STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155814	A. BUILDING _____ B. WING _____	C 03/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKE KNOLL VILLAGE	1108 KINGWOOD DRIVE AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00427498 and IN00428895. Complaint IN00427498 - No deficiencies related to the allegations are cited. Complaint IN00428895 - Federal/State deficiencies related to the allegations are cited at F0689. Survey dates: March 8, 11, and 12, 2024 Facility number: 012901 Provider number: 155814 AIM number: 201215100 Census Bed Type: SNF/NF: 71 SNF: 14 Total: 85 Census Payor Type: Medicare: 14 Medicaid: 49 Other: 22 Total: 85 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 21, 2024.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		

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

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F 689	Continued From page 1 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident's wheelchair wheels were engaged into the facility van wheelchair-locks properly for 1 of 3 residents reviewed for accidents (Resident B). The deficient practice was corrected on 2/22/24, prior to the start of the survey, and was therefore Past Noncompliance. Finding includes: A confidential interview during the survey indicated on 2/20/24 Resident B was being transported in the facility van while seated in her wheelchair. Resident B's wheelchair was not strapped into the van properly. The wheelchair and resident tipped over and the resident hit her head. During an interview, on 3/8/24 at 2:00 p.m., the Corporate Consultant (CC) indicated Resident B had an accident while riding in the facility van. The van made a sudden stop that caused the resident and the wheelchair to tip backwards. The resident her hit head on the wall/floor of the van. A facility nurse went to the van and assessed the resident. The resident had a bump on the back of her head. The resident went to the hospital. The facility spoke with the van manufacturer about the van's automatic wheelchair locks, and they suggested getting upgraded hand crank straps to hold the wheelchair better in place. The facility	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2	F 689		

van has been out of commission since the incident. The facility had another van which had hand crank straps to hold the wheelchairs in place during transports that the facility had been utilizing.

Resident B's record was reviewed on 3/8/24 at 2:30 p.m. The resident was admitted to the facility on 2/12/24 with the diagnoses that included, but were not limited to, type 2 diabetes mellitus with diabetic chronic kidney disease (high blood sugar with kidney damage) and dependence on renal dialysis (procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly).

An admission Minimum Data Set (MDS) assessment, dated 2/15/24, indicated the resident was cognitively intact, required supervision or touching assistance for transfers, and received dialysis while a resident at the facility.

An Accident and Incident Report and Investigation, dated 2/20/24 at 8:40 a.m., indicated the Administrator (ADM) had contacted a nurse to come assess Resident B, who had fallen while riding in the facility van with noted hematoma (bump) to the forehead. Resident B denied pain and indicated she was sitting in her wheelchair in the van when the driver hit the brakes and the wheelchair flipped backwards causing the resident to fall into the back of the van. The resident's family arrived and requested Resident B be sent to the emergency room for further evaluation.

A hospital record, dated 2/20/24 at 9:50 a.m., indicated the resident was being transported in the facility van. The wheelchair wheels were not

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F 689	Continued From page 3	F 689		

engaged in the van properly. The van made a sudden stop which caused the wheelchair to tip backwards and the resident hit her head on wall/floor of van. The resident required assistance to stand and endorsed constant frontal headache since incident. Noticed head swelling but not bleeding. An x-ray of the resident's head and neck showed low force trauma to the head without signs of active bleeding and no abnormalities. The resident was discharged from the hospital and returned to the facility the same day as the incident.

The transportation driver's statement, dated 2/20/24, indicated, that morning, during transport of Resident B, the driver began merging into traffic, had to tap the van brakes, and he observed Resident B begin to tip in her wheelchair. Upon stopping the van, the driver immediately opened the back hatch to view the resident. Resident B was attempting to rise by herself, and the driver assisted the resident by bringing the wheelchair into the upright position to prevent any injury, as the resident was demanding to get up and attempting to rise by herself. The driver contacted the ADM about the incident. The ADM had a nurse come to the site to assess the resident within 15 minutes. The resident's family arrived and requested the resident be sent to the hospital for evaluation. The ADM and driver confirmed the wheelchair brakes were applied and the back two wheelchair wheel restraints were locked into place, but the front two wheelchair wheel restraints were not attached. The van was inspected by the automobile dealership with results of the wheel restraints and vehicle securement system were working properly.

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The ADM's statement, dated 2/20/24, indicated she had received a call from the transportation driver indicating while transporting Resident B he had tapped his brakes and saw the resident tip in her wheelchair. The ADM had a nurse go to the scene and assess the resident. The resident was sent to the emergency room via 911, and the ADM immediately took the vehicle out of service. The wheelchair was assessed with no concerns. No obvious signs of equipment damage in the van. The vehicle was taken to the dealership for inspection. The dealership advised that no malfunctions of equipment were noted and that there was a potential that if the resident was too close at the time she was secured that the latch would not secure. Dealership advised that the facility could upgrade to self-securement system, but this incident was possibly the result of user error and not ensuring the securement device "clicked" prior to moving the vehicle. Upon return of the van, on 2/22/24, the ADM provided education to transportation drivers, to confirm a secure click, when securing residents' wheelchairs wheels properly in the facility van with a return demonstration from the transportation drivers.

A confidential interview during the survey indicated, on 2/20/24, the interviewee was waiting for Resident B at the dialysis center and had called Resident B to see where she was. Resident B answered the phone, explained the van incident, and they went to the scene of the van incident to see the resident. The transportation driver, the ADM, and a nurse were at the scene. They observed swelling on Resident B's head and a knot on the front of the resident's forehead, and requested the resident be sent to the hospital emergency room for examination.

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The hospital staff indicated the resident did not have any active bleeding from the incident and the resident returned to the facility.

On 3/8/24 at 3:35 p.m., the Corporate Consultant provided and identified a document as a current facility policy, titled "Accident and Incident Reporting," dated 10/2014. The policy indicated, "...Purpose: To document all accidents and incidents occurring to residents, employees and visitors...Policy: An Accident/Incident Report form is to be completed for all incidents involving residents, employees and visitors. A written description of circumstances surrounding the incident is to be completed and submitted to the nursing supervisor as soon as possible during the tour of duty in which the incident occurred. The report form should be initiated as soon as possible following the incident, after appropriate assessment and necessary emergency intervention is completed...Procedure: 1. Resident: Complete assessment and provide necessary emergency care...Notify physician, family and nursing supervisor...4. In All Cases: Generate Accident/Incident Report Form...Provide an accurate, written description of the circumstances surrounding the accident/incident...."

The Past Noncompliance deficiency began on 2/20/24 and was removed and corrected by 2/22/24, after the facility implemented a systemic plan that included the following actions: the facility van was out of commission since the incident, the van was inspected by the dealership, and the facility staff in-serviced the transportation drivers to ensure the van's wheelchair wheels locks were fully engaged into the wheelchair restraint locks before transporting a resident.

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F 689	Continued From page 6 This citation relates to Complaint IN00428895. 3.1-45(a)(1)	F 689		