STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT LAPORTE	2002 ANDREW AVE LA PORTE, IN 46350

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00440038. Complaint IN00440038 - State deficiencies related to the allegations are cited at R052. Survey date: August 13, 2024 Facility number: 010890 Residential Census: 104 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 8/19/24.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense Based on record review and interview, the facility failed to ensure interventions to prevent resident-to resident abuse perpetrated by a cognitively impaired resident (Resident C) were effectively implemented to prevent further abuse directed towards other cognitively impaired residents who resided on the Memory Care Unit (MCU) for 4 of 4 residents reviewed for abuse. (Residents F, E, D, and B) This deficient practice resulted in the escalation of resident-to-resident abuse perpetrated by Resident C, Resident F and Resident D being punched, Resident E and Resident B being pushed to the floor, and Resident B sustaining a laceration above the right eye, a swollen right eye, a swollen right knee, a skin tear to the right knee, and a skin tear to the right elbow which required hospital evaluation.	R 0052	**Plan of Correction** **Name of Community** **Brentwood 2002 Andrew Ave** **Laporte, IN 46350** **Date** 9/5/2024 **Section / Tag** **Violation** **Appeal?** **Plan of Correction** **Complete?** **R 0052** 410 IAC 16.2-5-1.2(v)(1-6)	10/01/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Smith	DON	09/05/2024

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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	Using the reasonable person concept, it is likely this deficient practice would lead to chronic anxiety or fear for the other residents on the Memory Care Unit. Findings include: An IDOH (Indiana Department of Health) Facility Reported Incident, dated 3/6/24, indicated Resident C was being assisted to his room by a CNA when he turned and walked the other direction. Another CNA rounded the corner and saw Resident C punch Resident F in the chest twice. The residents were separated and assessed for injury. No physical injury was noted. Preventative measures added indicated, on 3/7/24, the Nurse Practitioner conducted a medication review. An IDOH Facility Reported Incident, dated 6/20/24, indicated Resident E had an unwitnessed fall and had claimed another resident had pushed her. On 6/21/24, management and nursing reviewed camera footage and saw Resident C push Resident E to the floor. Resident E was complaining of pain and was sent to the hospital for evaluation. Preventative measures added indicated the Nurse Practitioner reviewed Resident C's medications due to increased aggression towards staff and residents. An IDOH Facility Reported Incident, dated 7/5/24, indicated CNA heard a resident yelling, "stop hitting her", CNA looked up and saw Resident C punch Resident D in the shoulder twice. No injuries were noted to either resident. Preventative measures added indicated Resident C was sent to the hospital for a psychological evaluation. An IDOH Facility Reported Incident, dated		Residents' Rights - Offense ___ Yes _X_ No What Has Been Done to Correct? This plan of correction is not to be construed as an admission of, or agreement with the findings and conclusions in the statement of deficiencies. This Plan of Correction is being submitted as required by the regulation. Resident removed from the facility to ensure the well-being of other residents, while residents that were affected were immediately separated from the situation and are being engaged in activities to prevent future reoccurrence. During pre-admission assessments potential residents will be screened and will not be admitted if they have a history of violent or aggressive behaviors. All residents with psych diagnosis will be set up with psych services upon admission. All staff were in-serviced on abuse policy and procedures. Staff were in-serviced on proper interventions for resident-to-resident incidents. Staff and memory care coordinator worked together to add more activities to the memory care calendar to keep residents engaged throughout the day. DON made and in-serviced staff on new resident to resident form and procedures. ____ Yes	

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	7/31/24, indicated Resident C was observed forcibly pushing Resident B down in the Memory Care Coordinator's office. The resident had a laceration above the right eye, a swollen right eye, swollen right knee, a skin tear to the right knee and a skin tear to the right elbow. Resident C's record was reviewed on 8/13/24 at 9:33 a.m. The resident was admitted to the facility on 9/25/23. Diagnoses included, but were not limited to, unspecified dementia, delirium due to known physiological condition, and general anxiety disorder. Resident C resided on the locked memory care unit. The resident's Behavior Notes included, but were not limited to, the following entries: 3/3/24 - The resident was inappropriate with other residents, observed attempting to touch the legs of another resident. 3/11/24 - The resident was walking through the unit and his pants were noted to be falling down. The CNA attempted to assist him with his pants and he hit her. 3/18/24 - The resident was upset with a CNA, yelling at her calling her a b**ch and banging his fist on the wall. He then went to the nurses' station door and started punching it. 3/30/24 - The resident was screaming and yelling obscenities at another resident and staff, saying he would fu**ing kill them because he wanted another resident's chocolate. 4/9/24 - Staff was assisting the resident on the toilet attempting to change his pants, he was cussing and punched the staff member in the stomach. 4/20/24 - a CNA put away a pair of women's boots he was trying to put on, the resident followed her to the family room and punched her in the jaw. 5/8/24 - The resident had been found on the floor.		____ No How Will Recurrence Be Prevented? All resident-to-resident occurrences will be reviewed at time of incident. Residents will be separated, checked for injuries, and vitals will be obtained at the time of the incident. CNA's will be assigned to engage each resident in activities. Families will be called to set up a care plan meeting. DON will reach out to MD to consult for medication review or to see if resident should be sent out for evaluation. Residents will be monitored for 72 hours after the incident. All resident-to-resident occurrences will be reviewed during the monthly QA meetings. DON will audit all incident reports twice weekly x3 months, then once weekly indefinitely. Person Responsible: DON and ED Due Date: 10/01/24	

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	Upon assessment, the resident became aggressive and combative multiple times with staff, shoving them into a wall and causing staff to hit their head on the wall. 5/21/24 - Writer saw the resident's hands raised, standing by another resident who was yelling "Get away from me". 6/16/24 - The resident grabbed a desert bowl from another resident. When asked to please put the food back on the table, the resident shoved this writer and swung to hit, the resident then threw the food dish and was yelling and cursing. Fellow residents were scared of this resident's behaviors. 7/2/24 - Resident C came up to the medication cart and punched the laptop and walked away, yelling profanities. Two female residents came up and said he needs to be gone. Writer reassured them they were ok and redirected them to the dining room. 7/5/24 - a CNA was assisting the resident getting a shirt on and the resident punched her in the chest. Per the IDOH Facility Reported Incident, dated 3/6/24, the Nurse Practitioner conducted a medication review for Resident C on 3/7/24. A Quarterly Level of Care assessment, dated 6/10/24, indicated the resident had behaviors of confusion, irritability, aggression and wandering. The resident got upset if someone touched his right hand or arm. A peer would at times try to hold his hand when walking down the hallway and he would try to smack or punch at them. An intervention included staff should watch if a peer was walking beside him and redirect one of them. After the incident on 6/20/24, the Nurse Practitioner reviewed Resident C's medications due to increased aggression towards staff and			

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	residents. Resident C was sent to the hospital for evaluation on 7/5/24 and transferred to a Neurobehavioral Hospital on 7/6/24. He returned to the facility on 7/15/24. There was no change to the resident's medications. Redirection, distraction, and talking with his wife were interventions and coping strategies identified. After the incident on 7/31/24, Resident C was transferred to the hospital for evaluation due to the altercation. A Service Plan, undated, indicated the resident had been physically aggressive (to other residents) on dates that included, but were not limited to, 3/6/24, 6/21/24, 7/5/24 and 7/31/24. Interventions were to call for assistance if behavior was a threat to themselves or others, resident to be receptive to team member interventions of validation of feeling and redirection when agitation occurs, analyze triggers and what de-escalates behaviors and a medication review by the Nurse Practitioner. There were no other consistent, effective interventions documented to indicate the facility put a plan in place to protect the other MCU residents from physical abuse by Resident C. An Alert Note, dated 8/2/24, indicated the hospital had stated Resident C was transferred to a behavioral hospital. He had not returned to the facility. Resident F's record was reviewed on 8/13/24 at 2:27 p.m. Diagnoses were dementia, hypertension and osteoporosis. The resident resided on the locked memory care unit.			

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	An Incident Note, dated 3/6/24, indicated a CNA had reported Resident F had been hit on the chest twice by another resident. Resident F was in her room scared, but no physical injury noted. The CNA who witnessed the event took immediate action by separating the residents. "This writer talked to Resident F and was able to calm her down a little. Checked the resident for chest injury and none was noted." Resident E's record was reviewed on 8/13/24 at 12:45 p.m. Diagnoses included, but were not limited to dementia, blindness, angina and hypertension. She resided on the locked memory care unit. An Incident Note, dated 6/20/24, indicated Resident E was heard yelling for help in the common area and found lying on her back. Resident E was alert with some confusion and complaining of pain to her neck and pelvis. A male resident was hovering over her. When asked how she fell, she answered she felt someone push her. As she was legally blind, she was unable to say who had pushed her. The resident was sent to the hospital for evaluation. A Progress Note, dated 6/23/24, indicated Resident E was doing well from the previous fall. "Hospital cleared of serious injury. Resident had a shower today and CNA noticed a small bruise to the back of her head." A Skin/ Wound Note, dated 6/25/24, indicated the resident had a 3.5 centimeter (cm) x 2 cm bruise on the back of her head related to the prior fall. Resident D's record was reviewed on 8/13/24 at 1:20 p.m. Diagnoses included, but were not limited			

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	to, unspecified dementia, major depressive disorder and malignant neoplasm of breast. She resided on the locked memory care unit. An Incident Note, dated 7/5/24, indicated a fellow resident was yelling in the dining room, the CNA looked up and another resident was punching Resident D in the shoulder several times, this resident was sitting by herself at a dining room table. Staff immediately separated the residents and assessed for physical injury. No injury was noted. Resident B's record was reviewed on 8/13/24 at 11:36 a.m. Diagnoses included, but were not limited to, unspecified dementia, major depressive disorder and hypertension. The resident resided on the locked memory care unit. An Incident Note, dated 7/31/24, indicated Resident C was observed pushing Resident B, who fell and landed on her right side. Resident B was laying on her right side with a large laceration to the right side of her forehead, which was dripping profusely with blood. There was a large pool of blood under her head. Resident B also had skin tears to left hand, right knee, right elbow, and complained of right hip pain. First aid was rendered until EMS (Emergency Medical Services) arrived and transported Resident B to the hospital for evaluation. During an interview on 8/13/24 at 10:45 a.m., the Memory Care Coordinator indicated Resident C had "lots of behaviors." The staff would provide care in pairs, as some of the staff were afraid of him. Staff would try to keep him occupied and he was usually easy to redirect. Some of the residents would express they were afraid of him, but it was the dementia unit, and they would			

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	quickly forget. During an interview on 8/13/24 at 11:18 a.m., the Director of Nursing (DON) indicated Resident C would be calm, then as if a switch was flipped, he would become combative. She had discussed not allowing the resident to return with the Executive Director (ED) after he was sent to the behavioral hospital July 6, but the hospital had assured them he was fine and could return. During an interview on 8/13/24 at 1:47 p.m., the Executive Director (ED) indicated they had hoped his last admission to the behavioral hospital would have helped, but they were not going to allow the resident to return. The facility policy titled, "Elder Abuse Policy", was reviewed and did not pertain to the above citation. There was nothing in the facility's abuse policy to indicate the facility's plan for preventing resident to resident abuse. This citation relates to Complaint IN00440038.			