PRINTED: 11/13/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		B. WING		10/17/2024	
			STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF PROVIDER OR SUPPLIER				ECUTIVE DR	
BROOKE	DALE CARMEL		CARM	EL, IN 46032	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG R 0000	REGULATORY O.	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
1 0000					
Bldg. 00	This visit was for the Investigation of Complaints IN00435497, IN00435498, IN00435788 and IN00435971. Complaint IN00435497 - State deficiencies related to the allegations are cited at R0036. Complaint IN00435498 - State deficiencies related to the allegations are cited at R0029, R0036 and R0240. Complaint IN00435788 - State deficiencies related to the allegations are cited at R0029. Complaint IN00435971 - State deficiencies related to the allegations are cited at R0029 and R0240. Survey dates: October 16 and 17, 2024. Facility number: 010416 Residential Census: 50 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on October 24, 2024.		R 0000	The Following plan of correctic Brookdale Carmel regarding the statement of Deficiencies date October 24th, 2024. This Plan Correction is not to be construed as an admission of or agreem with the findings and conclusion in the statement of Deficiencies or any related sanction or fine Rather, it is a submitted as confirmation of our ongoing effort to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response each allegation or finding, nor we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to no changes and improvement to satisfy that objective.	ne ed of leed ent lons les, lond forts les to have s.
R 0029	410 IAC 16.2-5-1 Residents' Rights	• •			
Bldg. 00	Based on observati review, the facility treated with respec a CNA used an imp	on, interview and record failed to ensure a resident was t and dignity during care when proper technique to turn the 1 of 1 resident reviewed for	R 0029	R029- Based on the observati interview and record review, the facility failed to ensure a resid was treated with respect and dignity during care when a CN used an improper technique to turn resident.	ne ent
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIC	NATURE	TITLE	(X6) DATE

(X6) DATE

Pamala Williams **Executive Director** 11/08/2024

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.

State Form Event ID: L1X911 Facility ID: 010416 If continuation sheet Page 1 of 6

PRINTED: 11/13/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
			B. WING			10/17	/2024
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD	<u>I</u>	
NAME OF F	PROVIDER OR SUPPLIE	R			ECUTIVE DR		
BBOOKE	DALE CARMEL				EL, IN 46032		
DROUKL	DALE CARIVIEL			CARIVIE	EL, IIN 40032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		1	TAG	DEFICIENCY)		DATE
					What corrective action(s) will t	ре	
	During an observat	ion of a facility video, on			accomplished for those reside	ents	
	10/17/24 at 1:33 p.1	m., with the Director of Nursing			found to have been affected b	y the	
	present, CNA 1 wa	s observed to approach			deficient practice.		
		as laying her bed. The CNA put					
		resident's legs then using her			*Resident B was discharg	jed	
		Resident B's right hand and			to the hospital on June 11th, 2	2024,	
		and pulled the resident onto			and did not return to the		
	her left side. The C	NA was not observed to use a			community.		
	bed pad or a draw s	sheet for the transfer.					
					How the facility will identify oth	ner	
		for Resident B was reviewed			residents having the potential	to	
		25 a.m. The diagnoses included,		be affected by the same deficient		ient	
	but were not limited to, repeated falls, Alzheimer's			practice and what corrective action		ction	
	dementia, and hypertension.			will be taken.			
					*All residents had the		
	During an interview, on 10/17/24 at 1:34 p.m., the				potential to be affected.		
	_	g indicated the CNA did grab					
		o turn her which was an			What measures will be put into	0	
	incorrect way to car	re for a resident.			place or what systemic change	es	
					the facility will make to ensure	!	
		interview, on 10/17/24 at 2:10			that the deficient practice does	s not	
	-	ated when turning a resident, the			recur:		
		uld be crossed over the chest			*Direct care associates w	ere	
		egs should be crossed. Then			re-educated on repositioning		
		a draw sheet, the resident			technique while the resident is		
	could be turned. Sta	aff should not grab a resident's			bed, by the Health & Wellness	3	
	arm and pull them	to turn.			Director, Home Health Physic	al	
					therapist, or designee. This		
		olicy, titled "Indiana Resident			retraining will utilize demonstra	ating	
	-	ust 2012 and received from the			and return demonstration by		
	Director of Nursing on 10/17/24 at 3:09 p.m.,				associate.		
	indicated "You have a right to the followingTreatment with consideration, respect and recognition of your dignity"						
					How the corrective action(s) w		
					monitored to ensure the defici		
					practice will not recur, i.e., who		
		s to Complaint IN00435788,			quality assurance program wil	l be	
	IN00435971 and IN	N00435498.			put into place.		
					*Health & Wellness Direc	ctor	
			1		or designee to observe three ((3)	

State Form Event ID: L1X911 Facility ID: 010416 If continuation sheet Page 2 of 6

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/13/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>00</u>		COMPLETED			
			B. WING		10/17/2024			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
					ECUTIVE DR			
BROOKDALE CARMEL			CARMEL, IN 46032					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	SHOULD BE COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)			
					associates weekly for proper b	ed		
					positioning techniques for eigh			
					weeks. Health & Wellness	it (0)		
					Director and or designee to			
					observe ten (10) associates pe	or		
					month for 4 months. Any issue	;5		
					identified will be brought to			
					morning meeting Monday thro	ugh		
					Friday and addressed per			
					community policy.			
					By what date the systemic			
					changes will be completed			
					11.6.2024			
R 0036	410 IAC 16.2-5-1.	2(k)(1-2)						
	Residents' Rights-	- Deficiency						
Bldg. 00	-							
	Based on interview	and record review, the facility	R 00	36	R0036 Evalution Deficiency-	ļ	11/08/2024	
	failed to notify a res	sponsible party of a resident's			Residents Rights based on			
	•	ents reviewed for notification.			interview and records review,	the		
	(Resident B)				facility failed to notify a			
	,				responsible party of a resident	ts		
	Finding includes:				fall 1 of 7 residents reviewed f			
	1 maning merades.				notification. (Resident B).	OI		
	During a telephone	interview, on 10/17/24 at 9:16			nouncation. (Resident D).	ļ		
		ant indicated Resident B had			M/b at carractive action(a) will b			
		alls. The resident had also			What corrective action(s) will be			
	-				accomplished for those reside			
		lip and an injury to her left			found to have been affected by	y ine		
	_	plainant did not feel the facility			deficient practice.			
		the family of all falls and skin			*Resident B was discharg	•		
	issues.				to the hospital on June 11th, 2	.024,		
					and did not return to the			
		for Resident B was reviewed			community.	ļ		
		5 a.m. The diagnoses included,				ļ		
	but were not limited	d to, repeated falls, Alzheimer's			How the facility will identify oth	ner		

State Form Event ID: L1X911 Facility ID: 010416 If continuation sheet Page 3 of 6

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/13/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPL	ETED
			B. WING			10/17/2024	
				OTD PPT	ADDRESS CITY STATE ZIP COP		
NAME OF P	ROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
BROOKBALE OARMEL			301 EXECUTIVE DR CARMEL, IN 46032				
BROOKDALE CARMEL				CARINE	EL, IN 46032		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	dementia, and hyper	rtension.			residents having the potential	to	
					be affected by the same defici	ent	
	There was no docur	nentation in the record to			practice and what corrective a	ction	
	show the resident's	Power of Attorney (POA) had			will be taken.		
	been notified of an	unwitnessed fall on 5/12/24 or			Any residents with a fall ha	ve	
	of the unwitnessed	fall on 5/14/24.			the potential to be affected.		
	During an interview	y, on 10/17/24 at 12:33 p.m., the			What measures will be put into)	
	Director of Nursing	indicated a staff member did			place or what systemic change		
	contact the POA on	5/15/24 to inform the POA of			the facility will make to ensure		
	the need to get an x-	-ray. The notes did not			that the deficient practice does		
	indicate notification	had been made on the date of			recur: Health & Wellness Direc		
	the fall.				and or designee to educate		
					nursing staff on Brookdale falls	S	
	A current facility policy, titled "Falls Management				change in condition policy with		
	Policy," dated as las	st revised 1/2024 and received			emphasis on notification to		
	from the Director of Nursing on 10/17/24 at 3:09				responsible party.		
	p.m., indicated "N				' ' '		
	_	party and document in the			How the corrective action(s) w	ill be	
	resident record"	•			monitored to ensure the deficie		
					practice will not recur, i.e., wha		
	This citation relates	to Complaints IN00435497			quality assurance program will		
	and IN00435498.	•			put into place. Executive Direc		
					and or designee to audit 20%		
					falls a month for 3 months, 10		
					falls for 3 months, to verify	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
					physician & POA were notified		
					Any issues identified will be	•	
					brought to morning meeting		
					Monday-Friday and addressed	l ner	
					community policy.	, poi	
					Community policy.		
					By what date the systemic		
					changes will be completed		
					11.8.2024		
					11.0.2027		
	l		ı		I		

State Form Event ID: L1X911 Facility ID: 010416 If continuation sheet Page 4 of 6

PRINTED: 11/13/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
		B. WING			10/17/2024		
NAME OF PROVIDER OR SUPPLIER BROOKDALE CARMEL			STREET ADDRESS, CITY, STATE, ZIP COD 301 EXECUTIVE DR CARMEL, IN 46032				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ΓE	(X5) COMPLETION	
TAG R 0240	REGULATORY OR LSC IDENTIFYING INFORMATION 410 IAC 16.2-5-4(d)			TAG	DEFICIENCY		DATE
Bldg. 00	Health Services - Deficiency Based on observation, interview and record review, the facility failed to ensure assistance with activities of daily living was provided based on the resident's needs and as ordered by therapy for 1 of 1 resident reviewed for transfers. (Resident B)		R 0240		R0240- Based on the observatinterview and record review, the	ne	11/06/2024
					facility failed to ensure assistar with activities of daily living wa provided based on the residen needs and as ordered by there	s ts apy	
	Finding includes: During an observation of a facility video, on				for 1 of 1 resident reviewed for transfers. (Resident B)		
	10/17/24 at 1:33 p.m., with the Director of Nursing present, CNA 1 was observed to transfer Resident B using a mechanical lift to assist the resident from a sitting position to a standing position from the bed to a wheelchair. The CNA performed the task alone.				What corrective action(s) will be accomplished for those resider found to have been affected by deficient practice. *Resident B was discharg to the hospital on June 11th, 2 and did not return to the	nts y the ged	
	The clinical record for Resident B was reviewed on 10/16/24 at 10:25 a.m. The diagnoses included, but were not limited to, repeated falls, Alzheimer's dementia, and hypertension. A facility document, titled "Visit Note Report," dated 5/17/24, indicated "Discussed 2-3 person assisted transfers needed, or sit to stand mechanical lift with assist of 2 persons" The document was signed by the physical therapist on 5/20/24. During an interview, on 10/17/24 at 1:34 p.m., the Director of Nursing indicated the lift procedure was for a two (2) person transfer and the CNA should have had assistance with the transfer.				community. How the facility will identify oth residents having the potential to be affected by the same deficiency practice and what corrective as	to ent	
					will be taken. *Any residents that have order for mechanical lifts have potential to be affected.	an the	
					What measures will be put into place or what systemic change the facility will make to ensure that the deficient practice does recur: *Direct care associates to be a seed on the Proceedings.	es s not o	
During a telephone interview, on 10/17/24 at 2:10 p.m., CNA 1 indicated when using the mechanical lift, you should have two (2) staff.				be re-educated on the Brookda mechanical lift policy, by Healt Wellness Director, Home Heal Physical Therapist, and or	h &		

State Form Event ID: L1X911 Facility ID: 010416 If continuation sheet Page 5 of 6

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/13/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COMPLETED 10/17/2024				
			<u> </u>		10/17/	2024		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 301 EXECUTIVE DR					
BROOKDALE CARMEL			CARMEL, IN 46032					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TE	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE		
	_	v, on 10/17/24 at 2:20 p.m., CNA		designee with an emphasis or	า			
		was a two-person transfer, one		using two (2) associates with				
	•	and observed it was safe and		mechanical lifts.				
	the other person sho	ould operate the lift.						
		1' - ('d 1994 1 ' 17'0		How the corrective action(s) w				
		olicy, titled "Mechanical Lift		monitored to ensure the defici				
	•	om the Director of Nursing on		practice will not recur, i.e., what				
	_	m., did not discuss the need for		quality assurance program will be				
	two person transfers when using the mechanical			put into place. *Health & Wellness				
	lift.							
	This citation relates to Complaints IN00435498 and IN00435971.			Director or designee to observ	/e			
				three (3) associates weekly				
				utilizing mechanical lift for 8				
				weeks. And then observe 10				
				associates per month for 4	.:11			
				months. Any issue identified v				
				be brought to morning meeting	y			
				Monday through Friday and	iov			
				addressed per community pol	icy.			
				By what date the systemic				
				changes will be completed				
				11.6.2024				

State Form Event ID: L1X911 Facility ID: 010416 If continuation sheet Page 6 of 6