STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E064	A. BUILDING 00 B. WING	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE CARE STRATEGIES	505 N GAVIN ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00404302. 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 Type: Medicaid: 36 Other: 1 Total: 37 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 4, 2023.	F 0000		
F 0600 SS=G Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Derrek Keith	HFA	04/22/2023

Any defiencystatement 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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	chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, record review and interview the facility failed to prevent physical abuse of a dependent resident (Resident B) by another resident (Resident E) for 1 of 4 residents reviewed for abuse. This deficient practice resulted in Resident B being sent to the hospital for evaluation of pain and experiencing fear for safety and ridicule when returning to the facility. Findings include: During an interview on 3/29/2023 at 9:50 a.m., Resident B indicated Resident E had entered her room and sat on her feet. The resident indicated her feet were very sensitive and Resident E had caused significant pain. Resident E had also "loved on" her breast. She had blown a whistle several times to call for help during the incident and repeatedly asked Resident E to leave. The resident was holding a whistle in her right hand during the interview and indicated she kept it with her at all times for safety. During an interview on 3/29/2023 at 10:21 a.m., Resident C, roommate of Resident B, indicated Resident E entered their room and she told him to leave. Resident E did not leave and walked to Resident B's side of the room. Resident C indicated she could see Resident B's bed and saw Resident E get on the bed and lay on Resident B's feet. Resident C indicated Resident B blew her whistle several times to call for help and Resident	F 0600	The filing of the plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and continue to provide quality care. The facility respectfully requests paper review for compliance. It is the policy of this provider that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident B was assessed for psychosocial distress, none noted and is free from abuse. 2. Resident E was redirected to safe place if getting to close to other residents with increased aggravation. Requested from NP to send for evaluation at Indy Neuropsychic. How will you identify other residents having the potential to be affected by the same deficient	04/28/2023

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	C put on the call light. Staff came and removed Resident E from their room. Resident C indicated no one had asked her what she witnessed or anything about the incident. During an interview on 3/29/2023 at 12:50 p.m., CNA 5 indicated Resident E was physically strong. The CNA did not believe Resident E had the cognitive ability to know how to climb onto Resident B's bed. Resident B kept the bed in a higher position. During an interview on 3/29/2023 at 11:18 a.m., the Director of Nursing (DON) indicated, on 3/17/2023, she was working late and the police had arrived in response to a 911 call for an allegation of sexual assault. The facility did not know who called the police. The police said Resident B had called them. Paramedics also responded. When the facility and police interviewed Resident B, the resident indicated she called because of pain in her feet and she wanted to go to the hospital. The resident was transported to the hospital for evaluation. The DON indicated the facility had reviewed the security video and it showed, during the day, only one male resident had entered the room and was in the room for only a short period of time. The police call report, provided by the Administrator on 3/30/2023 at 9:05 a.m., indicated the 911 call came in on 3/17/2023 at 11:41 p.m. The report indicated the resident alleged another resident sat on her feet and laid on top of her. The resident requested an ambulance due to pain in her feet and demanded to talk to a police officer. The police report indicated the DON told officers the security cameras showed no one had entered the resident's room.		practice and what corrective action will be taken? Residents that reside at the facility may be affected by the alleged deficient practice. Staff members have been educated on 4/24/23 by the ADON on abuse and answering call lights. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not reoccur. Staff have been re-educated on 4/1/23 on reporting suspected abuse immediately. Inservice on 4/24/23 will be conducted on abuse for all 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? 2. Clinical Documentation Audits will be performed by Social Services/or Administrator 2 x weekly x 4 weeks, then monthly x 3 months. The Abuse audit tool will be completed weekly for four weeks , and monthly for six months by the Administrator. The results of these audits will be reviewed in Quality Assurance Meeting Quarterly. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	During a interview on 3/31/2023 at 10:44 a.m., the hospital Case Manager indicated the DON had indicated the facility security video showed Resident E was in Resident B's room for approximately ten seconds. The DON told the Case Manager Resident E would have been unable to climb onto Resident B's bed. The Case Manager indicated they had known the resident for several years and Resident B had a diagnoses of Post Traumatic Stress Disorder and the cause was believed to be sexual in nature. The hospital discharge report, dated 3/18/2023, indicated Resident B alleged another resident entered her room and sat on her feet, climbed on the bed, and fondled her breast. The resident denied sexual assault stating the other resident did not know what he was doing. The resident was medicated with Toradol (analgesic) for pain. The resident did not want to press charges and did not want to return to the facility, due to not feeling safe. The resident reported hyperalgesia (increased pain or sensitivity) in the feet and had increased pain in bilateral feet since the incident. The resident was also bothered by the facility staff telling EMS they were sorry for wasting their time while they were transporting the resident out of the facility, and felt her concerns were not being taken seriously. Review of hospital bilateral ankle x-rays, dated 3/18/2023, indicated no acute displaced fractures, symmetric dorsal soft tissue swelling of feet, and severe bone demineralization due to patient being non-ambulatory as a result of cerebral palsy. An undated, written statement by CNA 2 indicated at 8:40 a.m. (no date given) Resident B's whistle was heard. The CNA entered the room and found Resident E leaning on the resident's			

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	wheelchair, eating one of her cupcakes. Resident B told the CNA that Resident E had been on her chair and never indicated anything about Resident E assaulting her. During an interview on 3/29/2023 at 12:23 p.m., CNA 2 confirmed the written statement. The CNA indicated she forgot to date the statement but it was written a couple of days after the incident. The incident happened the day after Resident B's birthday, because Resident E was eating the birthday cupcakes provided by the DON. During an interview on 3/29/2023 at 12:57 p.m., CNA 6 indicated the day of the incident she had heard Resident B blowing her whistle and CNA 2 had responded. Review of the facility security audio/video for 3/17/29023 at 8:24 a.m. through 9:07 a.m., completed on 3/20/2023 at 11:00 a.m. with the Assistant Director of Nursing (ADON), indicated the following: a. At 8:25 a.m. Resident E was seen entering Resident B's room. b. At 9:02 a.m. a whistle could be heard being blown multiple times. c. At 9:05 a.m. a staff member was observed passing the room, while the whistle was being blown, without investigating. d. At 9:07 a.m. Resident E was seen leaving Resident B's room. He had been in the room a total of 42 minutes. No staff member was observed entering or leaving the resident's room during the time period reviewed on the video. During an interview at the time of the video			

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	review, the ADON indicated she had not been in the facility during the day on 3/17/2023, but had been working that night. The ADON indicated she was present when the police arrived and reported Resident B had made an allegation of sexual assault. The DON told her Resident B had denied the sexual assault and was sent to the hospital for pain in her feet. The ADON indicated Resident E was strong enough to climb onto Resident B's bed. 1. The clinical record for Resident B was reviewed on 3/29/2023 at 9:11 a.m. Diagnoses included, cerebral palsy, scoliosis, post-traumatic stress disorder, anxiety, depression, borderline personality disorder, and paranoid personality disorder. The most recent admission Minimum Data Set (MDS) assessment, dated 1/30/2023, was reviewed on 3/29/2023 at 9:11 a.m. The MDS indicated the resident required extensive assistance of 2 persons for bed mobility, transfers, toilet use, personal hygiene and dressing. The resident had impairment in the upper and lower extremities on both sides. Resident B was assessed as being cognitively intact. A progress noted, dated 3/18/2023 at 12:09 a.m., indicated Resident B had called the police with an allegation of sexual assault. The resident denied sexual assault when interviewed by the police and facility staff, but complained of pain in both feet. The resident was taken to the hospital for evaluation. 2. During an observation on 3/29/2023 at 1:40 p.m., Resident E was going from sit to stand without assistance, and was ambulating in the hallway independently.			

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	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. Resident E had a care plan, dated 2/6/2023, 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.			

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	An undated policy, titled "ABUSE PREVENTIONS AND PROHIBITION POLICY," provided by the DON on 3/29/2023 at 12:51 p.m., indicated the following: "...PURPOSE: To ensure the resident's right to remain free from...physical abuse...POLICY...Residents residing in this facility will be treated with dignity and respect in accordance with their individual needs. They will not be subjected to physical...abuse...." This Federal tag relates to complaint IN00404302. 3.1-27(a)(1)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.			

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	§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview, and record review, the facility failed to report abuse to the State Agency for 1 of 3 abuse incidents reviewed for reporting to State Agency (Resident B and Resident E). Findings include: During an interview on 3/29/2023 at 9:50 a.m., Resident B indicated Resident E had entered her room and sat on her feet. The resident indicated her feet were very sensitive and Resident E had caused significant pain. Resident E had also "loved on" her breast. She had blown a whistle several times to call for help during the incident and repeatedly asked Resident E to leave. The resident was holding a whistle in her right hand during the interview and indicated she kept it with her at all times for safety. During an interview on 3/29/2023 at 10:21 a.m., Resident C, roommate of Resident B, indicated Resident E entered their room and she told him to leave. Resident E did not leave and walked to Resident B's side of the room. Resident C indicated she could see Resident B's bed and saw Resident E get on the bed and lay on Resident B's feet. Resident C indicated Resident B blew her whistle several times to call for help and Resident C put on the call light. Staff came and removed Resident E from their room. Resident C indicated no one had asked her what she witnessed or anything about the incident.	F 0609	F609 The filing of the plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and continue to provide quality care. The facility respectfully requests paper review for compliance. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident allegations of abuse have been reported to ISDH. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents have the potential to be affected by the alleged deficient practice. · Nurses fill out a daily check list, then turn into nursing administration. If any allegations of abuse will be reported to the Executive Director immediately, reported to ISDH,	04/28/2023

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	During an interview on 3/29/2023 at 11:18 a.m., the Director of Nursing (DON) indicated, on 3/17/2023, she was working late and the police had arrived in response to a 911 call for an allegation of sexual assault. The facility did not know who called the police. The police said Resident B had called them. Paramedics also responded. When the facility and police interviewed Resident B, the resident indicated she called because of pain in her feet and she wanted to go to the hospital. The resident was transported to the hospital for evaluation. The DON indicated the facility had reviewed the security video and it showed, during the day, only one male resident had entered the room and was in the room for only a short period of time. The facility did not report the incident to the State Agency. The facility had investigated the incident and found it to be unsubstantiated. The facility had received a call from the hospital case manager, who told her the resident had a history of making false allegations of this nature. During the interview, the DON indicated the facility should have reported the incident. During an interview on 3/29/2023 at 2:24 p.m., the Administrator indicated he received a call on 3/17/2023 between 10:30 p.m. and 11:30 p.m. from the DON indicating Resident B had been sent to the hospital for pain. He had received a second call informing him the resident was returning to the facility and had told the hospital another resident sat on her feet and touched her breast. The DON had a conversation with the hospital case manager, who stated this type of behavior was common for this resident. The Administrator indicated he had not learned the police were called to the facility until 3/29/2023. He did not think he needed to report the incident because the hospital had reported it.		and investigated. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · All staff in-serviced by the ADON by April 24, 2023, on the Abuse Prohibition, Reporting and Investigation Policy and Procedures · Reporting pending investigation immediately and at the conclusion of the investigation will be reported to the following agencies when applicable: ISDH , APS , Ombudsman , Licensing/Certification Agency , Local Police. 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? · The Abuse audit tool will be completed weekly for four weeks , and monthly for six months by the Administrator. Inservice on Resident rights was conducted on 3/23/2023. The results of these audits will be reviewed in Quality Assurance Meeting Quarterly. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	An undated, current facility policy, titled "ABUSE PREVENTIONS AND PROHIBITION POLICY," provided by the DON on 3/29/2023 at 12:51 p.m., indicated the following: "... PROCEDURE: All allegations of abuse...needs to be reported to the ISDH within 2 hours of being reported to the Administrator...." Cross reference F600. This Federal tag relates to complaint IN00404302. 3.1-28(c)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review the facility failed to conduct a complete and through investigation of an allegation of abuse for 1 of 4 residents reviewed for abuse. (Resident B)	F 0610	The filing of the plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction	04/28/2023

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	Findings include: During an interview on 3/29/2023 at 9:50 a.m., Resident B indicated Resident E had entered her room and sat on her feet. The resident indicated her feet were very sensitive and Resident E had caused significant pain. Resident E had also "loved on" her breast. She had blown a whistle several times to call for help during the incident and repeatedly asked Resident E to leave. The resident was holding a whistle in her right hand during the interview and indicated she kept it with her at all times for safety. During an interview on 3/29/2023 at 10:21 a.m., Resident C, roommate of Resident B, indicated Resident E entered their room and she told him to leave. Resident E did not leave and walked to Resident B's side of the room. Resident C indicated she could see Resident B's bed and saw Resident E get on the bed and lay on Resident B's feet. Resident C indicated Resident B blew her whistle several times to call for help and Resident C put on the call light. Staff came and removed Resident E from their room. Resident C indicated no one had asked her what she witnessed or anything about the incident. A progress noted, dated 3/18/2023 at 12:09 a.m., indicated Resident B had called the police with an allegation of sexual assault. The resident denied sexual assault when interviewed by the police and facility staff, but complained of pain in both feet. The resident was taken to the hospital for evaluation. During an interview on 3/29/2023 at 11:18 a.m., the Director of Nursing (DON) indicated, on 3/17/2023, she was working late and the police had		is filed as evidence of the facility's desire to comply with the requirements and continue to provide quality care. The facility respectfully requests paper review for compliance. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · 1. Resident B was assessed for psychosocial distress, none noted and is free from abuse. 2. Resident E was redirected to a safe place if getting to close to other residents with increased aggravation. SSD to send referral for evaluation at Indy Neuropsychic. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents have the potential to be affected by the alleged deficient practice. The clinical team will review the 24-hour report daily and sign off. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · The abuse policy will be reviewed and updated if needed to the section pertaining to sexual allegations , and staff will be in-service on the update/ policy on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E064	A. BUILDING 00 B. WING	03/30/2023

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	arrived in response to a 911 call for an allegation of sexual assault. The facility did not know who called the police. The police said Resident B had called them. Paramedics also responded. When the facility and police interviewed Resident B, the resident indicated she called because of pain in her feet and she wanted to go to the hospital. The resident was transported to the hospital for evaluation. The DON indicated the facility had reviewed the security video and it showed, during the day, only one male resident had entered the room and was in the room for only a short period of time. The facility had investigated the allegation and found it to be false. The facility investigation was in the resident's clinical record. The facility did not report the incident to the State Agency. The facility had investigated the incident and found it to be unsubstantiated. The facility had received a call from the hospital case manager, who told her the resident had a history of making false allegations of this nature. During the interview, the DON indicated the facility should have reported the incident. During an interview on 3/29/2023 at 2:24 p.m., the Administrator indicated he received a call on 3/17/2023 between 10:30 p.m. and 11:30 p.m. from the DON indicating Resident B had been sent to the hospital for pain. He had received a second call informing him the resident was returning to the facility and had told the hospital another resident sat on her feet and touched her breast. The DON had a conversation with the hospital case manager, who stated this type of behavior was common for this resident. The Administrator indicated he had not learned the police were called to the facility until 3/29/2023. He did not think he needed to report the incident because the hospital had reported it.		4/24/23. DON/ADON or designee will conduct residents interviews 3 residents a week for 6 weeks, than One resident interview for the next 6 weeks. 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? · The Administrator will conduct a Abuse Audit once a week for the next 8 weeks, than twice a month for the next 6 months. The results of these audits will be reviewed in Quality Assurance Meeting Quarterly. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Staff will also be giving a quiz relation to abuse, if staff gets below a 80%, they will be re-educated on abuse.	

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	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 following: "...Procedure: ... a. Investigation of abuse: When an incident or suspected incident of abuse is reported, the Administrator or designee will investigate the incident with the assistance of appropriate personnel. The investigation will include: i.Who [sic] was involved ii.Residents'[sic] statements 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 relates to complaint IN00404302. 3.1-28(d)			