10:21 a.m., ate of Resident B, indicated their room and she told him to lid not leave and walked to the room. Resident C see Resident B's bed and saw he bed and lay on Resident B's dicated Resident B blew her es to call for help and Resident			2. Resident E was redirected to safe place if getting to close to other residents with increased aggravation. Requested from to send for evaluation at Indy Neuropsychic. How will you identify other residents having the potential be affected by the same defici	NP to	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15E064	B. W	ING		03/30/	/2023
NAME OF F	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
DD001/6	NDE OADE OTDAT	F01F0			GAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES		MUNCI	E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		tht. Staff came and removed			practice and what corrective a	ction	
	Resident E from the	eir room. Resident C indicated			will be taken?		
	no one had asked he	er what she witnessed or			Residents that reside at the		
	anything about the	incident.			facility may be affected by the		
					alleged deficient practice.		
	During an interview	on 3/29/2023 at 12:50 p.m.,			Staff members have been		
	CNA 5 indicated Resident E was physically				educated on 4/24/23 by the Al	OON	
	strong. The CNA did not believe Resident E had				on abuse and answering call		
	the cognitive ability	to know how to climb onto			lights.		
		Resident B kept the bed in a	1		What measures will be put into)	
	higher position.				place or what systemic change	es	
					you will make to ensure that th	ne	
	1	on 3/29/2023 at 11:18 a.m., the			deficient practice does not		
	Director of Nursing	(DON) indicated, on			reoccur.		
		working late and the police had			Staff have been re-educated o	n	
	_	to a 911 call for an allegation			4/1/23 on reporting suspected	k	
		he facility did not know who			abuse immediately.		
	_	he police said Resident B had			Inservice on 4/24/23 will be		
		edics also responded. When			conducted on abuse for all sta	ff	
		ce interviewed Resident B, the			How the corrective action(s) w	ill be	
		he called because of pain in			monitored to ensure the defici-		
		nted to go to the hospital. The			practice will not recur, i.e., who		
	_	orted to the hospital for			quality assurance program wil	l be	
		ON indicated the facility had			put into place?		
		ty video and it showed, during			2. Clinical Documentation Aud	lits	
	1	ale resident had entered the			will be performed by Social		
		e room for only a short period			Services/or Administrator 2 x		
	of time.				weekly x 4 weeks, then month	ly x	
					3 months.		
	The police call repo				The Abuse audit tool will be		
		30/2023 at 9:05 a.m., indicated			completed weekly for four week		
		n on 3/17/2023 at 11:41 p.m. The			and monthly for six months by	the	
	_	resident alleged another			Administrator.		
		Feet and laid on top of her.			The results of these audits will		
	1	ted an ambulance due to pain			reviewed in Quality Assurance	е	
		anded to talk to a police officer.			Meeting Quarterly. The QA		
		dicated the DON told officers			Committee will identify any tre	nds	
	1	s showed no one had entered	1		or patterns and make		
	the resident's room.				recommendations to revise the		
			1		plan of correction as indicated		

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E064	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/30/2023	
	PROVIDER OR SUPPLIER		505 N C	ADDRESS, CITY, STATE, ZIP COD GAVIN ST E, IN 47303		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE	
IAU	During a interview hospital Case Mana indicated the facility Resident E was in Fapproximately tens Case Manager Resident E was in Fapproximately tens Case Manager Resident I was believed to be some the bed, and fondled denied sexual assaudid not know what I was medicated with The resident did not want to reture feeling safe. The resident was also staff telling EMS that time while they were of the facility, and for the facility, and for the facility, and for the facility, and for the facility of the facility and for the facility of the facility and for the facility and for the facility of the facility and for th	on 3/31/2023 at 10:44 a.m., the ger indicated the DON had a security video showed desident B's room for econds. The DON told the dent E would have been as Resident B's bed. The Case they had known the resident desident B had a diagnoses tress Disorder and the cause sexual in nature. The resident B had a diagnoses tress Disorder and the cause sexual in nature. The resident B had a diagnoses tress Disorder and the cause sexual in nature. The resident B had a diagnoses tress Disorder and the cause sexual in nature. The resident B had a diagnoses tress Disorder and the cause sexual in nature. The resident B had a diagnoses tress Disorder and the cause sexual in nature. The resident B had a diagnoses tress Disorder and the resident and the stating the other resident the was doing. The resident Toradol (analgesic) for pain. The want to press charges and the torate of the facility, due to not sident reported hyperalgesia ensitivity) in the feet and had lateral feet since the incident. So bothered by the facility ey were sorry for wasting their te transporting the resident out telt her concerns were not	IAU		DATE	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E064	l í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 03/30/	ETED		
	PROVIDER OR SUPPLIER BIDE CARE STRAT			STREET ADDRESS, CITY, STATE, ZIP COD 505 N GAVIN ST MUNCIE, IN 47303					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	wheelchair, eating of B told the CNA that	one of her cupcakes. Resident t Resident E had been on her icated anything about							
	CNA 2 confirmed t indicated she forgo was written a coupl The incident happe birthday, because R	w on 3/29/2023 at 12:23 p.m., he written statement. The CNA to date the statement but it e of days after the incident. ned the day after Resident B's tesident E was eating the provided by the DON.							
	CNA 6 indicated th	o on 3/29/2023 at 12:57 p.m., e day of the incident she had lowing her whistle and CNA 2							
	3/17/29023 at 8:24 completed on 3/20/	ity security audio/video for a.m. through 9:07 a.m., 2023 at 11:00 a.m. with the of Nursing (ADON), indicated							
	Resident B's room. b. At 9:02 a.m. a w blown multiple tim c. At 9:05 a.m. a st passing the room, v blown, without invo d. At 9:07 a.m. Res	aff member was observed while the whistle was being estigating. Sident E was seen leaving He had been in the room a							
		as observed entering or leaving during the time period leo.							
	During an interviev	v at the time of the video							

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

PRINTED: 04/25/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E064	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/30/2023		
	PROVIDER OR SUPPLIEF SIDE CARE STRAT		STREET ADDRESS, CITY, STATE, ZIP COD 505 N GAVIN ST MUNCIE, IN 47303				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE COMPLETION		
	the facility during the been working that reshe was present where ported Resident Esexual assault. The denied the sexual ashospital for pain in Resident E was strong Resident B's bed. 1. The clinical record on 3/29/2023 at 9:1 cerebral palsy, scold disorder, anxiety, depersonality disorder disorder. The most recent and (MDS) assessment, on 3/29/2023 at 9:1 resident required expersons for bed molestopersonal hygiene ar	indicated she had not been in he day on 3/17/2023, but had hight. The ADON indicated en the police arrived and B had made an allegation of DON told her Resident B had sasult and was sent to the her feet. The ADON indicated ong enough to climb onto and for Resident B was reviewed 1 a.m. Diagnoses included, iosis, post-traumatic stress epression, borderline r, and paranoid personality mission Minimum Data Set dated 1/30/2023, was reviewed 1 a.m. The MDS indicated the stensive assistance of 2 bility, transfers, toilet use, and dressing. The resident had apper and lower extremities on					
	both sides. Resider cognitively intact. A progress noted, d indicated Resident allegation of sexual sexual assault wher facility staff, but co	at B was assessed as being lated 3/18/2023 at 12:09 a.m., B had called the police with an assault. The resident denied interviewed by the police and emplained of pain in both feet. ken to the hospital for					
	Resident E was goi	vation on 3/29/2023 at 1:40 p.m., ng from sit to stand without ambulating in the hallway					

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STREET ADDRESS, CITY, STATE, ZIP COD 505 N GAVIN ST MUNCIE, IN 47303 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG During an observation on 3/30/2023 at 1:47 p.m., Resident E was observed ambulating in the hallway while holding hands with a female resident. Resident E stopped and grabbed handrails and jerked repeatedly, as if trying to pull them off the wall. He was redirected by staff and continued to ambulate in the hallway. The clinical record for Resident E was reviewed on 3/29/2023 at 1:23 p.m. Diagnoses included, Wernicke's encephalopathy, anxiety disorder, violent behaviors, dementia with behavioral disturbances and severe agitation, depression, hallucinations, and delusional disorder. The most recent quarterly Minimum Data Set (MDS) assessment, dated 3/9/2023, indicated the resident E had a care plan, dated 2/6/2023,	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064		(X2) MULT A. BUILD B. WING		NSTRUCTION 00	(X3) DATE (COMPL 03/30/	ETED		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION During an observation on 3/30/2023 at 1:47 p.m., Resident E was observed ambulating in the hallway while holding hands with a female resident. Resident E stopped and grabbed handrails and jerked repeatedly, as if trying to pull them off the wall. He was redirected by staff and continued to ambulate in the hallway. The clinical record for Resident E was reviewed on 3/29/2023 at 1:23 p.m. Diagnoses included, Wernicke's encephalopathy, anxiety disorder, violent behaviors, dementia with behavioral disturbances and severe agitation, depression, hallucinations, and delusional disorder. The most recent quarterly Minimum Data Set (MDS) assessment, dated 3/9/2023, indicated the resident was severely cognitively impaired.				5	505 N GAVIN ST				
Resident E was observed ambulating in the hallway while holding hands with a female resident. Resident E stopped and grabbed handrails and jerked repeatedly, as if trying to pull them off the wall. He was redirected by staff and continued to ambulate in the hallway. The clinical record for Resident E was reviewed on 3/29/2023 at 1:23 p.m. Diagnoses included, Wernicke's encephalopathy, anxiety disorder, violent behaviors, dementia with behavioral disturbances and severe agitation, depression, hallucinations, and delusional disorder. The most recent quarterly Minimum Data Set (MDS) assessment, dated 3/9/2023, indicated the resident was severely cognitively impaired.	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION	
indicated a potential to be physically aggressive. Goal: "The resident will not harm self or others through the review date." Resident E had a care plan, dated 2/6/2023, for wandering aimlessly without regards to needs or safety. Goal: "Resident will not wander from facility nor injure self or others while wandering daily through next review." 3. The clinical record for Resident C was reviewed on 3/29/2023 at 12:13 p.m. The most recent admission MDS assessment, dated 3/1/2023, indicated the resident was cognitively intact. During an interview on 3/29/2023 at 2:07 p.m., the Social Services Director indicated Resident C was reliable with no behaviors of making false allegations.		Resident E was obshallway while hold resident. Resident handrails and jerket them off the wall. It continued to ambult the continued the continu	erved ambulating in the ing hands with a female E stopped and grabbed d repeatedly, as if trying to pull He was redirected by staff and ate in the hallway. for Resident E was reviewed on i.m. Diagnoses included, alopathy, anxiety disorder, dementia with behavioral vere agitation, depression, delusional disorder. arterly Minimum Data Set dated 3/9/2023, indicated the ly cognitively impaired. are plan, dated 2/6/2023, il to be physically aggressive. It will not harm self or others date." are plan, dated 2/6/2023, for y without regards to needs or ident will not wander from elf or others while wandering review." ard for Resident C was reviewed 13 p.m. The most recent sessment, dated 3/1/2023, ant was cognitively intact.						

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PRINTED: 04/25/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E064	ì	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 03/30/	ETED
	PROVIDER OR SUPPLIER			505 N G	ADDRESS, CITY, STATE, ZIP COD BAVIN ST E, IN 47303		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0609 SS=D Bldg. 00	provided by the DO indicated the follow the resident's right the resident's right the resident's right the resident's right the abusePOLICYR will be treated with accordance with the not be subjected to provide the subjected t	ND PROHIBITION POLICY," NN on 3/29/2023 at 12:51 p.m., ring: "PURPOSE: To ensure to remain free fromphysical desidents residing in this facility dignity and respect in the rindividual needs. They will physicalabuse" ates to complaint IN00404302. (B)(c)(1)(4) ed Violations to allegations of exploitation, or mistreatment, are that all alleged grabuse, neglect, extreatment, including the source and of resident property, are tely, but not later than 2 telegation is made, if the the allegation involve abuse as bodily injury, or not later the events that cause the involve abuse and do not odily injury, to the telefacility and to other to the State Survey protective services where to for jurisdiction in long-term accordance with State law					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		15E064	B. W	ING		03/30	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			GAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES		MUNCI	IE, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		oort the results of all					
		ne administrator or his or					
		presentative and to other					
	officials in accordance with State law,						
	_	ate Survey Agency, within					
		the incident, and if the					
		s verified appropriate					
	corrective action r		БО	(00	F000		04/29/2022
		, and record review, the facility	F 00	509	F609	tion	04/28/2023
		se to the State Agency for 1 of eviewed for reporting to State			The filing of the plan of correct		
	Agency (Resident F				does not constitute an admiss		
	Agency (Resident E	and Resident E).			that the alleged deficiency did		
	Findings include:				fact exist. This plan of correcti is filed as evidence of the facil		
	Tindings include.				desire to comply with the	iity S	
	During an interview	on 3/29/2023 at 9:50 a.m.,			requirements and continue to		
	1	d Resident E had entered her			provide quality care.		
		feet. The resident indicated			The facility respectfully reques	ete	
		ensitive and Resident E had			paper review for compliance.	313	
		pain. Resident E had also			paper review for compliance.		
		st. She had blown a whistle			What corrective action(s) will	be	
		I for help during the incident			accomplished for those reside		
		ed Resident E to leave. The			found to have been affected by		
		g a whistle in her right hand			the deficient practice?	-,	
		v and indicated she kept it with			Resident allegations of abuse	have	
	her at all times for s				been reported to ISDH.		
					How will you identify other		
	During an interview	y on 3/29/2023 at 10:21 a.m.,			residents having the potential	to	
	Resident C, roomm	ate of Resident B, indicated			be affected by the same defic	cient	
	Resident E entered	their room and she told him to			practice and what corrective		
	leave. Resident E d	lid not leave and walked to			action will be taken?		
	Resident B's side of	the room. Resident C			All residents have the potentia	al to	
		see Resident B's bed and saw			be affected by the alleged def	icient	
	_	ne bed and lay on Resident B's			practice.		
		dicated Resident B blew her			Nurses fill out a daily check lis	st,	
		es to call for help and Resident			then turn into nursing		
		tht. Staff came and removed			administration.		
		eir room. Resident C indicated			If any allegations of abuse will		
		er what she witnessed or			reported to the Executive Dire		
	anything about the	incident.			immediately, reported to ISDF	1 ,	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		15E064	B. WI	NG		03/30/	
					_		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					GAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES		MUNCII	E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					and investigated. What measu	res	
	During an interview	on 3/29/2023 at 11:18 a.m., the			will be put into place or what		
	Director of Nursing	(DON) indicated, on			systemic changes you will mal	ке	
	3/17/2023, she was working late and the police had				to ensure that the deficient		
	arrived in response to a 911 call for an allegation				practice does not recur? ·		
	of sexual assault. The facility did not know who				All staff in-serviced by the AD0	ON	
		ne police said Resident B had			by April 24, 2023, on the Abus		
	_	dedics also responded. When			Prohibition, Reporting and		
		ce interviewed Resident B, the			Investigation Policy and		
		he called because of pain in			Procedures ·		
		nted to go to the hospital. The			Reporting pending investigation	n	
		orted to the hospital for			immediately and at the conclu		
	_	ON indicated the facility had			of the investigation will be repo		
		ty video and it showed, during		to the following agencies when			
		ale resident had entered the			applicable: ISDH , APS ,		
		e room for only a short period			Ombudsman ,		
		y did not report the incident to			Licensing/Certification Agency		
	· · · · · · · · · · · · · · · · · · ·	Γhe facility had investigated			Local Police.	,	
		and it to be unsubstantiated.			How the corrective action(s) v	vill	
		eived a call from the hospital			be monitored to ensure the	• • • • • • • • • • • • • • • • • • • •	
	-	told her the resident had a			deficient practice will not recur		
	_	alse allegations of this nature.			i.e., what quality assurance	,	
		w, the DON indicated the			program will be put into place?	· .	
	_	reported the incident.			The Abuse audit tool will be		
	incline, sile ala liave	Topozood uno mioruomi			completed weekly for four wee	ks	
	During an interview	on 3/29/2023 at 2:24 p.m., the			and monthly for six months by		
		ated he received a call on			Administrator.		
		10:30 p.m. and 11:30 p.m. from			Inservice on Resident rights w	as	
		Resident B had been sent to			conducted on 3/23/2023.	45	
		a. He had received a second			The results of these audits will	he	
		the resident was returning to			reviewed in Quality Assurance		
	_	told the hospital another			Meeting Quarterly. The QA	•	
		eet and touched her breast.			Committee will identify any tre	nds	
		eet and touched her breast.			or patterns and make	ilus	
		stated this type of behavior			recommendations to revise the	_	
		is resident. The Administrator			plan of correction as indicated		
		t learned the police were called			piail of correction as indicated	•	
		3/29/2023. He did not think he					
		e incident because the hospital					
	had reported it.	merdent occause the nospital					
	nau reporteu it.						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E064	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			SURVEY ETED 2023
	PROVIDER OR SUPPLIER		B. WI	STREET A 505 N G	ADDRESS, CITY, STATE, ZIP COD	03/30/	2020
BROOKS	SIDE CARE STRAT	EGIES 		MUNCI	E, IN 47303		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	PREVENTIONS A provided by the DO indicated the follow allegations of abuse ISDH within 2 hour Administrator"	facility policy, titled "ABUSE ND PROHIBITION POLICY," IN on 3/29/2023 at 12:51 p.m., ring: " PROCEDURE: Allneeds to be reported to the res of being reported to the root being reported to the root. 100. 110					
F 0610 SS=D Bldg. 00	§483.12(c) In resp abuse, neglect, ex the facility must:	nt/Correct Alleged Violation conse to allegations of cploitation, or mistreatment, re evidence that all alleged					
	substitution with the substitution of the subs	oughly investigated. vent further potential abuse, on, or mistreatment while in progress. out the results of all the administrator or his or oresentative and to other ance with State law, ate Survey Agency, within the incident, and if the investigated appropriate must be taken.	E 0.0	510	The filling of the plan of correct	tion.	04/28/2022
	failed to conduct a convestigation of an a	and record review the facility complete and through allegation of abuse for 1 of 4 for abuse. (Resident B)	F 06	010	The filing of the plan of correct does not constitute an admiss that the alleged deficiency did fact exist. This plan of correcti	ion in	04/28/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15E064	B. W	ING		03/30/	2023
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	t .			GAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES			E, IN 47303		
	Г					1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	ì ·	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	+	TAG			DATE
	E' 1' ' 1 1				is filed as evidence of the facil	lity's	
	Findings include:				desire to comply with the		
	D	2/20/2022 4.0.50			requirements and continue to		
	_	on 3/29/2023 at 9:50 a.m.,			provide quality care.		
		d Resident E had entered her			The facility respectfully reques	sts	
		feet. The resident indicated			paper review for compliance.		
	her feet were very sensitive and Resident E had) NATI (
	caused significant pain. Resident E had also				What corrective action(s) will		
	"loved on" her breast. She had blown a whistle				accomplished for those reside		
		for help during the incident			found to have been affected by	ру	
		d Resident E to leave. The			the deficient practice?	,	
		g a whistle in her right hand			1. Resident B was assessed		
		v and indicated she kept it with			psychosocial distress, none no	oted	
	her at all times for s	safety.			and is free from abuse.		
	D	2/20/2022 4 10 21			2. Resident E was redirected		
	_	y on 3/29/2023 at 10:21 a.m.,			safe place if getting to close to		
		ate of Resident B, indicated			other residents with increased		
		their room and she told him to			aggravation. SSD to send refe	erral	
		lid not leave and walked to			for evaluation at Indy		
		f the room. Resident C			Neuropsychic.		
		see Resident B's bed and saw			How will you identify other	4	
	_	ne bed and lay on Resident B's			residents having the potential		
		dicated Resident B blew her			be affected by the same defic	cient	
		es to call for help and Resident			practice and what corrective		
		tht. Staff came and removed			action will be taken?	.14-	
		eir room. Resident C indicated er what she witnessed or			All residents have the potentia		
					be affected by the alleged def	icient	
	anything about the	meident.			practice.		
	A progress noted d	ated 3/18/2023 at 12:09 a.m.,			The clinical team will review th		
		B had called the police with an			24-hour report daily and sign of		
		assault. The resident denied			What measures will be put into		
	_	interviewed by the police and			place or what systemic chang		
		mplained of pain in both feet.			you will make to ensure that to deficient practice does not re-		
		ken to the hospital for				cui !	
	evaluation.	Ken to the hospital for			The abuse policy will be review	wed	
	CvaruatiOII.				The abuse policy will be review	weu	
	During an interview	on 3/29/2023 at 11:18 a.m., the			and updated if needed to the		
	_	(DON) indicated, on			section pertaining to sexual allegations, and staff will be		
	1	working late and the police had			in-service on the undate/ police	v on	
1	1 3/1//2023. SHE WAS	WOLKING IAM AND THE DOUGH HAD			T THE SELVICE OF THE HOUSTE/ DONG	.w t 11 1	

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E064	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/30/2023		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 505 N GAVIN ST MUNCIE, IN 47303				
	SUMMARY: (EACH DEFICIEN REGULATORY OR arrived in response of sexual assault. T called the police. The called them. Paramethe facility and polices resident indicated share feet and she was resident was transperevaluation. The DO reviewed the securithe day, only one more room and was in the of time. The facility allegation and found investigation was in The facility did not Agency. The facility had received manager, who told to find making false alled the interview, the Doshould have reported. During an interview Administrator indicated he had no to the facility until facility and had resident sat on her for the DON had a correspondent to the facility until facility unti	EGIES STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION to a 911 call for an allegation the facility did not know who ne police said Resident B had edics also responded. When ce interviewed Resident B, the ne called because of pain in inted to go to the hospital. The orted to the hospital for ON indicated the facility had ty video and it showed, during ale resident had entered the e room for only a short period by had investigated the d it to be false. The facility the resident's clinical record. The report the incident to the State ty had investigated the it to be unsubstantiated. The d a call from the hospital case her the resident had a history gations of this nature. During ON indicated the facility			DATE 3 , or the will ir, ?? . et a the onth Il be ce ends ne d.		
	had reported it.						

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

PRINTED: 04/25/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED			
		15E064	B. WING		03/30/2023			
			STREET	ADDRESS, CITY, STATE, ZIP COD				
NAME OF P	PROVIDER OR SUPPLIER	t e e e e e e e e e e e e e e e e e e e	505 N GAVIN ST					
BROOKSIDE CARE STRATEGIES			MUNCIE, IN 47303					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
	A current undated facility policy titled "Abuse							
	Prevention and Prohibition Policy," provided by							
	the DON on 3/29/2023 at 12:51 p.m. indicated the							
	_	edure: a. Investigation of						
	abuse: When an inc	eident or suspected incident of						
	abuse is reported, th	ne Administrator or designee						
	will investigate the	incident with the assistance of						
	appropriate personnel. The investigation will							
	include:							
	i.Who [sic] was inv							
	ii.Residents'[sic] sta	itements						
	a.For [sic] non-verbal residents, cognitively							
	impaired residents or residents who refuse to be							
	interviewed, attempt to interview residents first. If							
	unable, observe resident, complete an evaluation							
	of resident behavior, affect and response to							
	interaction, and document findings							
	iii.Resident's [sic] roommate statements (if							
	applicable)							
	iv.Involved [sic] staff and witness statements of							
	events.							
	v.A [sic] description of the resident's behavior							
	and environment at the time of the incident"							
	No further information was provided. Cross reference F600.							
	This Federal tag rel	ates to complaint IN00404302.						
	3 1-28(d)							

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