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	01/27/2023

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 IN00399521 and IN00399351. Complaint IN00399521 - Unsubstantiated due to lack of evidence. Complaint IN00399351 - Substantiated. No deficiencies related to the allegations are cited. Unrelated deficiencies are cited at F657 and F919. Survey dates: January 26 and 27, 2023. Facility number: 000311 Provider number: 15E064 AIM number: 100285520 Census Bed Type: SNF/NF: 37 Total: 37 Census Payor Type: Medicaid: 36 Other: 1 Total: 37 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 31, 2023.	F 0000		
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Derrek Keith	HFA	02/23/2023

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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	of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on record review and interview, the facility failed to ensure a resident's care plan was revised with new interventions to prevent further falls for 1 of 3 residents reviewed for falls (Resident D). Findings include: Resident D's clinical record was reviewed on 1/26/23 at 9:21 a.m. His diagnoses included essential hypertension, other secondary kyphosis, cervicothoracic region, pain in thoracic spine, generalized anxiety disorder, psychotic disorder with hallucinations due to known physiological condition and unspecified dementia, severe, with agitation and psychotic disturbance.	F 0657	The filing of the plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and continue to provide quality care. The facility respectfully requests paper review for compliance. What corrective action(s) will be accomplished for those residents found to have been affected by the	02/28/2023

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	His medications included amlodipine besyl-benazepril (blood pressure) 5-40 mg (milligram) daily, hydrochlorithiazide (blood pressure) 12.5 mg daily, lorazepam (antianxiety) 0.5 mg every six hours, and risperidone (antipsychotic) 0.5 mg daily. A quarterly MDS (Minimum Data Set) assessment, dated 1/10/23, indicated he was severely cognitively impaired. He required extensive assistance for bed mobility, transfers, dressing, toilet use and personal hygiene. He required limited assistance for walking in his room and the corridor, locomotion on and off the unit. He was frequently incontinent of bowel and bladder. He had a prognosis of less than six months life expectancy. He had experienced two or more falls. He had one fall with injury. Review of his nurses notes indicated the following: On 10/5/22 at 4:22 p.m., he stated he had fallen asleep and fell to the floor. He had some redness on his forehead and a small 0.5 cm (centimeter) x 0.5 cm skin tear to his right elbow. A fall risk assessment, dated 10/5/22, indicated he was at a high risk for falling. His intervention was initiated on 10/5/22 for physical therapy to screen him due to the fall. He had a 10/7/22 initiated care plan that indicated he was at risk for falls due to confusion and gait/balance problems. His interventions initiated on 10/7/22 included assist with toileting, assist with transfers, encourage and assist him to wear non-skid footwear.		deficient practice? Residents care plan was reviewed and made changes accordingly. Resident was transferred per family request to sister facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The IDT team did an audit of the residents identified as a fall risk. Updated Care Plans accordingly. Therapy screens were completed for residents identified as frequent fallers. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not reoccur. The facility fall policy was updated. On 1/20/23 Nursing staff was in-serviced on the importance of care plans. Implementation of the Falling Star Program. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Falls will be reviewed by the QA committee quarterly for six months. On 2/27/23 DON/ADON with conduct an in-service on Care plans focusing on when and how to update them when necessary	

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	The clinical record and care plan lacked a new individualized intervention to prevent further falls. On 11/9/22 at 10:45 p.m., he was found on the floor, naked and had started to have a bowel movement. He had a purple area to his left hip that measured 13 cm x 9.5 cm. A fall risk assessment, dated 11/9/22, indicated he was at high risk for falling. The clinical record and care plan lacked a new individualized intervention to prevent further falls. On 11/24/22 at 9:02 p.m., he was found sitting on the floor in his bathroom. He had a skin tear on his left elbow. Neurological and 15 minute checks were started. A fall risk assessment, dated 11/24/22, indicated he was at a high risk for falling. The clinical record and care plan lacked a new individualized intervention to prevent further falls. On 12/25/22 at 4:45 p.m., he was found on the floor between his bathroom and his room, with a blanket under his head. Blood spots were smeared in front of him. He had a skin tear and a bruise on his right elbow. He had a bleeding abrasion to his right eyebrow. Hospice was called about his injuries, and they were instructed to send him to the emergency room. On 12/26/22 at 1:50 a.m., he returned from the emergency room. He had a small laceration to his right eyebrow with dried blood present and purple bruising around it. He had a CT (Computerized Tomography) of his head and spine with negative			

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	findings. No new orders were received. The clinical record and care plan lacked a new individualized intervention to prevent further falls. On 12/26/22 at 9:53 p.m., he was found sitting behind the door to his room. He was sitting on his bottom with his legs out in front of him. He had no new injuries. A therapy screen, dated 12/29/23, indicated he had severe cognitive deficits, and he would not benefit from therapy services due to cognitive status and he was on hospice. He was unable to actively participate in therapy services due to his cognitive deficit. The clinical record and care plan lacked a new individualized intervention to prevent further falls. On 1/10/23 at 1:49 a.m., a noise was heard in Resident D's room. He was found sitting on the floor with blood on his face. He had a cut above his left eye. He was sent to the emergency room. On 1/10/23 at 4:58 a.m., he returned from the hospital with no new orders. He had cervical spine and head x-rays that showed no injuries. He had an abrasion to his face with no stitches, or staples. He was on neurological and fifteen minutes checks. A fall risk assessment, dated 1/10/23, indicated he was at a high risk for falling. The clinical record and care plan lacked a new individualized intervention to prevent further falls. On 1/17/23 at 6:30 p.m., he had a witnessed fall in the dining room after dinner. He was seen trying			

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	to sit down on an orange cone. He fell to the floor with his feet straight out in front of him. The orange cone was used for the wet floor, which was dry at the time. The intervention was for the orange cone to be removed when the floor was dry. Staff were made aware. No injuries were observed and he did not hit his head. A fall risk assessment, dated 1/17/23, indicated he was at a high risk for falling. A care plan intervention initiated on 1/17/23 was orange cone was to be removed once the floor was dry. The clinical record and care plan lacked a new individualized intervention to prevent further falls. On 1/18/23 at 1:10 p.m., blood was noticed on the floor in Resident D's room. He had bleeding to his forehead. His forehead was cleaned and revealed a large hematoma. The bleeding was from a small area in the hematoma and had started to form a clot. He complained of pain to his right foot. He was sent to the emergency room for evaluation and treatment. A fall risk assessment, dated 1/18/23, indicated he was at a high risk for falling. A review of the emergency room visit, on 1/18/23, indicated he had a chest x-ray, CT of cervical spine, and CT of his head with no injuries noted. The clinical record and care plan lacked a new individualized intervention to prevent further falls. On 1/18/23 at 8:06 p.m., Resident D was sent to a sister facility per family's request. During an interview with the DON, on 1/26/23 at			

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	9:46 a.m., she indicated Resident D had already been planning to move to a sister facility as he needed a safety unit and Brookside was not a good fit for him. He was on hospice, declining, and not steady on his feet towards the end of his stay. They would put him in a wheelchair and walk with him to the shower room. After his falls, they completed a fall note and initiated 15 minute checks. The IDT (Interdisciplinary Team) reviewed care plans. Because of his falls, staff coddled him. He forgot he could not walk. After a fall they would add interventions to the care plan. During an interview with LPN 13, on 1/26/23 at 11:04 a.m., she indicated Resident D had dementia. He was able to walk independently. The past couple weeks, he had declined and was combative and wanted to stay in bed a lot. He would just get up and didn't know how to use the call light for assistance. He kept falling because he was weak. They would put him in a wheelchair and he would get right up and walk. They monitored him closer. The interventions they would initiate were educating the resident, rearranging the resident's room, therapy evaluations and 15 minute checks. The new intervention should be added to the care plan and charted in the clinical record. During an interview with the MDS Coordinator, on 1/26/23 at 11:28 a.m., she indicated she attended the IDT meetings when she was able to. The floor nurse normally created the intervention after a fall but they worked together as a team. During an interview with the DON, on 1/27/23 at 11:20 a.m., she indicated staff were to put interventions in place after a resident fell. They communicated the new intervention after a fall with the CNAs.			

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	During an interview with CNA 5, on 1/27/23 at 11:25 a.m., she indicated was not aware if she was able to see the fall interventions on the electronic heath record. As she looked on the computer, she clicked on a couple different tabs and then clicked on the care plan tab to bring up the resident's care plans. During an interview with the ADON, on 1/27/23 at 12:52 p.m., she indicated Resident D was a frail older man, and had come to them due to behaviors at a previous facility. He was resistant to care and would urinate anywhere. He did not use an assistive device. His gait was unsteady and needed assistance of one to keep him balanced. He had gotten sick from flu going through the building. He did not use a call light for assistance. They did frequent checks on him and left his door open, but he was a mover, he felt independent and would get up on his own. The facility talked about falls daily, in the morning meetings, they would talk about what they had tried to do and what they could do and put interventions in place to work. Interventions normally started with the nurses. Immediate interventions were typically 15 minute checks to make sure the resident's needs were being met. During an interview with CNA 8, on 1/27/23 at 1:27 p.m., she indicated Resident D had not been stable on his feet for the past couple months. He should had been in a wheelchair "24/7". They would try to put him in a wheelchair or in bed and he would just get up. The last time he fell was after breakfast and he had been changed and cleaned. She was in the next room with another resident and Resident D was seen scooching across the floor and he had busted his head. Review of a current facility policy, with the			

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	effective date of 6/26/19 titled " Fall Policy & Procedure," and provided by the DON on 1/27/23 at 11:13 a.m. indicated the following: "...5. The resident care plan should be updated to reflect any new or change in interventions...." 3.1-35(b)(1)			
F 0919 SS=F Bldg. 00	483.90(g)(1)(2) Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. Based on observation and interview, the facility failed to ensure there were interventions in place when the call light system was not functioning properly for all resident rooms in the facility. Findings include: During an interview with Resident G, on 1/27/23 at 9:08 a.m., he indicated that he had fallen out of bed the night before and pushed his call light and it didn't work. He did not get hurt but struggled to get back into bed by himself. On 1/27/23 at 9:11 a.m., CNA 15 was observed testing the call lights on Resident G's hall. The call lights did not work. During an interview with the Maintenance Director and Social Service Director, on 1/27/22 at 9:13 a.m., the Maintenance Director indicated the fire and security company had been at the facility	F 0919	The filing of the plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and continue to provide quality care. The facility respectfully requests paper review for compliance. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The call lights in the residents' room identified to be nonfunctioning, had equipment replaced and issued a bell while	02/28/2023

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	to work on the fire alarm the day prior, but didn't have time to fix the call lights and would be in sometime later in the week to fix them. The Social Service Director indicated their sister facility had their bells (for resident use) and they would have to get them back. The call lights had worked yesterday because she had answered two calls. During an observation of testing the resident's call lights, on 1/27/23 at 10:26 a.m., room 12-D did not have a call light present and his roommates call light did not work. Resident K indicated his call light had not worked in the last three to four days. The call lights in all residents' rooms were not functioning. During an interview with Resident H, on 1/27/23 at 10:30 a.m., she indicated her call light had not worked in three to four days. During an interview with CNA 5, on 1/27/23 at 10:43 a.m., she indicated the call lights had not worked since the day before when the company was in the building to work on the fire alarm. During an interview with the Maintenance Director, on 1/27/23 at 11:03 a.m., he indicated one of the CNAs came to him a week ago and indicated a couple of the resident's call lights were not working. He changed the bulbs, but they still didn't work and the Administrator was aware. During an observation of the Maintenance/Requisition/Work orders for the two rooms, each dated 1/23/23, one indicated the call light was burnt out and the other was broken. During an interview with the Administrator, on 1/27/23 at 11:11 a.m., he indicated he was not aware of the call lights not working at all. He knew		the system was offline for repairs. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? A facility-wide audit was performed by the Director of Maintenance, to determine if any of the call lights are nonoperational or not functioning properly. No other issues were identified. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not reoccur. Staff received an in-service on 2/7/2023, on proper steps to take if the call light is not working properly. We will conduct a call light audit twice a week for six-week times 5 rooms. Then once a week for six weeks times 5 rooms. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The results from the Call light audit will be reviewed by the QA committee quarterly for six months.	

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	the bulbs had been replaced. During an interview with Resident J, on 1/27/23 at 11:28 a.m., she indicated her call light had not worked for at least a week. A review of the fire and security company's service tickets, provided by the Administrator, on 1/27/23 at 11:57 a.m., indicated the following: On 12/6/23, the company was at the facility to service the nurse call system. The annunciator to the nurse call system was not making any sound when station was active. The connections were tightened and was able to get the annunciator to make a buzz for the nurses to hear. Onsite staff was happy with the notification it was making and the system was functioning at the time of their departure. On 1/10/23, the company was at the facility to service the fire alarm. On 1/25/23, the company was at the facility to service the fire alarm. During an interview with the ADON, on 1/27/23 at 12:52 p.m., the Administrator indicated to her the reason for the call light system not working was a blown fuse. Review of a current facility policy, revised 12/31/22 titled "Call Lights: Policy and Procedure," and provided by the Administrator, on 1/27/23 at 11:57 a.m., indicated the following: "Procedure: 1. Each Resident will be provided with a call light at his or her bedside...7. In the event the call light system malfunctions the facility will distribute hand bells to all resident and staff will check in with each Resident twice an hour. Additionally, a			

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	staff member will be assigned to monitor each Resident hallway and respond to bells.... 3.1-19(u)			