STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKDALE CARMEL	301 EXECUTIVE DR CARMEL, IN 46032

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R 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 correction for Brookdale Carmel regarding the statement of Deficiencies dated October 24th, 2024. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts 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 to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.	
R 0029 Bldg. 00	410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency Based on observation, interview and record review, the facility failed to ensure a resident was treated with respect and dignity during care when a CNA used an improper technique to turn the resident in bed for 1 of 1 resident reviewed for respect and dignity. (Resident B) Finding includes:	R 0029	R029- Based on the observation, interview and record review, the facility failed to ensure a resident was treated with respect and dignity during care when a CNA used an improper technique to turn resident.	11/06/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(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.

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	During an observation of a facility video, on 10/17/24 at 1:33 p.m., with the Director of Nursing present, CNA 1 was observed to approach Resident B, who was laying her bed. The CNA put her left hand on the resident's legs then using her right hand grabbed Resident B's right hand and wrist, said roll over and pulled the resident onto her left side. The CNA was not observed to use a bed pad or a draw sheet for the transfer. 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. During an interview, on 10/17/24 at 1:34 p.m., the Director of Nursing indicated the CNA did grab the resident's arm to turn her which was an incorrect way to care for a resident. During a telephone interview, on 10/17/24 at 2:10 p.m., CNA 1 indicated when turning a resident, the resident's arms should be crossed over the chest and the resident's legs should be crossed. Then using a bed pad or a draw sheet, the resident could be turned. Staff should not grab a resident's arm and pull them to turn. A current facility policy, titled "Indiana Resident Rights," dated August 2012 and received from the Director of Nursing on 10/17/24 at 3:09 p.m., indicated "...You have a right to the following...Treatment with consideration, respect and recognition of your dignity...." This citation relates to Complaint IN00435788, IN00435971 and IN00435498.		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. *Resident B was discharged to the hospital on June 11th, 2024, and did not return to the community. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. *All residents had the potential to be affected. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: *Direct care associates were re-educated on repositioning technique while the resident is in bed, by the Health & Wellness Director, Home Health Physical therapist, or designee. This retraining will utilize demonstrating and return demonstration by associate. 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. *Health & Wellness Director or designee to observe three (3)	

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			associates weekly for proper bed positioning techniques for eight (8) weeks. Health & Wellness Director and or designee to observe ten (10) associates per month for 4 months. Any issues identified will be brought to morning meeting Monday through Friday and addressed per community policy. By what date the systemic changes will be completed 11.6.2024	
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency Based on interview and record review, the facility failed to notify a responsible party of a resident's fall for 1 of 7 residents reviewed for notification. (Resident B) Finding includes: During a telephone interview, on 10/17/24 at 9:16 a.m., the complainant indicated Resident B had many bruises and falls. The resident had also sustained a swollen lip and an injury to her left forehead. The complainant did not feel the facility had been notifying the family of all falls and skin issues. 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	R 0036	R0036 Evalution Deficiency- Residents Rights based on interview and records review, the facility failed to notify a responsible party of a residents fall 1 of 7 residents reviewed for notification. (Resident B). What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. *Resident B was discharged to the hospital on June 11th, 2024, and did not return to the community. How the facility will identify other	11/08/2024

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	dementia, and hypertension. There was no documentation in the record to show the resident's Power of Attorney (POA) had been notified of an unwitnessed fall on 5/12/24 or of the unwitnessed fall on 5/14/24. During an interview, on 10/17/24 at 12:33 p.m., the Director of Nursing indicated a staff member did contact the POA on 5/15/24 to inform the POA of the need to get an x-ray. The notes did not indicate notification had been made on the date of the fall. A current facility policy, titled "Falls Management Policy," dated as last revised 1/2024 and received from the Director of Nursing on 10/17/24 at 3:09 p.m., indicated "...Notify the resident's family/responsible party and document in the resident record...." This citation relates to Complaints IN00435497 and IN00435498.		residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Any residents with a fall have the potential to be affected. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Health & Wellness Director and or designee to educate nursing staff on Brookdale falls change in condition policy with emphasis on notification to responsible party. 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. Executive Director, and or designee to audit 20% of falls a month for 3 months, 10% of falls for 3 months, to verify physician & POA were notified. Any issues identified will be brought to morning meeting Monday-Friday and addressed per community policy. By what date the systemic changes will be completed 11.8.2024	

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R 0240 Bldg. 00	410 IAC 16.2-5-4(d) 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) Finding includes: During an observation of a facility video, on 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. 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. 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.	R 0240	R0240- Based on the observation, interview and record review, the facility failed to ensure assistance with activities of daily living was provided based on the residents needs and as ordered by therapy for 1 of 1 resident reviewed for transfers. (Resident B) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. *Resident B was discharged to the hospital on June 11th, 2024, and did not return to the community. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. *Any residents that have an order for mechanical lifts have the potential to be affected. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: *Direct care associates to be re-educated on the Brookdale mechanical lift policy, by Health & Wellness Director, Home Health Physical Therapist, and or	11/06/2024

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	During an interview, on 10/17/24 at 2:20 p.m., CNA 2 indicated the lift was a two-person transfer, one person should spot and observed it was safe and the other person should operate the lift. A current facility policy, titled "Mechanical Lift Policy," received from the Director of Nursing on 10/17/24 at 3:09 p.m., did not discuss the need for two person transfers when using the mechanical lift. This citation relates to Complaints IN00435498 and IN00435971.		designee with an emphasis on using two (2) associates with mechanical lifts. 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. *Health & Wellness Director or designee to observe three (3) associates weekly utilizing mechanical lift for 8 weeks. And then observe 10 associates per month for 4 months. Any issue identified will be brought to morning meeting Monday through Friday and addressed per community policy. By what date the systemic changes will be completed 11.6.2024	