| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00416462.<br><br>Complaint IN00416462 - No deficiencies related to the allegations are cited.<br><br>Survey dates: January 18, 19, 22, 23, 24, and 25, 2024.<br><br>Facility number: 012901<br>Provider number: 155814<br>AIM number: 201215100<br><br>Census Bed Type:<br>SNF: 9<br>SNF/NF: 79<br>Total: 88<br><br>Census Payor Type:<br>Medicare: 9<br>Medicaid: 61<br>Other: 18<br>Total: 88<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on February 8, 2024. | F 0000 | The submission of this plan of correction does not constitute an admission or an agreement of the truth of the facts or correction set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted in accordance with requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance as of January 26th, 2024. | |
| F 0558<br>SS=E<br>Bldg. 00 | 483.10(e)(3)<br>Reasonable Accommodations Needs/Preferences<br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Megan (Miller) Davison | Administrator | 02/20/2024

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | endanger the health or safety of the resident or other residents.<br>Based on observation, interview and record review, the facility failed to ensure call lights were placed within reach for 4 of 4 residents randomly observed for call light placement (Residents 13, 31, 52 and 71).<br><br>Findings include:<br><br>1. On 1/19/24 at 11:38 a.m., Resident 13 was observed during a hall-tray lunch meal service. She was seated in her wheelchair at the foot of her bed. Her bed was neatly made but her call light was observed draped on top of the mattress near her pillow. The call light was out of sight and out of reach.<br><br>During an interview on 1/19/24 at 11:40 a.m., Resident 13 indicated she did not like the meal because it was fried fish, and she did not like any fish. When asked if she could call and ask for an alternative meal, Resident 13 indicated she thought she had a "call button," but did not know where it was, so not to bother with it.<br><br>On 1/19/24 at 11:50 a.m., CNA 8 and an unidentified Dietary aide returned with a new lunch tray. Resident 13 was provided with a fresh garden salad and a peanut butter and jelly sandwich. The staff helped her set up her tray and exited her room. Resident 13's call light remained out of her line of sight and out of reach behind her on the mattress near her pillow.<br><br>On 1/24/24 at 2:30 p.m., Resident 13's medical record was reviewed. She was a long-term care resident who had a diagnosis which included, but was not limited to, a history of falling. | F 0558 | All residents who have the physical ability to utilize a call light have the potential to be affected by this alleged deficient practice.<br>Upon immediate notification of this alleged deficiency, the facility conducted house-wide observations to ensure no other concerns related to call lights were identified. No further concerns were identified.<br>Additionally, the facility initiated ongoing, shift-to-shift education to all its staff regarding the importance of call lights remaining within the reach of the residents.<br>To ensure ongoing compliance, the Director of Nursing/Designee shall be responsible for conducting random observations throughout the facility to ensure all call lights remain within the reach of the facility's residents. On three days of work and for a period of one month, the Director of Nursing/Designee shall conduct four random observations each day. Thereafter, the Director of Nursing/Administrator shall conduct these observations of resident rooms on two days of work per week for a period of two months and one day of work per week for a period of three months.<br>The Quality Assurance Committee shall review the results of the observations and any corrective | 01/26/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | A quarterly Minimum Data Set (MDS) assessment, dated 12/5/23, indicated Resident 13 was only moderately cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 10 of 15.<br><br>She had a comprehensive care plan, revised on 12/8/23, which indicated she was at risk for complications and limited range of motion due to a right shoulder dislocation and osteoarthritis.<br><br>2. On 1/22/24 at 9:54 a.m., Resident 31 was observed. He was seated in his wheelchair at the foot of his bed and indicated he wanted to get into bed. When asked where his call light was, to call for an aide, he shrugged his shoulders and asked the visitor to get his aide. His call light was observed wrapped around the half bed rail, which was positioned behind the resident, out of sight and out of reach.<br><br>On 1/22/24 at 9:55 a.m., a passing CNA was notified Resident 31 wanted to get back into bed.<br><br>On 1/24/24 at 9:15 a.m., Resident 31 was observed. He was seated in his wheelchair at the foot of his bed as he intermittently watched television. At that time his call light was observed out of sight and out of reach, located behind him and wrapped around the bedrail of his bed.<br><br>On 1/24/24 at 10:10 a.m., Resident 31's call light remained out of sight and out of reach, located behind him and wrapped around the bedrail.<br><br>On 1/24/24 at 2:35 p.m., Resident 31's medical record was reviewed. He was a long-term care resident with a diagnosis which included but was not limited to repeated falls. | | action taken during its monthly meetings for a period of no less than six months. Monitoring shall be reviewed/revised as warranted and on the basis of compliance. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | An admission MDS assessment, dated 11/13/23, indicated Resident 31 was cognitively intact with a BIMS score of 13 of 15.<br><br>3. On 1/23/24 at 2:29 p.m., Resident 52 was observed. He was seated in a wheelchair at the foot of his bed. A soft touch call light was observed draped near the end of his bed, but Resident 52 appeared to have limited range of motion. When asked if he could reach his light, he shook his head "no," and demonstrated his limited ability to reach with his arm. He pointed to the bed. When asked if he wanted to get back into bed, he nodded "yes." The call light was pressed for him.<br><br>On 1/23/24 at 2:32 p.m., an unidentified housekeeper knocked and entered Resident 52's room. She turned off his light and left the room. She indicated she would look for the nurse or aide to let them know he wanted to return to bed.<br><br>On 1/23/24 at 3:06 p.m., Resident 52 was observed. He remained in his wheelchair and slowly ambulated into the hallway. He asked a passing staff member if he could lay down. She indicated she would get an aide.<br><br>On 1/24/24 at 2:40 p.m., Resident 52's medical record was reviewed. He was a long-term care resident with a history of a stroke which affected his right dominate side and caused hemiplegia/hemiparesis (muscle paralysis/weakness)<br><br>A quarterly MDS assessment, dated 11/23/23, indicated he was cognitively intact with a BIMS score of 14 of 15.<br><br>He had a comprehensive care plan, revised 1/8/24, | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | which indicated he needed assistance and was at risk for complications related to his history of stroke.<br><br>4. On 1/22/24 at 9:54 a.m., Resident 71 was observed. He was seated in his high back wheelchair at the right-side foot of his bed. His call light was observed wrapped around the left half bedrail and draped on top of the mattress on the left side of the bed. The call light was out of reach. Resident 71 did not speak English but pointed with his right hand to his bed and it appeared he asked to get back into bed. He was unable to use his left arm.<br><br>On 1/22/24 at 9:55 a.m., a passing CNA was notified Resident 71 wanted to get back into bed.<br><br>On 1/22/24 at 11:06 a.m., Resident 71's medical record was reviewed. He was a long-term care resident with a diagnosis which included but was not limited to a history of stroke which affected his left non-dominant side.<br><br>On 1/24/24 at 2:22 p.m., the Infection Preventionist (IP) provided a copy of current facility policy titled, "Call Light," revised 10/2014. The policy indicated, " ...Resident will have a call light to summon facility personnel to ensure the resident's needs will be met. Resident's call light is to be within reach and answered promptly by facility personnel ... offer further services before leaving the room. Ensure call light is within reach. Call lights must remain functional and within reach of the resident ...."<br><br>3.1-3(v)(1) | | | |
| F 0641 SS=D | 483.20(g)<br>Accuracy of Assessments | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| Bldg. 00 | §483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>Based on observation and interview, the facility failed to accurately code the MDS (Minimum Data Set) for 1 of 2 residents reviewed for PASARR (Pre-Assessment Screening and Resident Review) for 1 of 2 residents reviewed for accuracy (Resident 39).<br><br>Findings include:<br><br>During a comprehensive record review on 1/29/24 at 12:36 p.m. Resident 39 had the following diagnoses which included but were not limited to major depressive disorder, anxiety disorder, unspecified dementia with behavioral disturbance, schizoaffective disorder, delirium, and mood disorder.<br><br>Resident had a Level II evaluation to identify the specialized needs of individuals with mental illness, intellectual or developmental disability ID/DD, or both (MI/ID/DD) related to her diagnoses. It was determined on 7/6/2021 that she required level II services.<br><br>She had a MDS completed on 4/25/34. The question, "Is resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition." The answer was "no" indicating resident did not require a level II.<br><br>During an interview with the IP (Infection Preventionist) on 1/23/24 at 2:00 p.m., he indicated the MDS Coordinator informed him, they followed the RAI (Resident Assessment Instrument) for accuracy of MDS assessments and that they did not have a specific policy for accuracy. | F 0641 | All residents who suffer from mental illness have the potential to be affected by this alleged deficient practice.<br>Resident 39's MDS was modified to accurately reflect the need for level II services. Upon immediate notification of this alleged deficiency, the facility initiated education to both the Minimum Data Set (MDS) Coordinator and Director of Nursing related to the accurate coding of level II's on the MDS Assessment. Additionally, the facility conducted a house-wide audit to ensure any other similar inaccuracies were identified. If identified, each resident's MDS Assessment was corrected and submitted with said corrections.<br>To ensure ongoing compliance, the Director of Nursing/Designee is responsible for conducting audits of the MDS Assessment coding to ensure it accurately reflects each resident's need for a level II. Three times a month and for a period of one month, the Director of Nursing shall conduct random audits of the MDS Assessment coding for four residents. The Director of Nursing/Designee shall continue these audits twice monthly for a period of two months. Then, the Director of Nursing/Designee shall | 01/26/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | | | continue these audits monthly for a period of three months. The Quality Assurance Committee shall review the results of these observations and any corrective action taken during its monthly meetings for a period of no less than six months. Monitoring shall be reviewed/revised as warranted and on the basis of compliance. | |
| F 0644 SS=A Bldg. 00 | 483.20(e)(1)(2)<br>Coordination of PASARR and Assessments<br>§483.20(e) Coordination.<br>A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:<br><br>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.<br><br>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.<br>Based on interview and record review, the facility failed to ensure a new Level of Care screen was submitted for a resident (Resident 59) after she received a new mental health illness diagnosis and was ordered a new antipsychotic medication for 1 of 2 residents reviewed for Preadmission Screen and Resident Review (PASRR). | F 0644 | All residents who have mental illness diagnosis have the potential to be affected by this alleged deficient practice.<br>Upon immediate notification of this alleged deficiency, the facility conducted house-wide audits to | 01/26/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | Findings include:<br><br>On 1/19/24 at 10:50 a.m., Resident 59's medical record was reviewed. She was a long-term care resident with diagnoses which include, but were not limited to, unspecified dementia and disorientation with unspecified delirium/hallucinations.<br><br>On 1/6/23, Resident 59 received a new diagnosis of schizoaffective disorder.<br><br>On 1/6/23, Resident 59 received a new physician's order to start Seroquel (an antipsychotic medication) for schizoaffective disorder.<br><br>A PASRR Level I dated, 12/18/20, indicated no level II screen was required as she did not have any serious mental health illness diagnoses.<br><br>The record lacked documentation that a new level of care screen was submitted for Resident 59 after she was newly diagnosed with schizoaffective disorder and prescribed a new antipsychotic medication.<br><br>During an interview on 1/23/24 at 2:00 p.m., the Infection Preventionist (IP) indicated a new level of care should have been submitted according to the Resident Assessment Instrument (RAI) requirements and state regulations. | | ensure that all resident PASSR information and Level I's accurately reflects all mental health diagnoses for each resident. Any other concerns identified were immediately remedied.<br>To ensure ongoing compliance, the Director of Nursing is responsible for conducting audits of the PASSR information to ensure that all mental health diagnoses are accurately reflected on the Level I. Three times a month and for a period of one month, the Director of Nursing shall conduct random audits of the MDS Assessment coding for four residents. The Director of Nursing/Designee shall continue these audits twice monthly for a period of two months. Then, the Director of Nursing/Designee shall continue these audits monthly for a period of three months. The Quality Assurance Committee shall review the results of these observations and any corrective action taken during its monthly meetings for a period of no less than six months. Monitoring shall be reviewed/revised as warranted and on the basis of compliance. | |
| F 0677<br>SS=D<br>Bldg. 00 | 483.24(a)(2)<br>ADL Care Provided for Dependent Residents<br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | hygiene;<br>Based on observation, interview, and record review the facility failed to ensure a resident's toenails were cut to prevent discomfort for 1 of 1 resident reviewed for activities of daily living care (Resident 15).<br><br>Findings include:<br><br>On 1/18/24 at 11:30 a.m., Resident 15 indicated she could not see the podiatrist (foot doctor) to get her toenails cut. She had diabetes and needed his care.<br><br>On 1/22/24 at 11:08 a.m., an observation of Resident 15's toes showed very long, clean toenails. She indicated her daughter had been cutting them when the podiatrist did not see her. She had been in the facility for 4 and a half months. The podiatrist had been here three times and did not see her. She preferred the podiatrist to do her toenails because she was diabetic (blood sugar disorder) and did not want an injury on her foot. The facility had kept telling her she was on the list, but she had not seen him yet.<br><br>On 1/22/24 at 2:28 p.m., the Infection Preventionist (IP) provided the podiatrist's resident list for the 8/14/23, 10/16/23, and 12/18/23 visits. Resident 15 was not on the lists.<br><br>On 1/23/24 at 10:06 a.m., the IP provided the podiatrist's resident list for his next visit on 2/26/24. Resident 15 was not on the list.<br><br>On 1/23/24 at 10:44 a.m., Resident 15 indicated she and her daughter had asked the facility staff several times to be put on the podiatrist resident list. She indicated she worried about her toenails because she had diabetes mellitus. | F 0677 | All residents who require podiatry services have the potential to be affected by this alleged deficient practice.<br>Upon immediate notification of this alleged deficiency, the facility initiated education to the Social Services Director that when an appointment is cancelled that the podiatrist should be immediately contacted and arrangements made for a follow-up visit within a period of thirty (30) days and/or the option of an outpatient appointment presented to the resident/resident representative.<br>To ensure ongoing compliance, the Social Services Director is responsible for ensuring residents receive podiatry services as requested by the facility. On the next working day immediately following each of the podiatrist's visit to the facility, the Social Services Director shall audit the list of referrals provided to the podiatrist with the podiatrist's list of residents to whom he/she performed services. Should a resident who was referred/requested services not have been visited by the podiatrist, the Social Services Director shall be responsible for contacting the podiatrist to ensure the resident will be evaluated and treated within thirty (30) days. If the podiatrist is unable to accommodate this appointment request, the Social | 01/26/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | On 1/23/24 at 11:03 a.m., Resident 15's record was reviewed. She was admitted on 9/5/23. Her diagnoses included, but were not limited to, insulin-dependent diabetes mellitus (disorder in which the amount of sugar in the blood is elevated and insulin was required) with diabetic neuropathy (nerve damage leading to pain, weakness, numbness or tingling in the affected area), age-related debility (state of being weak, feeble, or infirm), epilepsy (brain disorder characterized by repeated seizures), toxic encephalopathy (damage in the brain that can lead to altered mental state), and cerebral infarction (stroke).<br><br>Her insulin medications included but were not limited to Novolog (rapid-acting insulin that helps lower mealtime blood sugar spikes) and Basaglar (long-acting insulin).<br><br>Her epilepsy medication included, but were not limited to, levetiracetam (slows the electrical bursts of activity in the brain).<br><br>Her physician's orders, dated 9/5/23, indicated she may be seen by a podiatrist.<br><br>A nursing progress note, dated 9/8/23, indicated Resident 15's daughter had requested the resident be placed on the podiatry list.<br><br>A nursing progress note, dated 9/15/23, indicated Resident 15's daughter had notified the nurse that she was not seen by the podiatrist.<br><br>A nursing progress note, dated 9/16/23, indicated nursing notified Resident 15's daughter that the podiatrist left earlier due to an emergency. | | Services Director shall be responsible for assisting the resident/resident representative with arranging an outpatient appointment for said services or electing to have the in-house podiatrist provide care at the next available appointment. The Quality Assurance Committee shall review the results of these observations and any corrective action taken during its monthly meetings for a period of no less than six months. Monitoring shall be reviewed/revised as warranted and on the basis of compliance. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | A nursing progress note, dated 12/22/23, indicated Resident 15's daughter indicated Resident 15 was skipped by podiatry again.<br><br>Her care plan, dated 1/21/24, indicated she had a diagnosis of diabetes mellitus. An intervention indicated to refer her to podiatry.<br><br>On 1/23/24 at 11:04 a.m., the Infection Preventionist (IP) indicated the facility did rounds on everyone in the building to create the list of residents who needed to be seen by podiatry on 2/26/24. Resident 15 was not on the list. He indicated he would be sure to add her to the podiatrist list for his next visit to the facility.<br><br>On 1/24/24 at 11:37 a.m., the IP indicated the Certified Nursing Aides (CNA) cannot cut the toenails of diabetes mellitus residents, but the nursing staff can. But the facility preferred the podiatrist to do it.<br><br>On 1/25/24 at 9:31 a.m., Resident 15 indicated her shoes rub on the long toenails. Her shoes push the toes nails down and it's painful, especially the big toes that could be alleviated with a trim.<br><br>On 1/25/24 at 9:41 a.m., IP indicated the podiatrist did not come back to finish the resident on the list in December after his family emergency.<br><br>A podiatry and facility contract, dated 4/23/18, was provided by the IP, on 1/25/24 at 9:05 a.m. A review of the contract indicated, " ...Eligibles person are resident of FACILITY who shall be entitled to received Services ...FACILITY Services and Obligations. FACILITY shall ...requested Services for the Eligible persons ...."<br><br>A policy titled, "Ancillary Companies Servicing | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | Facilities," dated 2023, was provided by the IP, on 1/25/24 at 9:05 a.m. A review of the policy indicated that ancillary service provider must remain educated regarding, " ...Resident Rights, Abuse Prohibition...Elder Justice Act ...." It did not provide information about providing services to residents in a timely manner.<br><br>3.1-39(a)(3)(E) | | | |
| F 0689 SS=D Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, interview, and record review, the facility failed to ensure resident's equipment was maintained and free from the potential for accidents for 1 of 5 residents reviewed for accidents (Resident 33), and failed to ensure medications were not left at bedside for 1 of 5 residents reviewed for accidents (Resident 21).<br><br>Findings include:<br><br>1. On 1/18/24 at 11:07 a.m., Resident 33's bed was initially observed. She had two, half siderails installed to her bed. The bedrail on the right side of the bed was observed to have fallen to the side, and when manipulated was observed to be loose and unsteady. The loose bedrail created a large gap between the mattress and rail. At that time, | F 0689 | All residents who utilize bedrails have the potential to be affected by the alleged deficient practice regarding the maintenance of bedrails. All residents have the potential to be affected by the alleged deficient practice regarding the storage of medications. Resident 33's bedrail was immediately repaired. Resident 21's medications were immediately removed from the room and stored appropriately. Upon immediate notification of this alleged deficiency, the facility conducted house-wide observations of all resident rooms to ensure that all other | 01/26/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | Resident 33 was seated in her wheelchair beside her bed and the plastic/rubber protective endcap of the wheelchair brake extender was observed to be missing so that the blunt metal end was level with her armrest.<br><br>During an interview on 1/18/24 at 11:07 a.m., Resident 33 indicated her bedrail had been like that for some time, but she was still able to use it to get herself in and out of bed. The cap to her wheelchair had been missing for a while and staff were supposed to be getting a replacement.<br><br>On 1/19/24 at 9:46 a.m., Resident 33 was observed lying in bed. She appeared to be asleep at that time, and her bedrail was observed and still leaned away from the mattress. She slept in the middle of the bed.<br><br>On 1/19/24 at 11:05 a.m., Resident 33's bedrail was observed and remained loose and leaned away from the mattress.<br><br>On 1/22/24 at 9:48 a.m., Resident 33 was observed. She sat on the right edge of her bed and used the loose bedrail to transfer herself to a standing position and seated herself in her wheelchair. At that time, the wheelchair brake extender was observed and remained uncapped.<br><br>On 1/23/24 at 9:19 a.m., Resident 33 was observed seated in her wheelchair beside her bed. The brake extender remained uncapped, and her bedrail leaned away from the bed.<br><br>On 1/23/24 at 2:30 p.m., Resident 33 was observed. She lay in the middle of her bed with the lights off and appeared to be asleep. The right bedrail leaned away from the mattress. Her wheelchair was beside the bed, and the brake extender was | | medications were secure and inaccessible to unauthorized staff and that no other bedrails required maintenance. No other concerns similar in nature were identified.<br>The facility immediately initiated on-going, shift-to-shift education to all staff related to the importance of routinely evaluating bedrails to ensure they remain in good repair, reporting concerns related to the condition of bedrails, and the immediate need to repair bedrails when identified as requiring maintenance. Additionally, the facility immediately initiated on-going, shift-to-shift education to all staff related to the immediate reporting of unsecure medications to a licensed nurse.<br>To ensure ongoing compliance, the Administrator/Designee is responsible for conducting random observations to assess the condition of bedrails and to ensure all medications are secure and inaccessible to unauthorized individuals. On three days of work per week and for a period of one month, the Administrator/Designee shall conduct four random observations of resident rooms to assess for bedrails in need of repair and unsecure medications. Thereafter, the Administrator/Designee shall conduct four random observations two days of work per week for a period of two months and one day of work per week for a period of | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | observed to remain uncapped.<br><br>On 1/24/24 at 4:00 p.m., Resident 33's bedrail and wheelchair brake extender were observed with the Infection Preventionist (IP). He indicated the bedrail was too loose and needed to be repaired/tightened, and the extender needed a new cap.<br><br>On 1/24/24 at 2:30 p.m., Resident 33's medical record was reviewed. She was a long-term care resident who had a diagnosis which included, but was not limited to, repeated falls.<br><br>She had a comprehensive care plan, revised on 11/23/23, which indicated she used bilateral half bedrails as a mobility device. Interventions for this plan of care included, but were not limited to, " ... inspect bed rails to ensure the rails properly latch, only appropriate space within the rail, between the rails and mattress, the rails and the head of the bed that could entrap limbs or other body parts that could cause injury or death...."<br><br>ON 1/24/24 at 11:52 a.m., the IP provided a copy of current facility policy titled, "Bed Rail Use," revised 9/2017. The policy indicated, "Bed rails are used, as indicated by resident or per physician's order, as needed to enable the residents to turn and reposition while in bed ... while providing resident care, inspect the bed rails for proper function and ability to lock into place. Report any malfunction to maintenance personnel ...."<br>2. During an observation on 1/18/24 at 10:57 a.m., Resident 21 was sitting in her recliner with her bedside table over her. Sitting on the bedside table were timolol eye drops (used to treat glaucoma), refresh eye drops and orajel ointment.<br><br>During an observation on 1/19/24 at 11:00 a.m. | | three months. The Quality Assurance Committee shall review the results of these observations and any corrective action taken during its monthly meetings for a period of no less than six months. Monitoring shall be reviewed/revised as warranted and on the basis of compliance. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | Resident 21 was sitting in her recliner with her bedside table over her. 2 eye drops (timolol and refresh) were sitting on her table, along with orajel ointment.<br><br>During an observation on 1/22/24 at 10:15 a.m., Resident 21 was not present in her room. She had 2 eye drops (timolol and refresh) sitting on her table. She had a tube of orajel ointment sitting on the table, as well.<br><br>During an interview with Resident 21 on 1/22/24 at 12:24 p.m., she indicated she could not see the label on her eye drops. She knew she had 2. She was unable to feel which eye was which.<br><br>On 1/22/24 at 2:30 p.m., a record review was completed for Resident 21. She had the following diagnoses which included but were not limited to essential hypertension, acute kidney failure, glaucoma, vitamin deficiency, arthritis, osteoporosis, essential tremor, and hyperlipidemia.<br><br>Resident 21 had orders for timolol maleate 0.5%, 1 drop both eyes two times daily, do not administer within 10 minutes of any other eye drop. She had an order for refresh tears 0.5%, 1 drop both eye three times daily. She did not have an order for orajel.<br><br>On 1/23/24 at 2:00 p.m., the Corporate Nurse Consultant indicated her care plan addressed the orajel and oil to flush her ears was on her care plan. He also indicated she did not have a medication self-administration assessment that would allow her to have medications in her room.<br><br>A policy titled, "Storing Drugs" dated 4/2021 was provided by the IP (Infection Preventionist) on | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | 1/22/24 at 1:23 p.m. He indicated to use this policy for medications at bedside. The policy did not contain any information pertaining to medications being at bedside.<br><br>3.1-45(a)(1) | | | |
| F 0693<br>SS=D<br>Bldg. 00 | 483.25(g)(4)(5)<br>Tube Feeding Mgmt/Restore Eating Skills<br>§483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and<br><br>§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.<br>Based on observation, record review, and interview, the facility failed to date feeding and water bags for 1 of 2 residents reviewed for feeding tubes (Resident 78).<br><br>Findings include:<br><br>During an observation on 1/18/24 at 10:57 a.m., | F 0693 | All residents who receive enteral feedings have the potential to be affected by this alleged deficient practice.<br>Resident 78's feeding tube and water bag were labeled appropriately. Upon immediate notification of this alleged | 01/26/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | Resident 78 was observed sitting in his wheelchair next to his bed. He had a bag of Isosource 1.5 with formula inside the bag and a bag with clear fluids hanging on a pole behind him. The feeding was disconnected from the resident. The formula was dated, and the clear fluid was not dated.<br><br>During an observation on 1/19/24 at 10:24 a.m., Resident 78 was sitting up in his wheelchair. He had a bag of Isosource 1.5, with formula in it and a bag of clear fluid. Both bags lacked a date.<br><br>On 1/19/24 at 2:15 p.m., Resident 78 had a bag of Isosource and a bag of clear fluid with no date on them and disconnected from the resident.<br><br>A comprehensive record review was completed on 1/23/24 at 11:05 a.m. He had the following diagnoses which included but were not limited to respiratory failure, obstructive sleep apnea, malignant neoplasm, weakness, heart failure and type 2 diabetes mellitus.<br><br>Resident 78 had orders to administer 75ml of free water via feeding tube every 2 hours via pump.<br><br>Resident 78 had orders to be NPO (Nothing by Mouth).<br><br>He had orders for enteral feeding formula of Isosource 1.5 continuous via tube with pump every shift.<br><br>A policy titled, "Tube Feedings (naso-gastric or gastrostomy tube), with a date of 10/2014, was provided by the IP (Infection Preventionist) It indicated, " ...label feeding bag or container with resident's name, date, and time opened ....".<br><br>3.1-44(a)(2) | | deficiency, the facility conducted house-wide observations to ensure that all other feeding and water bags were dated appropriately. No other concerns were identified. Additionally, the facility initiated ongoing, shift-to-shift education to all licensed staff related to the importance of appropriately labeling feeding and water bags. To ensure ongoing compliance, the Director of Nursing/Designee is responsible for conducting random observations to evaluate the appropriate labeling of feeding and water bags. On three days of work per week and for a period of one month, the Director of Nursing/Designee shall conduct random observations of two feedings and water bags to ensure appropriate labeling for two residents who require enteral feeding each day. Thereafter, the Director of Nursing/Designee shall conduct these observations two days of work per week for a period of two months and one day of work per week for a period of three months. The Quality Assurance Committee shall review the results of these observations and any corrective action taken during its monthly meetings for a period of no less than six months. Monitoring shall be reviewed/revised as warranted and on the basis of compliance. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 0695 SS=D Bldg. 00 | 483.25(i)<br>Respiratory/Tracheostomy Care and Suctioning<br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>Based on observation and interview, the facility failed to exchange oxygen equipment for a resident who received oxygen therapy for 1 of 4 residents (Resident 37).<br><br>Findings include:<br><br>During an observation on 1/18/24 at 10:55 a.m., Resident 37 was sitting up in his wheelchair next to his bed. He was wearing oxygen per nasal cannula. He had an oxygen bag, tubing, and humidified water attached to a wall unit of oxygen. The tubing, humidified water, and bag were dated 12/23/23.<br><br>During an observation on 1/18/24 at 2:15 p.m., Resident 37 was sitting up in his wheelchair in his room. An oxygen bag with tubing inside and humidified water attached to a wall unit were dated 12/23/23.<br><br>During an observation on 1/19/24 at 10:00 a.m., Resident 37 was sitting in his wheelchair in his room. He had an oxygen bag with tubing attached to an oxygen wall unit, along with humidified water dated 12/23/23. | F 0695 | All residents who receive oxygen therapy have the potential to be affected by this alleged deficient practice.<br>Resident 37's oxygen tubing, humified water, and bag were replaced. Upon immediate notification of this alleged deficiency, the facility conducted house-wide observations to ensure that all other oxygen tubing and humidified water were changed out in accordance with the facility's policy and procedures.<br>Additionally, the facility initiated ongoing, shift-to-shift education to all licensed staff related to the importance of appropriately changing out respiratory care supplies at the appropriate intervals.<br>To ensure ongoing compliance, the Director of Nursing/Designee is responsible for conducting random observations to evaluate the appropriate changing out of oxygen tubing and humidification | 01/26/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | During an observation on 1/19/24 at 2:00 p.m., Resident 37 was sitting up in his wheelchair in his room. A wall unit of oxygen had tubing connected to it with humidified water. The tubing was placed inside a bag. The equipment and bag were dated 12/23/23.<br><br>On 1/19/23 at 10:17 a.m., a comprehensive record review was completed for Resident 37. He had the following diagnoses which included but not limited to muscle weakness, difficulty swallowing, difficulty walking, malignant neoplasm of the right lung, insomnia, and hyperlipidemia.<br><br>A document titled, "Supply Change Out" was provided by the IP (Infection Preventionist). It indicated to change out oxygen tubing weekly and as needed. It indicated to change out humidification jar weekly and as needed.<br><br>3.1-47(a)(2) | | water. On three days of work per week and for a period of one month, the Director of Nursing/Designee shall conduct four random observations of oxygen tubing and humidification water to ensure the supplies have been changed out in accordance with the facility's policy and procedure. Thereafter, the Director of Nursing/Designee shall conduct four random observations two days of work per week for a period of two months and one day of work per week for a period of three months. The Quality Assurance Committee shall review the results of these observations and any corrective action taken during its monthly meetings for a period of no less than six months. Monitoring shall be reviewed/revised as warranted and on the basis of compliance. | |
| F 0699<br>SS=D<br>Bldg. 00 | 483.25(m)<br>Trauma Informed Care<br>§483.25(m) Trauma-informed care<br>The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.<br>Based on observation, interview, and record review, the facility failed to ensure culturally appropriate and person-centered services, routine/preferences, and activities were available | F 0699 | All residents have the potential to be affected by this alleged deficient practice.<br>The facility held a meeting with | 01/26/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | and/or implemented for a resident who spoke a different language for 1 of 1 residents reviewed for culturally competent care (Resident 71).<br><br>Findings include:<br><br>On 1/18/24 at 10:23 a.m., Resident 71 was initially observed. He was seated in a specialized high-back wheelchair (WC) in his room near the foot of his bed. He did not speak English, but there was a 3-ring binder observed on his dresser top. The binder indicated Resident 71 spoke Punjabi and included several pages of clip art pictures with Punjabi words. Most of the pages were tattered, folded, ripped or scribbled on. There were some words spelled phonetically in English but without indication of what the words were. Resident 71 was observed to have long hair pulled back into a ponytail, and a beard with long hair that came to a point at the top of his stomach.<br><br>On 1/18/24 at 2:01 p.m., Resident 71 was observed as he laid in bed. He called out in his native language. Staff passed and did not answer.<br><br>On 1/19/24 at 9:48 a.m., Resident 71 was observed. He was seated in his WC and called out in his native Language. Admission Staff 20 knocked and entered. His communication binder was not observed. Admission Staff 20 attempted to ask what he called for, but indicated she would get an aide. Resident 71's beard remained long and pointed triangularly to the top of his stomach.<br><br>On 1/19/24 at 9:52 a.m., Certified Nursing Aide (CNA) 21 knocked and entered his room. Resident 71 formed a circle with his right hand and placed it to his eyes as he mimicked "glasses." CNA 21 picked up a pair of glasses from beside the resident's bed and placed them on for him. | | Resident #71 and his responsible party to ensure clear understanding of specific cultural characteristics were incorporated into his plan of care, including but not limited to, cuisine, social habits, personal grooming preferences. Information gained was communicated to the applicable department, and careplans were updated to reflect culture considerations.<br>Additionally, the information gained was shared with direct caregivers through updated communication tools, visual cues, and one-on-one education. After conducting a house-wide audit, no other concerns related to cultural preferences of communication barriers were identified that warranted further action. Thus, no other residents were affected. The facility initiated on-going, shift-to-shift education for all staff related to the importance of providing culturally competent care and the necessary notification of administrative staff for additional support should staff be unable to effectively communicate with a resident with varied cultural or language needs to ensure said support is provided.<br>In an effort to ensure ongoing compliance, the Social Services Director/Designee shall meet with the resident and his representative at least weekly throughout the resident’s stay to confirm staff | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | Resident 71's T.V. was on and English subtitles were noted. CNA 21 indicated he did not know if Resident 71 could read the subtitles or not, but having his glasses would help. CNA 21 indicated he did not know the language the resident spoke, but he tried to communicate with "yes" and "no" questions and gestures.<br><br>On 1/19/24 at 10:43 a.m., Resident 71 was assisted to the main activity lounge for an English-speaking News and Trivia group activity. Residents already in attendance had been provided a piece of paper with American word and phrase riddles. He was not provided with a translated activity. He was unable to engage in the activity.<br><br>On 1/22/24 at 9:51 a.m., Resident 71 was observed. He was seated in his specialty wheelchair at the foot of his bed. He called out in his native language. Housekeeper 22 passed by the room and indicated, she was not sure what he asked or what he needed. He did not speak English and she could not understand him so she would get an aide. His communication binder was not observed or able to be located.<br><br>On 1/22/24 at 10:31 a.m., Resident 71 was observed. He remained seated in his wheelchair at the foot of his bed. His communication binder was not observed and unable to be located. Resident 71 put his fingers to his mouth, and it appeared he indicated he was hungry.<br><br>On 1/22/24 at 10:40 a.m., an observation of the puree meal preparation was conducted with the Corporate Dietary Consultant (DC) present. Cook 18 was observed as she prepared pureed beets. She indicated she had already completed the main course beef lasagna puree. There was one pan of | | compliance with facility policy, as well as to identify areas of potential improved. Should concerns arise, the facility shall collaborate with the resident and his representative to identify and implement appropriate measures of correction. The Quality Assurance Committee shall review the results of these observations and any corrective action taken during its monthly meetings for a period of no less than six months. Monitoring shall be reviewed/revised as warranted and on the basis of compliance. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | pureed lasagna on the steam table. Cook 18 indicated that was all she had prepared, there were no additional or separated servings and she would dip from that pan for all 6 pureed plates when it was time to serve.<br><br>On 1/22/24 at 11:00 a.m., Resident 71 was assisted to the main activity lounge for an English-speaking group activity. The Activity Director (AD) reviewed the Weekly Chronicle (a trivia newsletter) and each resident had been provided a piece of paper for an activity of "Wackey Wordies." Resident 71 was not provided with a translated copy. He was unable to participate in the activity. Throughout the activity, Resident 71 spoke in his native language and reached behind his headrest, and it appeared he attempted to ask for a position adjustment. Staff passed and did not ask what he needed.<br><br>During a dining observation on 1/22/24 at 11:24 a.m., until 12:01 p.m., the following was observed.<br><br>At 11:24 a.m., Resident 71 was assisted to the main dining room by the AD. Resident 71 was seated at a table alone. The AD asked if he would like a clothing protector but before he could finish giving a response in his native language, she placed the clothing protector around his neck and walked away as he spoke.<br><br>At 11:30 a.m., Resident 71 was offered hot chocolate or coffee. He indicated, "Chocolate" and was given a cup of hot chocolate. Hot tea was not a beverage option.<br><br>At 11:41 a.m., Resident 71 received his lunch tray. A staff member removed the lids from his bowls, and he spoke to her in his language, but she did not understand and walked away. Resident 71 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | attempted to readjust himself closer to the table.<br><br>At 11:45 a.m., Resident 71 had adjusted himself closer to the table and slowly unwrapped his utensil. He began to eat the prepared meal. His meal ticket was observed and indicated, "no beef."<br><br>During an interview on 1/22/24 at 12:01 p.m., the DC indicated Resident 71 had been given the same beef lasagna as the other pureed trays, but he had eaten most of it without concern.<br><br>On 1/23/24 at 9:15 a.m., Resident 71 was observed in his specialty wheelchair. He independently ambulated around the main nurse's station. It appeared he had a recent shower as his long hair was damp and pulled back into a braided ponytail. His beard, which had been longer and pointed triangularly to the top of his stomach was observed to have been bluntly cut straight across the top of his chest.<br><br>On 1/23/24 at 10:00 a.m., Resident 71 approached an unidentified CNA who was seated on a couch in the hallway as she charted. He attempted to speak to her, but she did not understand him, stood up, and walked away.<br><br>On 1/23/24 at 10:54 a.m., Resident 71 had ambulated to his room, but CNA 21 assisted him out of his room and back into the hallway without speaking. Resident 71 made his way back down to the main nurse's station where the ED assisted him to the main dining room.<br><br>On 1/23/24 at 2:45 p.m., Resident 71 was observed with a visitor. The visitor was a family member and both Resident 71 and his family were agreeable to a translated interview. Resident 71 immigrated to | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | the United States later in life, so he had a harder time learning the language but did speak some English words. The family member indicated Resident 71's beard had been cut. Both the family member and Resident 71 indicated they did not want his beard cut because they practiced Seik religion. Resident 71 tried to tell the aide not to cut his beard but only trim it, but he did not understand and made a blunt cut. Resident 71 was not angry but requested to please not cut the length of his beard again. Resident 71's dentures had been lost during his previous stay at the hospital and without them he was only able to eat soft foods. He did not like the American food, it was bland. The family member indicated they brough in food for him when they could. Resident 71 wanted to have a choice about what to eat but was never asked what he preferred to eat. He also preferred to drink hot tea from his country that the family had brought in.<br><br>During a translated interview on 1/24/24 at 9:30 a.m., Physical Therapist (PT) 23 indicated he spoke Hindi which was the national language of Resident 71's homeland. Although Resident 71 preferred and prominently spoke Punjabi, he was able to communicate with PT 23 and through him indicated, he was unhappy that his beard had been cut and explained that in his culture/religion it was not good to cut the beard. He tried to tell the aide not to cut his beard, and only trim his mustache, but the aide did not understand. "He said he is a Seik, and he does not cut his beard and he feels very sad."<br><br>During an interview on 1/24/24 at 12:57 p.m., CNA 14 indicated she had cut Resident 71's beard before, but he never appeared to be upset about it. She indicated she would trim his mustache and under his bottom lip area because food would get | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | stuck in it. When asked if she had ever cut length from the beard, she indicated, no, just enough of a trim around the shape of the beard to maintain it.<br><br>On 1/24/24 at 1:00 p.m., Resident 71 was observed with CNA 14. She observed his beard and indicated she had never cut it that short before, and she was glad to know it was his preference now so that she did not make that mistake. She indicated his record said he was Muslim, and she did not know he identified as Seik.<br><br>During a translated interview on 1/24/24 at 1:26 p.m., PT 24 indicated he not only spoke Resident 71's native Punjabi language but could speak the same dialect as well. When asked about his beard, PT indicated during his time with Resident 71 he had not been made aware that he preferred not to have his beard cut, but because he was Seik and not Muslim, it would be important not to cut the beard. PT 24 discussed the cut of his beard with Resident 71 and indicated, "he tried to tell someone not to cut his beard and because he thinks everyone speaks Punjabi, he thought they must have understood him." Resident 71 indicated before he was sick he liked to work, go for walks, and be in the garden. He liked to drink Punjabi tea. Resident 71 indicated the communication binder worked at first, but no one used it now, and really what he wanted was a speaking translator. Resident 71 indicated he did not like the food. PT 24 indicated he encouraged Resident 71 to eat the food anyway because he needed it to make him strong again so that he could get better. When asked what kind of food Resident 71 would prefer he indicated the following: curry, chickpeas, rice, lintels, a special Punjabi squash and baked fish.<br><br>On 1/22/24 at 11:06 a.m., Resident 71's medical record was reviewed. He was a long-term care | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | resident with diagnoses which included, but were not limited to, hemiplegia/hemiparesis (muscle paralysis/weakness) following a stroke which affected his left non-dominate side.<br><br>A handwritten admission Activity Assessment was completed on 8/29/23 but did not indicate who the information was obtained from. His Ethnicity was written: "white." His religious affiliation was written: "Muslim," with no special considerations noted. Activity goals indicated, a weekly Chronicle would be given to him for his family to read, and he would be provided with a monthly calendar, but did not specify if the calendar could be translated. Spiritual activities indicated: "Muslim Beliefs (Islam) and Chants in room." Gardening was crossed off even though he had interests and former business in agriculture, and his involvement with the T.V was "not much due to language barrier."<br><br>A handwritten quarterly Activity Review was completed the next day on 8/30/23 but did not indicate who the information was obtained from or discussed with. The review indicated, " ...Resident watches T.V. in room. And family was in daily for visits." The review noted he spoke little to no English, but lacked revision or inclusion of ways to adapt the activity program for his ability to participate through translated materials, use of an interpreter, inviting him to activities with family when present for group socialization, outreach to local cultural community for volunteers, etc.<br><br>The record lacked documentation of the next routine quarterly activity assessment on or around 11/30/23.<br><br>A late quarterly Activity Review was completed 1/17/24 and lacked revision or inclusion of ways | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | to adapt the activity program for his ability to participate such as through translated materials, use of an interpreter, inviting him to activities with family when present for group socialization, outreach to local cultural community for volunteers, etc.<br><br>Resident 71's nursing progress notes were reviewed. Several Medicare Charting notes which included but were not limited to notes written between 9/1/23-10/31/23 all referred to his language barrier, but that staff were able to communicate through his communication board and two therapists that spoke his language.<br><br>Resident 71's baseline care plan, dated 8/23/23, was reviewed and lacked identification of his language barrier, cultural identity and/or special needs/considerations/accommodations for communicating with him.<br><br>Resident 71's comprehensive care plans were reviewed and lacked revision to include the languages he spoke and/or the communication binder.<br><br>On 1/23/24 at 4:10 p.m., the Infection Preventionist (IP) provided a copy of current facility policy titled, "Trauma Informed and Culturally competent Care," dated 10/20/19. The policy indicated, "...A trauma informed, culturally competent approach to care acknowledges that caregivers have a complete picture of a resident's life situation -past and present- in order to provide effective healthcare services with a healing approach, and effective clinical care to residents from a particular ethnic or racial group ... the facility shall promote cultural competence, as possible, through awareness and communication of resident specific cultural characteristics such as language, religion, | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | cuisine, social habits, music and arts ...." | | | |
| F 0761 SS=E Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>Based on observation and interview, the facility failed to ensure that expired medications were replaced and failed to ensure a refrigerated medication was stored in the refrigerator for 5 of 6 residents reviewed for medication storage (Residents 5, 38, 58, 68, and 243).<br><br>Findings include: | F 0761 | All residents to whom the facility administers medications have the potential to be affected by this alleged deficient practice.<br>All expired medications and the medication that required refrigeration were disposed of and immediately replaced. Upon immediate notification of this | 01/26/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | 1. During an observation on 1/24/23 at 10:02 a.m., the 400-hall medication cart was observed. The cart contained erythromycin eye ointment lacked a date to indicate when it was opened and a NovoLog insulin pen that was dated 12/19/23 was expired, belonging to Resident 68.<br><br>2. During an observation on 1/24/23 at 10:15 a.m., the front 300 hall medication cart was observed. The cart contained several medications that were undated when they were opened.<br><br>a. Resident 5 had saline nasal (sodium chloride) aerosol spray 0.65% (use for thick or crusty mucus) with no date added to indicate when it was opened.<br><br>b. Resident 58 had fluticasone proprionate 50mcg/actuation (a medication used to treat sneezing, itching or runny nose and other symptoms caused by hay fever) with no date to indicate when opened. Resident 58 had fluticasone proprionated spray, 50mcg/actuation on the medication cart with no date to indicate when it was opened.<br><br>c. Resident 38 had carboymethycien 0.5% (refresh tears used to treat dry eyes) was present in the cart with no date on the bottle to indicate when opened.<br><br>3. During a medication administration observation. Licensed Practical Nurse (LPN) 20 pulled Resident 243's bottle of Mary's Magic Potion 300mg/5ml from the 400-hall medication cart. The bottle clearly indicated to refrigerate the medication. The medication was being stored at room temperature. LPN 20 indicated this was not her normal cart and that she floated all over the facility. | | alleged deficiency, the facility conducted house-wide audits to ensure that all other medications were labeled with an open date and replaced and stored in accordance with manufacturer's instructions. No other concerns were identified. Additionally, the facility initiated ongoing, shift-to-shift education to all licensed staff related to the importance of appropriately labeling of medications with open dates, disposal/replacement of medications based on expiration dates, and storage of medications in accordance with manufacturer's instructions.<br>To ensure ongoing compliance, the Director of Nursing/Designee is responsible for conducting random audits to evaluate the labeling, replacement, and storage of medications. Three times a week and for a period of one month, the Director of Nursing/Designee shall conduct one random audit of a medication cart to ensure that all medications are appropriately labeled with an open date, disposed of/replaced based on expiration date, and stored per in accordance with the manufacturer's instructions. The Director of Nursing/Designee shall continue to conduct these audits twice weekly for a period of two months and then one weekly for a period of three months. The Quality Assurance Committee | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | A policy titled "Storing Drugs" with a date of 4/2021 was provided by the IP (Infection Preventionist) of 1/22/24 at 1:23 p.m. It indicated, "refrigerated medications must be stored in a refrigerator designated for medication only at a temperature of 36-46 degrees Fahrenheit (2-8 degrees Celsius). The medication refrigerator must contain a functional thermometer designated for a refrigerator and any outdated, contaminated, deteriorated drugs. Or those drugs that have containers that are cracked, soiled, or without secure closures must be removed from stock and destroyed according to policy ....".<br><br>A policy titled "Medication Expiration" with a date of 9/2017 was provided by the IP (Infection Preventionist) on 1/2223 at 2:00 p.m., It indicated, " ...Facility staff shall date the label of any multi-use vial when the vial is first accessed and access the vial in dedicated medication preparation area: if a multi-dose vial had been opened or accessed, the vial should be dated discarded within 28 days unless the manufacturer specifies a different dated for that opened vial ....".<br><br>3.1-25(j)<br>3.1-25(m)<br>3.1-25(n) | | shall review the results of these observations and any corrective action taken during its monthly meetings for a period of no less than six months. Monitoring shall be reviewed/revised as warranted and on the basis of compliance. | |
| F 0812<br>SS=D<br>Bldg. 00 | 483.60(i)(1)(2)<br>Food Procurement,Store/Prepare/Serve-Sanitary<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>Based on observation, interview, and record review, the facility failed to ensure hand washing was completed according to policy for 2 of 4 residents (Residents 1 and 51).<br><br>Finding include:<br><br>On 1/18/24 at 11:55 a.m., Certified Nursing Aide (CNA) 19 was observed to pick up Resident 1's paper lunch ticket from the floor. Without hand washing or gelling her hands, she assisted Resident 1 and Resident 51 with eating.<br><br>She started with her left hand, providing a bite of food to Resident 51. Then, provided a drink with her left hand and a bite with her right hand for Resident 1. She went back to Resident 51 and wiped her mouth and provided a drink and several bites of food with both her right and left hands.<br><br>A current policy, titled, "Handwashing/Hand Hygiene," dated 10/2014, was provided by the Infection Preventionist (IP), on 1/24/24 at 11:53 a.m. A review of the policy indicated, " ...Hand hygiene is the single most important measure for | F 0812 | All residents to whom assistance is provided with meals have the potential to be affected by this alleged deficient practice. Of note, in both discussions with the Indiana Department of Health's (IDOH) Surveyor ("Surveyor") during the recertification visit, Surveyor informed the facility that at no such time did either of the CNA's hands meet any portion of a utensil or napkin that touched or entered the resident's mouth. Additionally, Surveyor informed the facility that at no such time did either of the CNA's hands touch the resident's mouth directly. Finally, the official record of recertification visit provided to the facility by IDOH fails to contain any information/observations that indicates that contact with the resident's mouth was made.<br>Upon immediate notification of this alleged deficiency, the facility | 01/26/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155814 | A. BUILDING 00<br>B. WING | 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKE KNOLL VILLAGE | 1108 KINGWOOD DRIVE<br>AVON, IN 46123 |

| (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 |
|---|---|---|---|---|
| | preventing the spread of infection ...The hand hygiene guidelines are part of an overall CDC [Centers for Disease Prevention and Control] strategy to reduce infections in health care setting to promote resident safety ...When the hands are not visibly soiled, the CDC recommends the use of alcohol-based hand rubs by health care personnel for resident care ...Before and after assisting a resident with meals ...."<br><br>3.1-21(i)(3) | | initiated ongoing, shift-to-shift education to all licensed staff related to the importance of performing hand hygiene when assisting residents with eating. To ensure ongoing compliance, the Director of Nursing/Designee is responsible for conducting random observations of licensed staff assisting residents with eating. Three times per week and for a period of one month, the Director of Nursing/Designee shall conduct two random observations of licensed staff assisting a resident with eating. The Director of Nursing/Designee shall continue to conduct these observations once weekly for a period of two months and then twice monthly for a period of three months. The Quality Assurance Committee shall review the results of these observations and any corrective action taken during its monthly meetings for a period of no less than six months. Monitoring shall be reviewed/revised as warranted and on the basis of compliance. | |