STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15E064	A. BUILDING 00 B. WING	08/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00415697 and IN00416170. Complaint IN00415697 - No deficiencies related to the allegations are cited. Complaint IN00416170 - Federal/State deficiencies related to the allegations are cited at F600, F740, and F943. Survey dates: August 29 and 30, 2023. Facility number: 000311 Provider number: 15E064 AIM number: 100285520 Census Bed Type: SNF/NF: 36 Total: 36 Census Payor Type: Medicaid: 36 Total: 36 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 5, 2023.	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulations. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of compliance effective October 27, 2023.	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ruth Fuchs	Administrator	09/22/2023

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

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	freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interviews and record review, the facility failed to protect a resident's right to be free from verbal abuse by CNA 12 for 1 of 5 residents reviewed for abuse (Resident B). Findings include: Review of video footage with audio, on 8/29/23 at 11:00 a.m., indicated on 8/19/23 Resident B was being escorted in his wheelchair to his room from the nurses station area. CNA 12 pushed his wheelchair while CNA 23 walked backwards holding his legs from touching the ground. LPN 8 held a gown on the right side of him to shield the other staff member from him spitting on them. As they entered his room, a staff member called Resident B "a nasty a--." Resident B's clinical record was reviewed on 8/29/23 at 10:38 a.m. Diagnoses included uncomplicated alcohol dependence, Wernicke's encephalopathy, delusional disorders, mild cognitive impairment of uncertain or unknown etiology, other seizures, drug induced subacute dyskinesia, major depressive disorder, recurrent severe without psychotic features, generalized anxiety disorder, psychotic disorder with hallucinations due to known physiological condition, impulse disorder, and diffuse traumatic brain injury with loss of consciousness of	F 0600	**F 600** It is the practice of Brookside Care Strategies to protect the residents' right to be free from verbal abuse by staff members. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** One resident affected by the deficient practice was assessed for psychosocial distress, with none noted at that time of the incident and no longer resides in the facility. All staff have been educated on the interventions in place to prevent abuse. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the alleged deficient practice. All interviewable residents were asked abuse questions to identify any other allegations or concerns. Primary family members questioned	09/28/2023

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	unspecified duration, subsequent encounter. His medications included levetiracetam (treat seizures) 250 mg (milligram) three times daily, divalproex sodium (treat seizures) 375 mg twice daily, quetiapine fumarate (treat psychotic features) 150 mg at bedtime, brexpiprazole (treat mood disorders) 3 mg daily, and folic acid-vitamin B6-vitamin B12 (treat Wernicke's encephalopathy) daily. An admission MDS (Minimum Data Set) assessment, dated 7/21/23, indicated he was cognitively intact. He required extensive assistance of one staff member for bed mobility, dressing, toilet use and personal hygiene. He required extensive assistance of two staff members for transferring. He required supervision with locomotion on and off the unit. He used a wheelchair. He had delusions (misconceptions or beliefs that are firmly held, contrary to reality) and other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) that occurred one to three days during the assessment period. His current care plans included the following: He had behaviors of yelling out in common areas (7/17/23). His interventions included to allow him time to voice frustrations (revised 8/12/23), approach calmly and in a soothing, non-judgmental manner (revised on 8/12/23), assess for pain and toileting needs (revised 8/12/23), give him your full attention to answer questions he had (revised 8/9/23), if he was in the common area/high activity area, please take him to		related to care concerns or abuse concerns by the administrator. Resident Council was conducted on August 29, 2023, and the administrator was present to educate residents on the types of abuse and how to report abuse. The administrator will attend resident council on September 28, 2023, to reeducate residents on abuse and follow up on any further concerns or questions related to abuse. All staff inserviced on the prevention of abuse, types of abuse, and reporting of abuse on September 15, 2023, and no staff were allowed to work until the inservice was completed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The facility's abuse prevention policy, including protecting residents from abuse, reporting abuse, and responding to an investigation of abuse was reviewed on 9/15/2023. The policy was found to be complete with no revision necessary. All staff were inserviced on 9/15/2023 and were not permitted to work until they were provided re-education on the facility's expectations, policies, and procedures regarding abuse prevention, reporting and investigation. Interviewable residents will be	

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	his room to assist him (revised 8/12/23), offer him a snack or a drink (revised 8/12/23), praise him for all appropriate behaviors (8/22/23), take him to a quiet area (revised 8/12/23), and talk to him about the feelings and rights of others who are exposed to the negative behavior (8/21/23). He had the potential for psychosocial well-being problem related negative interaction with staff (7/25/23). His interventions included allow him time to answer questions and to verbalize feelings, perceptions, and fears (7/25/23), monitor/document his usual response to problems: internal and external (7/25/23), monitor/document his feelings relative to incident with peer (7/25/23), when conflict arose, remove him to a calm, safe environment and allow him to vent/share his feelings (7/25/23). He had the potential to be verbally aggressive by yelling and cursing at staff, calling staff derogatory names, etc. (revised 8/9/23). His interventions included analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document (revised 8/12/23), assess his understanding of the situation, allow time for him to express himself and feelings towards the situation (revised 8/12/23), provide positive feedback for good behavior, emphasize the positive aspects of compliance (revised 8/12/23), when he became agitated; intervene before agitation escalate, guide him away from the source of distress, engage calmly in conversation, if his response was aggressive, staff were to walk away calmly and approach later (revised 8/12/23). He had behaviors of throwing items i.e.: books, water pitcher, threatening to tip over medication carts, pour water on computers, throw feces on		interviewed weekly for the next 30 days to identify any care or abuse concerns. For those residents who are unable to be interviewed a skin assessment will be completed weekly for the next 30 days to assess for any unusual skin concerns. Nursing staff assigned each shift, 7 days per week, will be responsible for the close monitoring of residents to reduce resident-to-resident altercations and staff to resident altercations. Nursing staff will encourage residents to attend activities and meals in the common areas for close monitoring. If a resident is exhibiting behaviors that may lead to a resident-to-resident altercation, the residents will be placed on 15-minute checks or one on one supervision if deemed necessary. On weekends, Administrator and/or designee is notified of resident-to-resident altercations or staff to resident altercations. The administrator and/or nurse manager will verify that an intervention has been put in place. For resident-to-resident altercations, the residents involved will be placed on 15-minute checks for up to 72 hours completed by the nursing staff to monitor and observe physically. **How the corrective action will be monitored to ensure the deficient practice will not**	

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	staff, throwing cups, etc.(revised 8/16/23). His interventions included ask him what you can do to help him (8/21/23), explain to him the behavior was inappropriate (8/12/23), offer to take him to quiet area to talk (revised 8/12/23), praise him for appropriate behavior (8/22/23), remove him from the area (revised 8/12/23), specific behavior management intervention: ask him if he would like to call his mother (revised 8/12/23), talk to him about the feelings and rights of others who are exposed to negative behavior (revised 8/12/23), and turn on soothing music (8/16/23). He had a behavior problem of self injurious behavior by banging on table, hitting the wall, threatening to break a window, etc. (revised 8/18/23). His interventions included answer his questions (8/18/23), approach/speak in a calm manner (revised 8/12/23), divert attention as necessary (revised 8/12/23), monitor behavior episodes and attempt to determine underlying cause, consider location, time of day, persons involved, and situations, document behavior and potential causes (revised 8/12/23), praise any indication of his progress/improvement in behavior (revised 8/12/23), remove from situation and take to alternate location as needed (8/12/23), and turn on soothing music for him in a quiet area (8/16/23). He had the potential to be physically aggressive i.e.: threats of harm to staff, scratching staff, etc. (revised 8/21/23). His interventions included to analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document (revised 8/12/23), assess and address for contributing sensory deficits (revised 8/12/23), assess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain etc. (revised 8/12/23), assist to		**recur, i.e., what quality assurance program will be put into place?** The Administrator and/or designee will conduct quality improvement audits on resident interview questions and resident skin assessments daily for 14 days on all that are completed within the last 30 days, then weekly for two weeks, then monthly for 90 days. Results of all quality improvement audits will be reported to the QAPI committee for review. There must be at least three consecutive months with no findings to discontinue the audit.	

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	set goals for more pleasant behavior and assist verbalization of source of agitation (8/21/23), when he became agitated, intervene before agitation escalates, guide him away from source of distress, engage calmly in conversation, if response is aggressive; staff were to walk away calmly and approach later (revised 8/12/23). His progress notes indicated the following: On 8/19/23 at 12:07 p.m., he was in the common area yelling at staff. He continued to make threats about harming himself and other residents. He called staff racial slurs and made bigoted statements. The nurse practitioner was aware of the situation, and no new orders were given. The facility was advised to give redirection to the date. On 8/19/23 at 2:31 p.m., he continuously yelled and shouted out racial slurs and derogatory names such b--ches, chubby, and fat a--. He was redirected to his room where he began to throw various items such as remotes, dresser pieces and his trash can. He took a water pitcher and threw it into the hallway, barely missing a staff member. He made threats to staff that he would take the dresser and beat you upside the head, [racial slur]. He continued to make threats of harm to staff. On 8/19/23 at 2:59 p.m., a staff member came into to help IT (Information Technology) to get the internet and the phone working. Resident B proceeded to threaten to throw urine and water pitchers on the staff member. The staff member was on the phone with IT and could not react to Resident B's questions. He was creating a hostile environment. On 8/19/23 at 6:03 p.m., he hocked up his spit, threatening to spit on an African- American staff			

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	member. He called staff names, when redirected by four staff members to his room, he began to spit on staff multiple times. He grabbed a CNA by her chest and began to scratch another CNA. He threw items and caused destruction in his room. He cursed loudly while continuing to spit. 911 was called by a staff member due to their injuries. The DON, psychiatric nurse practitioner, the administrator in training, and the manager on duty was aware. EMTs escorted him via ambulance. His mother was called and made aware of the situation. On 8/20/23 at 4:45 a.m., he returned from the local hospital via stretcher. He was awake and alert to person and place. He was transferred from stretcher to bed. A report from nurse at the ER indicated he was totally calm and cooperative while at the ER, other than he refused lab work when he first arrived. He agreed to lab work shortly after he refused. He had no other behaviors. No new orders were received. He denied any wants/needs at that time and his call light was in reach. Confidential interviews were conducted during the course of the survey. During a confidential interview, it was indicated Resident B was very confused. He knew he was confused, he wanted to know why he repeated himself and why he couldn't remember things. They tried to think of things to get his mind off his notebook. He constantly said he was going to kill himself or hurt himself and said he did not like living like that. He wanted to live in a group home. The SSD had told him he was going to a group home if he didn't have behaviors for two weeks. The SSD started writing the date in a notebook he carried. They told him if he had a behavior they			

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	would push the date back. The confidential interview didn't know why they gave him a date and then changed it if he had a behavior. They heard the SSD and the Environmental Supervisor tell him he had to stay longer because he had behaviors. The confidential interview felt this made him have more behaviors and frustrated him. They kept telling him he had to go two more weeks because he had a behavior. During an interview with the Interim Administrator, on 8/29/23 at 2:12 p.m., she indicated she started at the facility on 8/20/23. She became aware of the incident with staff and Resident B, on 8/25/23, while investigating a workman's comp issue. She was told Resident B had hurt two staff members during a behavior incident with Resident B on 8/19/23 at 5:20 p.m., and it lead her to view the video footage. After watching the video, she reported the incident to the State Agency and suspended the three staff members. They said Resident B had behaviors most of the day on 8/19/23. They tried to give him a date for discharge, they told him if he didn't have behaviors for 14 days he could go to the group home. There was a facility behavior care specialist that had a good relationship with him, and tried to redirect him. She was able to calm him after the incident. Another resident, Resident D, was protective of the staff. He watched Resident B's behaviors increase and he was going to potentially intervene by using metal from a cat food can to hurt Resident B. She thought the staff were trying to remove Resident B from the situation to keep him safe as well as others. He was to the point where he was unmanageable. Staff called the police, they came and took him to a local hospital, and the hospital sent him back to the facility. CNA 12 called Resident B a nasty a--. She tried to contact CNA 12 and she did not show			

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	up for work. The nurse practitioner had made some changes to his medication and attempted to do things in-house. During an interview with the Administrator, on 8/29/23 at 2:53 p.m., she indicated Resident B had a notebook that said he was going to a group home. She had initially thought he was really going to a group home. She spoke with the SSD about what group home he was going to, and she told her he wasn't going to a group home. He had to be good for 14 days before he could go. During an interview with the SSD, on 8/29/23 at 4:02 p.m., she indicated she was working on finding a group home for Resident B. She had reached out to three group homes. One was close to where his family lived. They said he could not have physical/aggressive behaviors for 14 to 30 days. He had not been accepted yet. She told him when he met his goals, she would fax the group homes the information they needed. Everyday they wrote the date and how many days he had left at the facility before he was going to a group home. He carried the notebook around with him all day. He threatened to throw urine at the staff, he made self injurious threats. A couple weekends ago, he was spitting, threatened to throw urine, called staff names and threw a dresser drawer into the hall. If there were a lot of people around, he wanted all the attention focused on him. If there were less people around, he was more controllable . An undated current facility policy, titled "ABUSE PREVENTION AND PROHIBITION POLICY," provided by the Interim DON, on 8/30/23 at 11:00 a.m., indicated the following: "...Policy...Residents residing in this facility will be treated with dignity and respect in accordance with their individual			

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	needs. They will not be subjected to verbal...and mental abuse...VERBAL ABUSE: Threatening a resident verbally, raising your voice to a resident in a scolding or abrupt manner, using offensive term/words...MENTAL ABUSE...saying anything to a resident which might cause him/her to worry or become alarmed...threats of punishment or deprivation.... " This Federal tag relates to complaint IN00416170. 3.1-27(a)(1) 3.1-27(b)			
F 0740 SS=G Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on interview and record review, the facility failed to develop and implement an individualized behavior plan that maximized the resident's dignity for 1 of 5 residents reviewed (Resident B) when the SSD indicated to Resident B he would be able to be discharged to a group home if he had good behavior for 14 days. This practice resulted in his fixation on the date he was to be discharged to go to a group home and contributed to his increased frustration and behaviors of self harm, yelling at staff, throwing items, and banging his head, which lead to an inpatient stay at a psychiatric hospital.	F 0740	**F 740** It is the practice of Brookside Care Strategies to develop and implement individualized behavior plans that maximize the resident's dignity. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Of the one resident affected by the	09/25/2023

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	Findings include: Review of video footage with audio, on 8/29/23 at 11:00 a.m., indicated on 8/19/23 Resident B was being escorted in his wheelchair to his room from the nurses station area. CNA 12 pushed his wheelchair while CNA 23 walked backwards holding his legs from touching the ground. LPN 8 held a gown on the right side of him to shield the other staff member from him spitting on them. As they entered his room, a staff member called Resident B "a nasty a--." Resident B's clinical record was reviewed on 8/29/23 at 10:38 a.m. Diagnoses included uncomplicated alcohol dependence, Wernicke's encephalopathy, delusional disorders, mild cognitive impairment of uncertain or unknown etiology, other seizures, drug induced subacute dyskinesia, major depressive disorder, recurrent severe without psychotic features, generalized anxiety disorder, psychotic disorder with hallucinations due to known physiological condition, impulse disorder, and diffuse traumatic brain injury with loss of consciousness of unspecified duration, subsequent encounter. His medications included levetiracetam (treat seizures) 250 mg (milligram) three times daily, divalproex sodium (treat seizures) 375 mg twice daily, quetiapine fumarate (treat psychotic features) 150 mg at bedtime, brexpiprazole (treat mood disorders) 3 mg daily, and folic acid-vitamin B6-vitamin B12 (treat Wernicke's encephalopathy) daily. Special instructions on his orders indicated, per his mother, Resident B could call her twice daily only from 12:30 p.m. - 1:00 p.m. (after lunch) and		alleged deficient practice, behavior care plans were reviewed and updated by the interdisciplinary team upon return from hospitalization. This resident no longer resides in the facility. Staff educated on the interventions in place to prevent behaviors. All behavior care plans have been placed in Point Click Care for easier access for nursing staff to document and reference interventions in place. Interventions sheets are in place for all staff to reference and are available at the nursing station. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** An audit of all residents with a current behavior care plan was conducted on September 15, 2023, by Courtney and Associates to assess any concerns related to dignity with none noted. Any recommendations made during that assessment have been implemented and updated and current interventions have been placed on the resident intervention sheet as of September 19, 2023, and is available to all staff. All staff inserviced on behavior documentation and the behavior intervention sheets on September 6, 2023, and no staff were allowed to work until the inservice was completed.	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	5:30 p.m. - 6:00 p.m. (after dinner). If he yelled at others or was being inappropriate, the call could be held. An admission MDS (Minimum Data Set) assessment, dated 7/21/23, indicated he was cognitively intact. He required extensive assistance of one staff member for bed mobility, dressing, toilet use and personal hygiene. He required extensive assistance of two staff members for transferring. He required supervision with locomotion on and off the unit. He used a wheelchair. He had delusions (misconceptions or beliefs that are firmly held, contrary to reality) and other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) that occurred one to three days during the assessment period. His current care plans included the following: He had behaviors of yelling out in common areas (7/17/23). His interventions included to allow him time to voice frustrations (revised 8/12/23), approach calmly and in a soothing, non-judgmental manner (revised on 8/12/23), assess for pain and toileting needs (revised 8/12/23), give him your full attention to answer questions he had (revised 8/9/23), if he was in the common area/high activity area, please take him to his room to assist him (revised 8/12/23), offer him a snack or a drink (revised 8/12/23), praise him for all appropriate behaviors (8/22/23), take him to a quiet area (revised 8/12/23), and talk to him about the feelings and rights of others who are exposed to the negative behavior (8/21/23).		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The administrator along with Courtney and Associates reeducated Social Service Designee on appropriate interventions related to behaviors and dignity related concerns. The administrator or designee will review behavior tracking logs daily to ensure that behavior care plans are written in a way that the plan maintains dignity for the resident. In addition, the behavior tracking tools will be reviewed during daily clinical meeting Monday through Friday. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Administrator and/or designee will randomly conduct quality improvement audits on behavior care plans daily for 14 days on at least 5 residents per day, then weekly for two weeks, then monthly for 90 days. Results of all quality improvement audits will be reported to the QAPI committee for review. There must be at least three consecutive months with no findings to discontinue the audit.	

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	He had the potential for psychosocial well-being problem related negative interaction with staff (7/25/23). His interventions included allow him time to answer questions and to verbalize feelings, perceptions, and fears (7/25/23), monitor/document his usual response to problems: internal and external (7/25/23), monitor/document his feelings relative to incident with peer (7/25/23), when conflict arose, remove him to a calm, safe environment and allow him to vent/share his feelings (7/25/23). He had the potential to be verbally aggressive by yelling and cursing at staff, calling staff derogatory names, etc. (revised 8/9/23). His interventions included analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document (revised 8/12/23), assess his understanding of the situation, allow time for him to express himself and feelings towards the situation (revised 8/12/23), provide positive feedback for good behavior, emphasize the positive aspects of compliance (revised 8/12/23), when he became agitated; intervene before agitation escalate, guide him away from the source of distress, engage calmly in conversation, if his response was aggressive, staff were to walk away calmly and approach later (revised 8/12/23). He had behaviors of throwing items i.e.: books, water pitcher, threatening to tip over medication carts, pour water on computers, throw feces on staff, throwing cups, etc.(revised 8/16/23). His interventions included ask him what you can do to help him (8/21/23), explain to him the behavior was inappropriate (8/12/23), offer to take him to quiet area to talk (revised 8/12/23), praise him for appropriate behavior (8/22/23), remove him from the area (revised 8/12/23), specific behavior			

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	management intervention: ask him if he would like to call his mother (revised 8/12/23), talk to him about the feelings and rights of others who are exposed to negative behavior (revised 8/12/23), and turn on soothing music (8/16/23). He had a behavior problem of self injurious behavior by banging on table, hitting the wall, threatening to break a window, etc. (revised 8/18/23). His interventions included answer his questions (8/18/23), approach/speak in a calm manner (revised 8/12/23), divert attention as necessary (revised 8/12/23), monitor behavior episodes and attempt to determine underlying cause, consider location, time of day, persons involved, and situations, document behavior and potential causes (revised 8/12/23), praise any indication of his progress/improvement in behavior (revised 8/12/23), remove from situation and take to alternate location as needed (8/12/23), and turn on soothing music for him in a quiet area (8/16/23). He had the potential to be physically aggressive i.e.: threats of harm to staff, scratching staff, etc. (revised 8/21/23). His interventions included to analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document (revised 8/12/23), assess and address for contributing sensory deficits (revised 8/12/23), assess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain etc. (revised 8/12/23), assist to set goals for more pleasant behavior and assist verbalization of source of agitation (8/21/23), when he became agitated, intervene before agitation escalates, guide him away from source of distress, engage calmly in conversation, if response is aggressive; staff were to walk away calmly and approach later (revised 8/12/23).			

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	His progress notes indicated the following: On 8/1/23 at 8:49 a.m., he continued to ask staff when was leaving to go to a group home. Staff replied he would need to change his behaviors to go to group home. He was agreeable. He then continued to ask the same questions. On 8/1/23 at 6:30 p.m., he came to the nurses station several times that shift and asked when he could go to the group home and asked the nurse to write it down. When he was reminded he had it on his notepad, he would get loud and cuss. He was reminded his behaviors had to improve prior to him discharging from the facility. He stated understanding and his behavior improved for only short amount of time before it started all over again. On 8/19/23 at 12:07 p.m., he was in the common area yelling at staff. He continued to make threats about harming himself and other residents. He called staff racial slurs and made bigoted statements. The nurse practitioner was aware of the situation, and no new orders were given. The facility was advised to give redirection to the date of potential discharge. On 8/19/23 at 2:31 p.m., he continuously yelled and shouted out racial slurs and derogatory names such b--ches, chubby, and fat a--. He was redirected to his room where he began to throw various items such as remotes, dresser pieces and his trash can. He took a water pitcher and threw it into the hallway, barely missing a staff member. He made threats to staff that he would take the dresser and beat you upside the head, [racial slur]. He continued to make threats of harm to staff.			

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	On 8/19/23 at 2:59 p.m., a staff member came into to help IT (Information Technology) to get the internet and the phone working. Resident B proceeded to threaten to throw urine and water pitchers on the staff member. The staff member was on the phone with IT and could not react to Resident B's questions. He was creating a hostile environment. On 8/19/23 at 6:03 p.m., he hocked up his spit, threatening to spit on an African- American staff member. He called staff names, when redirected by four staff members to his room, he began to spit on staff multiple times. He grabbed a CNA by her chest and began to scratch another CNA. He threw items and caused destruction in his room. He cursed loudly while continuing to spit. 911 was called by a staff member due to their injuries. The DON, psychiatric nurse practitioner, the administrator in training, and the manager on duty was aware. EMTs escorted him via ambulance. His mother was called and made aware of the situation. On 8/20/23 at 4:45 a.m., he returned from the local hospital via stretcher. He was awake and alert to person and place. He was transferred from stretcher to bed. A report from nurse at the ER indicated he was totally calm and cooperative while at the ER, other than he refused lab work when he first arrived. He agreed to lab work shortly after he refused. He had no other behaviors. No new orders were received. He denied any wants/needs at that time and his call light was in reach. On 8/21/23 at 12:53 p.m., he resorted to yelling for staff across the room, to get their attention for a continuously repeated reading of today's date and when he could depart. He continued to repeat			

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	requests for reading today's date. This would not change, but his behaviors were definitely belligerent. If staff did not stop in their tracks to repetitively answer today's date and his potential departure date. He would curse and threaten self harm or toss something at staff. He had no means or the mental capacity to harm himself. On 8/21/23 at 11:34 p.m., an SSD note indicated he could be easily redirected, but due to memory issues and behaviors he was redirected hundreds of times a day. His behaviors and questions on the date and when he was leaving were repetitively asked. It was difficult to get him on a task due to this complication of his disease process. At times, his memory was better than others. On 8/22/23 at 6:22 p.m., he sat at the nurses station consistently asked questions, "Can I call my mom?" and "Its August 22nd, and I am leaving August 3?" He carried around paper with this statement. Staff reminded him that only if behaviors decreased and if he followed his plan of care. He would state " I am going to hurt myself tonight." Staff tried to console him and he started with the same repetitive questions. This behavior had been constant for the last an hour and a half and he rotated between the staff. He had been unable to be redirected. He was listened to and he was talked to about his current plan of care and goals, they were ineffective and would often worsen the behaviors. On 8/23/23 at 10:35 a.m., he sat in his wheelchair outside of the Human Resource office, where the morning meeting was going on. The Administrator opened the door, answered his repetitive question regarding the date and when he could leave. The door was shut to commence with the meeting. He			

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	started yelling and cussing saying he was going to kill himself. The office door was opened and he was bashing his head into the door and door knob repetitively. Staff intervened and separated him from the door. The NP was notified and gave an order to send to him to the ER for evaluation, treatment and to be sent for a psych stay. 911 was called. On 8/23/23 at 3:29 p.m., he returned to the facility with a diagnoses of a UTI, and he quickly began cursing and threatened to harm self. On 8/23/23 at 6:31 p.m., he had been demanding since returning from the hospital. He was reminded to be patient with staff who answered his questions and he was going to go to psychiatric hospital as soon as a bed was confirmed this evening or Thursday the 24th. He was very verbally repetitive. If staff didn't answer his repetitive questions, he would threaten to harm self. He went so far as to say he was going to break the mirror on the wall with his head. He tried to bang his head on the wall. He was reminded him to be kind and to stop threatening to harm self every time someone does not answer him immediately. He yelled across the room to get staff's attention. He was called some of the staff the "N" word, as well. On 8/24/23 at 7:55 p.m., he was on a leave of absence to an inpatient psychiatric hospital. Confidential interviews were conducted during the course of the survey. During a confidential interview, it was indicated Resident B was very confused. He knew he was confused, he wanted to know why he repeated himself and why he couldn't remember things.			

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	They tried to think of things to get his mind off his notebook. He constantly said he was going to kill himself or hurt himself and said he did not like living like that. He wanted to live in a group home. The SSD had told him he was going to a group home if he didn't have behaviors for two weeks. The SSD started writing the date in a notebook he carried. They told him if he had a behavior they would push the date back. The confidential interview didn't know why they gave him a date and then changed it if he had a behavior. They heard the SSD and the Environmental Supervisor tell him he had to stay longer because he had behaviors. The confidential interview felt this made him have more behaviors and frustrated him. They kept telling him he had to go two more weeks because he had a behavior. During an interview with the Interim Administrator, on 8/29/23 at 2:12 p.m., she indicated she started at the facility on 8/20/23. She became aware of the incident with staff and Resident B, on 8/25/23, while investigating a workman's comp issue. She was told Resident B had hurt two staff members during a behavior incident with Resident B on 8/19/23 at 5:20 p.m., and it lead her to view the video footage. After watching the video, she reported the incident to the State Agency and suspended the three staff members. They said Resident B had behaviors most of the day on 8/19/23. They tried to give him a date for discharge, they told him if he didn't have behaviors for 14 days he could go to the group home. There was a facility behavior care specialist that had a good relationship with him, and tried to redirect him. She was able to calm him after the incident. Another resident, Resident D, was protective of the staff. He watched Resident B's behaviors increase and he was going to potentially intervene by using metal from a cat			

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	food can to hurt Resident B. She thought the staff were trying to remove Resident B from the situation to keep him safe as well as others. He was to the point where he was unmanageable. Staff called the police, they came and took him to a local hospital, and the hospital sent him back to the facility. CNA 12 called Resident B a nasty a--. She tried to contact CNA 12 and she did not show up for work. The nurse practitioner had made some changes to his medication and attempted to do things in-house. During an interview with the Administrator, on 8/29/23 at 2:53 p.m., she indicated Resident B had a notebook that said he was going to a group home. She had initially thought he was really going to a group home. She spoke with the SSD about what group home he was going to, and she told her he wasn't going to a group home. He had to be good for 14 days before he could go. During an interview with the SSD, on 8/29/23 at 4:02 p.m., she indicated she was working on finding a group home for Resident B. She had reached out to three group homes. One was close to where his family lived. They said he could not have physical/aggressive behaviors for 14 to 30 days. He had not been accepted yet. She told him when he met his goals, she would fax the group homes the information they needed. Everyday they wrote the date and how many days he had left at the facility before he was going to a group home. He carried the notebook around with him all day. He threatened to throw urine at the staff, he made self injurious threats. A couple weekends ago, he was spitting, threatened to throw urine, called staff names and threw a dresser drawer into the hall. If there were a lot of people around, he wanted all the attention focused on him. If there were less people around, he was more controllable			

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	An undated current facility policy, titled "ABUSE PREVENTION AND PROHIBITION POLICY," provided by the Interim DON, on 8/30/23 at 11:00 a.m., indicated the following: "...Policy...Residents residing in this facility will be treated with dignity and respect in accordance with their individual needs. They will not be subjected to verbal...and mental abuse...VERBAL ABUSE: Threatening a resident verbally, raising your voice to a resident in a scolding or abrupt manner, using offensive term/words...MENTAL ABUSE...saying anything to a resident which might cause him/her to worry or become alarmed...threats of punishment or deprivation.... " This Federal tag relates to complaint IN00416170. 3.1-27(a)(1) 3.1-27(b)			
F 0943 SS=D Bldg. 00	483.95(c)(1)-(3) Abuse, Neglect, and Exploitation Training §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and			

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	resident abuse prevention. Based on record review and interview, the facility failed to ensure yearly dementia in-service training was conducted for 2 of 5 staff members reviewed for employee records (RN 15 and LPN 8). Findings include: Employee records were reviewed on 8/30/23 at 9:15 a.m. RN 15's last dementia training was completed on 6/1/22. LPN 8's last dementia training was completed on 2/23/22. During an interview with the Interim DON, on 8/30/23 at 12:46 p.m., she indicated the facility could not locate a policy regarding training at that time. No further information was provided prior to exit. This Federal tag relates to complaint IN00416170. 3.1-19(u)	F 0943	**F 943** It is the practice of Brookside Care Strategies to ensure yearly dementia inservice training is conducted for all staff. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** All residents have the potential to be affected by the alleged deficient practice. All employee files have been audited at this time and the facility is in the process of obtaining the required dementia training. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the alleged deficient practice. The Business Office Manager has completed employee file audits and is in the process of obtaining the required documentation. Moving forward, the Business Office Manager and/or designee will audit the new employee files and ensure that all documentation is obtained as required. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**	10/27/2023

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			The Business Office Manager will complete an employee file audit on all new employees' files using a checklist which includes all required documentation. The administrator will sign off on all new employee files once the Business Office Manager ensures that the file is complete. This will allow for any corrections to be made in a timely manner. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Business Office Manager will bring the initial employee audit to (State Form 5540) as well as any new employee file audits to the monthly QAPI committee meeting for further review and recommendations. The QAPI team will continue to monitor the completion of employee files on an ongoing basis. The Business Office Manager is responsible for the implementation and monitoring of this plan.	