PRINTED: 10/07/2024

	PARTMENT OF HEALTH AND HUMAN SERVICES NTERS FOR MEDICARE & MEDICAID SERVICES						
			_			OMB NO. 0938-039	
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E064		ILDING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/23/2024	
	PROVIDER OR SUPPLIER			505 N (ADDRESS, CITY, STATE, ZIP COD GAVIN ST IE, IN 47303		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
F 0000 Bldg. 00	IN00441003 and IN a Partially Extended of Care - Immediate Complaint IN00441 related to the allega Complaint IN00440 related to the allega F626. Survey dates: Augu Facility number: 00 Provider number: 1 AIM number: 1002 Census Bed Type: NF: 32 Total: 32 Census Payor Type Medicaid: 29 Other: 3 Total: 32	1003 - Federal/State deficiencies tions are cited at F600. 10457 - Federal/State deficiencies tions are cited at F622 and 10311 5E064 85520	F 00	000	By submitting the following material, we are not admitting truth or accuracy of any specifindings or allegations. We rethe right to contest the finding allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The farequests the plan of correction considered our allegation of compliance effective 09/18/20 the state findings of the recent complaint investigation. We a requesting paper compliance.	offic serve as or e cility n be 024 to at re	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

interview, the facility failed to ensure a cognitively

accordance with 410 IAC 16.2-3.1.

Free from Abuse and Neglect

Based on observation, record review and

Quality review completed September 4, 2024.

TITLE

Requesting IDR review as facility

followed the Abuse policy and

(X6) DATE

09/18/2024

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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F 0600

483.12(a)(1)

F 0600

SS=G

Bldg. 00

10/07/2024 PRINTED: FORM APPROVED OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15E064 B. WING 08/23/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 505 N GAVIN ST **BROOKSIDE CARE STRATEGIES** MUNCIE. IN 47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE impaired resident who wandered (Resident D) was procedures. free from resident-to-resident physical abuse perpetrated by a resident known to be physically It is the practice of this facility to abusive towards others when approached ensure residents are free from (Resident C) for 1 of 3 residents reviewed for abuse, neglect, misappropriate of abuse. This deficient practice resulted in Resident resident property, and exploitation. D sustaining a head laceration and required emergent treatment at the hospital with six sutures 1. What corrective actions will be accomplished for those residents to repair. found to be affected by the Findings include: deficient practice: a. Resident C is no longer a Review of an Incident Report sent to the Indiana resident. Department of Health's reporting system b. The Resident D plan of care indicated, on 8/15/24 at 9:01 p.m., Resident D was was reviewed and updated to found lying on the floor in Resident C's room. reflect interventions as needed. Resident D had a laceration on the left side of his c. Staff were educated 9/18/2024 head and bruising to his chest and head. Resident on the location of interventions for C indicated there had been an altercation. each resident. A local police department's case report, dated 2. How other residents having the 8/15/24 and provided by the Director of Nursing potential to be affected by the same deficient practices will be (DON) on 8/21/24 at 10:25 a.m., indicated as the officer got to the door of Resident C's room, blood identified and what corrective was observed on the floor inside the entryway. action will be taken: Resident C was asked about what happened and a. All residents have the potential he advised that Resident D had walked into his to be affected by the alleged room while he was asleep. Resident C was unsure deficiency. how many times he stomped on Resident D's b. An audit of residents that head. Resident C also stated that he had thoughts exhibit the wandering behavior has of harming others. An employee had indicated to been completed and the plan of

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the officer they had not seen the incident, but

witnessed Resident C standing over the top of

Resident C's clinical record was reviewed on

cognitive impairment, alcohol use, history of

8/19/24 at 11:28 a.m. Diagnoses included mild

cerebral infarction, mood disorder, cocaine abuse,

Resident D while yelling.

and epileptic syndrome.

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care updated with interventions.

3. What measures will be put in place and what systemic changes

deficient practice does not recur:

a. An in-service was completed

on 9/18/2024 for all staff on the

Abuse policy and challenging

will be made to ensure that

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15E064	B. WI	NG		08/23	/2024
				CTD PPT	ADDRESS CITY STATE ZIR COP		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
BBOOKS		TOIT S			GAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES		MUNCI	E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	*	DATE
					behaviors for direct care staff.		
	A current care plan, revised on 5/3/24, indicated				b. An in-service was complete	ed	
	the resident had pot	ential to be verbally			on 9/18/2024 for all staff on th	е	
	aggressive and had	threatening behaviors when			location of interventions for ea	ch	
	others were loud, repetitive, or when there lacked				resident.		
	space at a dining room table he wanted to sit. An						
	intervention indicat	ed the resident's triggers for			4. How the corrective actions	will	
	verbal aggression w	vere when others come too			be monitored to ensure the		
	close to him. The bo	ehaviors were de-escalated by			deficient practices will not occ	ur:	
	keeping wanderers	away from him.			a. The Interdisciplinary Team	will	
					review 5 residents' behavior ca	are	
	The most recent qua	arterly Minimum Data Set			plans per week for the next 4		
	(MDS) assessment,	dated 6/6/24, indicated			weeks. Then reviews will be		
	resident was cogniti	ively intact, had verbal		completed for 5 residents 1 time			
	behaviors directed a	at others on one to three days			every 4 weeks for the next		
	during the assessme	ent period and physical			quarter. If compliance is		
	behaviors directed t	owards himself on one to			maintained for the next 6 mon	ths,	
	three days during th	e assessment period.			then reviews will be completed	t	
					during admission, quarterly,		
	A current care plan,	, revised on 6/20/24, indicated			significant change, or as need	ed.	
	the resident had pot	ential to be physically			If discrepancies are noted, the	en	
	aggressive to others	s, shoved others, and			immediate action will be taken	to	
	attempted to hit oth	ers. Interventions included			correct.		
	intervene before agi	itation escalates, guide away			b. Findings from review and a	ıny	
	from source of distr	ress, engage in conversation,			corrective actions will be		
		alk away and approach later.			discussed during QAPI meetir	ngs	
	The resident was to	be encouraged to seek out a			and the current plan revised a	s	
	staff member when	agitated. On 8/16/24, an			warranted.		
		ded to this care plan to offer					
	to take resident to the	ne courtyard if agitated.					
		ement Monthly Review, dated					
	8/6/24, indicated Resident C had 18 incidents of						
	verbal behaviors, 16 incidents of physical						
	behaviors and 18 incidents of yelling in a common						
	area. The behaviors currently being monitored						
	were verbal yelling and physical behaviors in						
	common areas. The	e report indicated the					
	interventions were s	successful.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL		00	COMPL	
		15E064	B. WINC	<u> </u>		08/23/	/2024
	PROVIDER OR SUPPLIER			505 N G	.ddress, city, state, zip cod GAVIN ST E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVINED'S BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	7	ΓAG	DEFICIENCY)		DATE
	-	rogress note, dated 8/12/24 at					
		ed the resident had seen the					
	mental health provider on 8/9/24. During the session, the resident had expressed to the						
		-					
		tion with loud peers. He e on his own. The clinician					
		sident on positives of living in					
		need him identify ways to take					
	breaks.						
	A nurse's note, date	d 8/15/24, indicated Resident					
		when he attacked another					
		C indicated he had been trying					
	-	C boasted about "stomping" on					
		head. The police removed					
		e facility and took him to the					
	emergency departm	ent.					
	The clinical record	for Resident D was reviewed					
		a.m. Diagnoses included mild					
	neurocognitive diso	order without behavioral					
	disturbances, anxiet	ty disorder, psychotic					
	disorder, and insom	mia.					
	•	, initiated on 9/5/23, indicated					
	_	riods of restlessness.					
		led to involve the resident in					
		es as possible and to redirect					
	the resident away fr	OIII UOOIS.					
	A current care plan.	, revised on 1/10/24, indicated					
	_	vanderer related to impaired					
	safety awareness, w	vandering up and down the					
		included to distract resident					
		offering pleasant diversions,					
		, food, conversation,					
	television, a book, and to ensure safety with						
	wandering.						
	The care plans lack	ed a interventions regarding					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· /		NSTRUCTION	(X3) DATE SI		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL		00	COMPLETED		
		15E064	B. WING	G		08/23/2	2024	
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD			
			505 N GAVIN ST					
BROOKS	SIDE CARE STRAT	EGIES		MUNCIE, IN 47303				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION age Resident D wandering and		TAG	DEFICIENCE		DATE	
	entering other resid	-						
	entering other resid	ent rooms.						
	A current care plan, revised 4/4/24, indicated the							
	resident had potential to be physically aggressive							
		times, felt he was protecting						
		s included to increase						
	activities and one of							
		resident showed increased						
	_	rs and monitor and document s of the resident posing						
	danger to self and o							
	danger to sen and o	thers.						
	A current care plan.	revised 5/3/24, indicated the						
	resident had impair	ed verbal communication as						
	evidenced by absen	t speech, weak voice,						
		orrect words and decreased						
		nsion. Interventions included						
	1	or "no" questions, give him						
		pond, speak slowly and simply						
	1	alm tone, and use non-verbal						
	etc.)	bs up, thumbs down, smile,						
	- Cic.)							
	An annual MDS ass	sessment, dated 7/30/24,						
		nt had a severe cognitive						
	1	ental illness. The resident had						
	_	difficulty communicating						
		shing thoughts. He usually						
		out missed some part or intent						
		e had episodes of wandering						
		s of the assessment period. He						
	_	assistance for eating and was for hygiene, toileting,						
		ssing. He was independent						
	with ambulation.	5. The was independent						
	with amountain.							
	A progress note, dated 8/16/2024 at 3:15 a.m.,							
	indicated Resident	D returned to the facility from						
	the emergency room	n with six sutures to the left						

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ľ í		NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	G	00	COMPL		
		15E064	B. WING	_		08/23/	/2024	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	-		
DDOOKS		ECIES	505 N GAVIN ST MUNCIE, IN 47303					
DROOKS	SIDE CARE STRAT	EGIES	IMU	INCIE	=, IIN 47 303			
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	CY MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY		DATE	
	his face, neck and c	, with multiple scratches on						
	ills face, fleck and c	nest.						
	During an interview	on 8/19/2024 at 2:49 p.m.,						
	CNA 1 indicated, on the evening of 8/15/24, staff							
		ing for help. CNA 1 found						
	_	loor of Resident C's room.						
	Resident C was star	nding over Resident D.						
		d aggressive and Resident D						
		oor in a pool of blood.						
		A 1 he had beaten Resident D						
		ten him up. CNA 1 asked if he						
		t D, and Resident C stated he						
	•	six to seven times. CNA 1						
	removed Resident I	nt C while other staff members						
	removed Resident I	Irom the room.						
	During an interview	on 8/19/2024 at 3:30 p.m.,						
	-	ne had heard a faint yell. CNA						
	1 had found Reside	nt D on the ground, bloody,						
	and Resident C was	standing over him. QMA 2						
	and CNA 1 stood be	etween the residents. QMA 2						
		with Resident D and held						
	_	until the ambulance arrived.						
		C what he had done, and he						
	indicated he had sto	omped on Resident D's head.						
	During an interview	on 8/19/24 at 3:46 p.m., the						
	-	staff had heard someone yell						
		e observed Resident D in						
		laying on the floor. Resident D						
		ad and on the floor. CNA 1						
		Resident C from Resident D.						
		she left the room and called						
	for more help. CNA	1 stayed with Resident C. The						
		lent D from the room while the						
	DON called the pol	ice and the ambulance.						
	-	on 8/20/2024 at 1:26 p.m., RN						
	3 indicated Residen	t C had a prior incident two	1	I				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/23/2024		
	OF PROVIDER OR SUPPLIED DKSIDE CARE STRAT		505 N	ADDRESS, CITY, STATE, ZIP COD GAVIN ST IE, IN 47303		
(X4) II PREFI TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION PREFIX GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
	months ago when have a sindicated she verificated to go to go responded "no." On 8/22/24 at 9:29 C remained in his rate he was out, he had to irritate him. The to his room, which not aware of any of behaviors. The resignate wanted to be less on 8/22/24 at 9:41 Resident C kept to verbally aggressive The Activity Aide with him and provitalk with him when reassure him, they sometimes he coul She knew of no oth than talking to him On 8/22/24 at 9:54 C remained in his rate bothered him and have believed the person got too closs and would have believed the move other resident redirect him to his resident C was seas in the dining room was unaware of other resident's behaviors.	be had shoved Resident D. RN coalized her concerns related to in the facility due to his if asked Resident C if he to a homeless shelter and he a.m. CNA 4 indicated Resident commuch of the time, but when a flashy temper. Noise seemed staff would try to redirect him was mostly effective. She was her interventions for his dent kept his blinds closed and off alone. a.m., Activity Aide 5 indicated himself a lot. He would become if someone got close to him. calmed him down by talking ding reassurance. She would someone got close to him and were not approaching him. d not be calmed or redirected. her interventions to try other and redirecting him. a.m., QMA 6 indicated Resident commost of the time. Noise we would "go off". When a e to him, he became agitated haviors. The QMA knew to t's away from Resident C and room. She tried to assure when ted with other residents to eat that they were not loud. She her interventions to manage the			DATE	

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		15E064	B. WI	NG		08/23	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			SAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES		MUNCI	E, IN 47303		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	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
	-	of months ago, she was					
	-	D, who lacked balance, as he t C's table in the main dining					
	-	tood from his chair and					
	punched Resident D in the chest. On another						
	occasion, Resident C was outside, and another						
	resident bumped Resident C's leg with his						
	wheelchair, and Resident C stood up and began to						
	yell and curse the other resident. The staff were						
	able to calm him do						
	During an interviev	v on 8/22/24 at 9:32 a.m., CNA 4					
	indicated Resident	D wandered up and down the					
	-	ne day, every day. Resident D					
		length of time. He went into					
	-	ently and was easily					
	redirected. She was						
		s wandering, but to redirect					
	him to the hallway.						
	During an interviev	v on 8/22/24 at 9:42 a.m.,					
	Activity Aide 5 ind	icated Resident D was very					
	sweet and wandered	d up and down the hallways.					
		ther resident's rooms. She					
		d redirect him out of other's					
		w him enter them or found him					
	in someone else's ro	oom.					
	During an interviev	v on 8/22/24 at 9:47 a.m., QMA					
		nt D mostly walked up and					
	down in the hallway	y and would go into other					
	resident's rooms. H	e was easily redirected, but					
	_	ted at times. He would calm,					
	and cooperated upo	on re-approaching.					
	During an interviev	v on 8/22/24 at 10:04 a.m., the					
		Director indicated Resident D					
	was very sweet and	wandered up and down the					
	hallways. She had	seen him enter other resident's					
	rooms. He entered	her office at times and was					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		15E064	B. W	/ING		08/23/	/2024
NAME OF B			_	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF P	PROVIDER OR SUPPLIER	(505 N G	GAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES		MUNCI	E, IN 47303		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
	easily re-directed.						
	During an interview on 8/20/24 at 1:03 p.m., CNA						
	1	Resident D returned to the					
		nergency department, he was					
	1	is room. Staff encouraged him					
		nal activities and assured him					
	he was safe.						
	During an observati	ion on 8/22/24 at 10:30 a.m.,					
	Resident D was obs	served walking up and down					
	the length of the hal	llway. The resident would stop					
	occasionally and ho	old on the rail and adjust his					
	shoe, then continue	to ambulate in the hall.					
		0.00.00					
	_	ion on 8/22/24 at 1:07 p.m.,					
		bulating in the hallway with an					
		ntered another resident's room,					
		room during the observation.					
		in the corner of the room and					
	were observed in th	entered the bathroom. No staff					
	were observed in th	e area.					
	A current facility po	olicy, revised 5/2024, titled,					
		Identification, and Reporting					
		y the Administrator on 8/2/24					
		ted the following: "All residents					
	I -	free from abuse, neglect,					
	misappropriation of						
		al punishment, involuntary					
		hysical or chemical restraint					
	_	the resident's medical					
		be the policy of the facility to					
	follow the Indiana Department of Health Policies						
		Long-term Care Abuse and					
	Incident Reporting.	 "					
	This citation relates to complaint IN00441003.						
	3.1-27(a)(1)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15E064 B. WING 08/23/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 505 N GAVIN ST **BROOKSIDE CARE STRATEGIES** MUNCIE. IN 47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE F 0622 483.15(c)(1)(i)(ii)(2)(i)-(iii) SS=J Transfer and Discharge Requirements Bldg. 00 Based on record review and interview, the facility F 0622 Requesting IDR review as facility 08/23/2024 failed to honor a resident's right to return to the followed transfer/dicharge facility from an emergency room visit following a procedures. resident-to-resident altercation (Resident C). The facility failed to demonstrate inability to meet the It is the practice of this facility to resident's needs or that the resident was an ensure transfer/discharge immediate danger to others with interventions procedures are completed per attempted. regulation: The Immediate Jeopardy began on 8/16/24 when 1. What correctived actions will the facility discharged the resident with his be accomplished for those belongings to a hotel located 26 miles away from residents found to be affected by the facility, with a two-day paid stay. This the deficient practice: deficient practice put the resident at risk for harm a. Resident returned to the facility related to lack of a safe environment, placing the and was discharged per his resident at risk of serious accidents. The request. Immediate Jeopardy was removed on 8/22/24, when the facility provided education to managers 2. How other residents having the and nurses regarding transfer and discharge potential to be affected by the rights, but noncompliance remained at the lower same deficient practices will be scope and severity of harm that is not Immediate identified and what corrective Jeopardy because the resident was found on a action will be taken: sidewalk by police back in the same city the a. All residents have the potential facility is located in and was hospitalized for to be affected by the alleged dehydration and acute kidney injury. deficiency. b. An audit of Findings include: discharges/transfers as shown on the monthly form for the State Review of the Facility Assessment, dated 8/2/24 Ombudsman for the last 30 days and provided by the Administrator on 8/21/24 at will be completed and no further 9:20 a.m., indicated the facility had an average issues noted. daily census of 26 and cared for residents with the following needs: psychiatric/mood disorders 3. What measures will be put in including psychosis (hallucinations, delusions, place and what systemic changes etc.) impaired cognition, mental disorder, will be made to ensure that depression, mania/depression, schizophrenia, deficient practice does not recur:

FORM CMS-2567(02-99) Previous Versions Obsolete

post-traumatic stress disorder (PTSD), anxiety

Event ID:

TQUJ11

Facility ID: 000311

If continuation sheet

a. An in-service was completed

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064 NAME OF PROVIDER OR SUPPLIER BROOKSIDE CARE STRATEGIES STRAIT ADDRESS, CITY, STATE, ZIP COD 505 N GAVIN ST MUNCIE, IN 47303 SUMMARY STATEMENT OF DEFICIENCIE PREFIX CACH DEFICIENCY MUST BE PRECEDED BY PULL TAG BEGULATORY OR ISE IDENTIFITYIN CHROMATION AGENCY TO BE THE CONTROL OF THE CONTROL	STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
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supplement) 50 mcg by mouth once daily, Keppra (anticonvulsant) 500 mg by mouth twice daily, and ziprasidone HCL (antipsychotic) 40 mg by mouth twice daily. A current, quarterly, Minimum Data Set assessment, dated 6/6/24, indicated the resident was cognitively intact. Behaviors were listed as: Verbal behavioral symptoms directed towards others occurred 1-3 days of the assessment etc.) shall be notified of the resident's decision and the concern(s) and efforts of the facility. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: a. The Social Service and/or Designee will complete audit form						· ·		
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ziprasidone HCL (antipsychotic) 40 mg by mouth twice daily. A current, quarterly, Minimum Data Set assessment, dated 6/6/24, indicated the resident was cognitively intact. Behaviors were listed as: Verbal behavioral symptoms directed towards others occurred 1-3 days of the assessment concern(s) and efforts of the facility. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: a. The Social Service and/or Designee will complete audit form						· ·		
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A current, quarterly, Minimum Data Set assessment, dated 6/6/24, indicated the resident was cognitively intact. Behaviors were listed as: Verbal behavioral symptoms directed towards others occurred 1-3 days of the assessment 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: a. The Social Service and/or Designee will complete audit form			intipsychotic) 40 mg by mouth					
assessment, dated 6/6/24, indicated the resident was cognitively intact. Behaviors were listed as: Verbal behavioral symptoms directed towards others occurred 1-3 days of the assessment be monitored to ensure the deficient practices will not occur: a. The Social Service and/or Designee will complete audit form		twice daily.				facility.		
assessment, dated 6/6/24, indicated the resident was cognitively intact. Behaviors were listed as: Verbal behavioral symptoms directed towards others occurred 1-3 days of the assessment be monitored to ensure the deficient practices will not occur: a. The Social Service and/or Designee will complete audit form		A current, quarterly, Minimum Data Set				4. How the corrective actions	s will	
was cognitively intact. Behaviors were listed as:deficient practices will not occur:Verbal behavioral symptoms directed towardsa. The Social Service and/orothers occurred 1-3 days of the assessmentDesignee will complete audit form								
Verbal behavioral symptoms directed towards others occurred 1-3 days of the assessment a. The Social Service and/or Designee will complete audit form							cur:	
others occurred 1-3 days of the assessment Designee will complete audit form		·						
						· ·		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL		00	COMPLETED	
		15E064	B. WING	·		08/23/	/2024
NAME OF S	DD OLUBER OR GURRI IEI			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	K		505 N G	BAVIN ST		
BROOK	SIDE CARE STRAT	EGIES		MUNCI	E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PF	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		,, physical symptoms such as			transfer/discharge Ombudsma		
	hitting or scratching self, pacing, rummaging,				form and document findings of		
	_	disrobing in public, throwing or			discharge/transfer paperwork	per	
	smearing food or bodily wastes, or verbal/vocal				regulation. This audit will be		
		eaming, disruptive sounds)			completed 5 times week for 30		
		of the assessment period. He			days, then 3 times week for 30		
		ches for mobility. He was			days, then 2 times week for 30		
	1	tinent of urine and required			days at random for 30 days.		
		or dressing the lower part of			monthly a review will be comp		
	his body. He was o	dependent for bathing.			based on the transfer/discharg	je	
		1 . 10/0/04 1 . 1			Ombudsman form. If		
	_	, dated 3/9/24, indicated			discrepancies are noted, then		
		to remain at the facility for long			immediate action will be taken	to	
		nly be asked about discharge			correct.		
	plans on comprehe				b. Findings from review and a	ıny	
		ded: 1. The facility will contact			corrective actions will be		
		unity agencies if needed. Date			discussed during QAPI meetir	_	
		. Encourage the resident to			and the current plan revised a	S	
	_	d concerns about remaining in			warranted.		
		nitiated: 3/9/24. 3. Observe for					
	_	es of anxiety, fear and/or					
		ated: 3/9/24. 4. Resident will be					
		ing to the community with each					
	3/9/24.	l as needed. Date Initiated:					
	3/9/24.						
	A current care plan	, dated 3/13/24, indicated					
	_	nood problem related to mood					
		g seen by mental health					
		express the following: trouble					
	_ ·	e days, verbal aggression,					
	_	times, missing their					
		ing like no one cared about					
	_	ith conflict and getting along					
		ed depression, frustration due					
	_	ate, and being easily annoyed					
	by peers. Interventions included the following:						
	1. Administer medications as ordered.						
	Monitor/document	for side effects and					
1		e Initiated: 3/13/24. 2. Assist					

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Event ID:

TQUJ11 Facility ID: 000311

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CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				ON	ИВ NO. 0938-039	
STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMP	LETED	
		15E064	B. W.	ING		08/23	3/2024	
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP CO 505 N GAVIN ST MUNCIE, IN 47303					
	1				_,			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	1	, caregivers to identify						
		coping skills and reinforce						
		d: 3/13/24. 3. Behavioral						
		needed (psycho-geriatric team,						
		Date Initiated: 3/13/24. 4.						
		nt/family/caregivers regarding						
	1 ^	tment, concerns with side						
	_	al adverse effects, evaluation,						
		Initiated: 3/13/24. 5. Mental						
		l work with resident on building						
		nate and help identify ways to						
		acility. Date Initiated: 7/22/24.						
		inician will work with resident						
		t no one care and helping						
		Date Initiated: 5/20/24. 7.						
		cian will work with resident on						
		hopelessness/helplessness						
		engths. Date Initiated: 3/26/24.						
	8. Mental health cl	inician will work with resident						
	on negative though	t of loss of control and help						
	identify things in h	is life he has control over.						
	Date Initiated: 4/30	/24. 9. Mental health clinician						
	will work with resi	dent on negative thought of						
	loss of control and	identify thing in his control.						
	Date Initiated: 6/17	7/24. 10. Mental health clinician						
	will work with resi	dent on positive peer						
	interactions and ide	entify ways to take breaks.						
	Date Initiated: 5/27	7/24. 11. Mental health clinician						
	will work with resi	dent on positives of facility and						
	identify ways to tak	ke breaks. Date Initiated:						
	8/12/24. 12. Ment	al health clinician will work with						
	resident on ways he	e contributes to conflict and						
	deep breathing. Da	te Initiated: 7/29/24. 13.						
	1 -	cian will work with resident on						
	ways to use compro	omise and explores ways to use						
		te Initiated: 6/10/24. 14.						
		report PRN any risk for harm						
		n, past attempt at suicide, risky						
	_	g pills, saying goodbye to						

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family, giving away possessions or writing a

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064		(X2) MULTIP A. BUILDIN B. WING		NSTRUCTION 00	(X3) DATE : COMPL 08/23/	ETED			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 505 N GAVIN ST MUNCIE, IN 47303						
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING DEFORMATION	ID PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION		
TAG	note), intentionally refusing to eat or dr sense of hopelessne judgment or safety a 3/13/24. 15. Monit problems seem to b medications, treatm Date Initiated: 3/13 to MD prn risk for langer, labile mood by others or though possession of weapoused as weapons. I Monitor/report to N or suicidal idealizat Observe for signs an hypomania racing the increased irritability pressured speech; flin need for sleep; as Initiated: 3/13/24. A current care plan, resident had the pot aggressive with three Interventions included Administer medicat Monitor/document reffectiveness. Date of key times, places what de-escalates behavior and docum 3. Assess and antic thirst, toileting need positioning, pain etc. Assess resident's consystem. Date Initiat resident's understantic resident's	led the following: 1. ions as ordered.	TAG	3	DEFICIENCY)		DATE		
	towards the situatio	n. Date Initiated: 3/19/24. 6.							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		15E064	B. WI	NG		08/23/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L			BAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES			E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		Document observed behavior					
	_	ventions. Date Initiated:					
	6/21/24. 7. Offer to take resident for a walk, etc. Date Initiated: 8/5/24. 8. Provide positive						
		-					
		pehavior. Emphasize the compliance. Date Initiated:					
		NP/Psychiatric/Psychogeriatric					
	_	. Date Initiated: 3/19/24. 10.					
		ers for verbal aggression are					
		to him. The resident's					
		alated by keeping wanderers					
		ate Initiated: 4/29/24. 11. When					
	_	es agitated: Intervene before					
		Guide away from source of					
	-	mly in conversation; If					
		ve, staff to walk calmly away,					
	and approach later.	Date Initiated: 3/19/24.					
	_	dated 4/1/24, indicated the					
	_	ential to be physically					
		, shoving others, attempting					
		tting others. Interventions					
	included the follow	_					
		geriatric consult as indicated.					
		/24. 2. When the resident					
	_	ntervene before agitation					
	· ·	ray from source of distress; conversation; If response is					
		walk calmly away, and					
		e Initiated: 4/1/24. 3.					
	Administer medicat						
	Monitor/document						
		Initiated: 4/1/24. 4. Analyze					
		, circumstances, triggers, and					
		ehavior and document. Date					
		Assess and address for					
		y deficits. Date Initiated:					
		and anticipate resident's needs:					
		g needs, comfort level, body					
		c. Date Initiated: 4/1/24. 7.					
			1				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/23/2024	
	PROVIDER OR SUPPLIER		505 N C	ADDRESS, CITY, STATE, ZIP COD GAVIN ST E, IN 47303	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
	communication staff member when 4/1424. 8. Comm and verbal cues to a Initiated: 4/14/24. 9. verbalize source of 5/23/24. 10. Monit signs or symptoms as self and others. Dai Psych NP of behavior Offer to take resided able when he exhibit Initiated: 8/16/24. Review of progress approximately 9:35 assaulted another reand Resident C was department for eval 49:12 p.m., indicated facility in regards to police that Resident resident's head (Resident's head (Resident's head (Resident's head) and times he stomped on the resident told the up by the other resident told the up by the other resident (Iber of the commented a "larg forehead. Resident and commented a "larg forehead. Resident told the commented a "larg forehead. Resident and commented a "larg forehead."	on: Encourage seeking out of agitated. Date Initiated: UNICATION: provide physical lleviate anxiety. Date Of Encourage resident to agitation. Date Initiated: cor/document/report PRN any of resident posing danger to the Initiated: 4/1/24. 11. Notify ors. Date Initiated: 4/1/24. 12. In to enclosed court yard as/if its any agitation, etc. Date notes indicated, on 8/15/24 at p.m., Resident C physically sident. The police were called taken to the emergency			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 00 COMPLETED D. WING 09/23/2023			ETED	
		15E064	B. WI	NG		08/23/	2024
	PROVIDER OR SUPPLIER			505 N G	ADDRESS, CITY, STATE, ZIP COD BAVIN ST E, IN 47303		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	'	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		at 10:23 p.m., indicated		IAG			DATE
		on following an altercation. He					
		back, and was experiencing					
		back pain. The nursing facility informed the					
	emergency department the resident was not						
	"welcome back there." The resident underwent						
	psychiatric and social work evaluations and no						
	significant behavioral changes were noted.						
		proceed back to Brookside Care them not wanting to accept him					
	back.	mem not wanting to accept min					
	Review of a hospita	al nursing note, dated 8/16/24,					
	indicated the reside	ent verbalized a desire to return					
	· ·	resident stated he had been at					
		oximately one month and					
	considered the facil	lity his home.					
	An emergency depa	artment note, dated 8/16/24,					
		C had received a psychiatric					
	and social work eva	aluation. The resident was					
		the facility "despite them not					
		im back." The resident had no					
	behavioral changes	•					
	A Social Service no	ote, dated 8/16/2024 at 11:03					
		resident was discharged to a					
		cated 61 miles from the facility.					
		iven all of his belongings,					
		0 cash, a lighter, and a pack of					
	cigarettes.						
	A Discharge Summ	nary Note, dated 8/16/2024 at					
	_	ed the resident was discharged					
		medications, money, and					
	cigarettes.	••					
	A Tuof/D' 1	Matica dat- 10/16/24					
		ge Notice, dated 8/16/24, C was discharged to a					
		downtown Indianapolis, 61					
	TOTAL COS SHORE III	acmoii maianapons, 01					

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PRINTED: 10/07/2024 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED		
		15E064	B. W	ING		08/23	/2024	
				_				
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD			
					GAVIN ST			
BROOKS	SIDE CARE STRAT	EGIES		MUNCI	E, IN 47303			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	DATE	
	miles away from the							
	innes away nom th	e facility.						
	The Interdisciplinar	ry, Social Service, and						
	-	locumentation, dated from						
	_	8/16/2024, did not include						
		rmine the facility provided a						
		otice of impending discharge						
	to Resident C. The clinical record did not contain documentation the resident had returned from the emergency room visit in a condition that was different from baseline that would warrant an emergency							
	discharge. The resident was not given an							
	opportunity to appeal the transfer or make choices							
	on this discharge lo	cation.						
	During on interview	on 8/19/24 at 2:49 p.m., the						
	_	eated, on 8/16/24, the hospital						
		_						
		the resident was being						
		facility. The Administrator						
		table with the resident being						
		due to his behaviors. When						
		at the facility via ambulance,						
		net them in the parking lot. He						
		if he remembered what had						
		before. The resident						
		new what he had done.						
		knew he was not wanted in the						
		ld sign any paperwork they						
		He just wanted his						
	cigarettes. The Adn	ninistrator asked the SSD						
	(Social Service Dire	ector) to look for a homeless						
	shelter that could ta	ke the resident. The						
	Administrator indic	ated he gave the resident						
	\$20.00, a bag of foo	od, his belongings, and						
		dent told the Administrator he						
		e and he did not need anyone.						
		transported the resident to the						
	homeless shelter in	-						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	LETED
		15E064	B. WI	NG		08/23	/2024
NAME OF D	PROVIDER OR SUPPLIE	R	-		ADDRESS, CITY, STATE, ZIP COD	•	
					SAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES		MUNCI	E, IN 47303		
(X4) ID		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 APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	During an interview	w on 8/20/24 at 9:18 a.m., a					
	representative from the named homeless shelter						
	_	C had not been admitted. No					
	one by that name a	nd date of birth had been in the					
	shelter for over a decade.						
	During an interview on 8/20/24 at 3:47 p.m., the						
		cated he had taken the resident					
		elter, but he did not feel it was					
		resident to another town (26					
	• •) and paid for a two-night stay at					
	a hotel. The hotel would provide the resident with breakfast. The resident said he would contact his						
	brother.						
	brother.						
	The undated face s	heet, included, but was not					
		tion to contact two family					
		ent of an emergency. The family					
		t be contacted for interview					
	using the informati	on on the face sheet.					
	D : 4	4 1 1 4 64					
	-	the whereabouts of the be determined until on, 8/22/24					
		n the Administrator provided a					
	· ·	a local hospital requesting a bed					
		ne referral indicated the resident					
		nospital on 8/18/24. The					
		cated he was told the resident					
		by the police after being					
		sidewalk in front of a local					
	homeless shelter.						
	-	contacted during the survey					
	and no report was a	available.					
	Review of an 8/18/	24 emergency room report					
		C was being admitted to the					
		ent of dehydration, acute					
	-	abnormal laboratory values					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064		IT OF DEFICIENCIES OF CORRECTION		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/23/2024	
		ROVIDER OR SUPPLIER		505 N (ADDRESS, CITY, STATE, ZIP COD GAVIN ST IE, IN 47303		
	(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION
	TAG	after being found or shelter. The hospital dehydration with in resident continued to kinase (CK) levels obrain injury or excellation. The facility dischart 8/21/24 at 9:50 a.m partial copy of a Di was provided. The 8/21/24 at 11:05 a.m. the policy from the	at the sidewalk outside of a all was able to treat the travenous fluids, but the to have elevated creatine (indicative of heart, muscle, or ssive drug or alcohol use). ge policy was requested on and again at 10:10 a.m., when a scharge Policy dated 1/2023 Administrator indicated, on the was awaiting a copy of corporate offices.	TAG			DATE
		and titled "Transfer provided by the DC indicated the facility written notice of an discharge. The notice practicable but before "a. The transfer is a welfare and the resist the facility; c. The safety of incendangered: 5. The reasons for be documented in the lack of the the lack	or Discharge Notice," ON on 8/21/24 at 11:45 a.m., y shall provide a thirty-day impending transfer or ice would be given as soon as ore the transfer or discharge: necessary for the resident's dent's needs cannot be met in dividuals in the facility is the transfer or discharge will ne resident's medical record; the transfer location for a on to transfer to a particular ermined by the needs, choices				
		Administrator on 8/ and titled "Resident purpose was to prov a resident for include cannot be met or the	facility policy provided by the /21/24 at 9:50 a.m., dated 1/2023 Discharge" indicated the /ide guidelines for discharging ling, but not limited to, needs a resident's clinical and dangered the health and				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/23/2024		
	ROVIDER OR SUPPLIER SIDE CARE STRAT		505 N	STREET ADDRESS, CITY, STATE, ZIP COD 505 N GAVIN ST MUNCIE, IN 47303		
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F 0626 SS=J Bldg. 00	was removed on 8/2 provided education regarding transfer a noncompliance rem severity of harm that because the resident police back in the cowas hospitalized for injury. This citation relates 3.1-12(a)(3) 3.1-12(a)(4) 483.15(e)(1)(2) Permitting Resided Based on record reversided to ensure facility and an emerging was not provided actional discharge prior to be a hotel 26 miles away. The Immediate Jeony when the facility facility policy. This resident at risk for henvironment, placin serious accidents. The Services Director (Supervisor were not Jeopardy on 8/20/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2	pardy that began on 8/16/24 12/24, when the facility to managers and nurses and discharge rights, but ained at the lower scope and at is not Immediate Jeopardy t was found on a sidewalk by try the facility is located in and and dehydration and acute kidney to Complaint IN00440457. The resident department of the facility for care ency room visit. The resident dequate notice to appeal the leing transported to and left at	F 0626	Request IDR as the facility foll the policy and procedure on readmitting residents. It is the practice of this facility ensure policies on permitting residents to return to the facility after they are hospitalized or placed on a therapeutic leave. 1. What corrective actions will accomplished for those reside found to be affected by the deficient practice: a. Resident returned to the far and was discharged per his request. 2. How other residents having	to ty I be nts cility	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15E064 B. WING 08/23/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 505 N GAVIN ST **BROOKSIDE CARE STRATEGIES** MUNCIE. IN 47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE completed education of management and nurses potential to be affected by the regarding discharge rights and the facility policy same deficient practices will be for resident discharge on 8/22/24, but identified and what corrective noncompliance remained at the lower scope and action will be taken: severity of isolated, no actual harm with potential a. All residents have the potential for more than minimal harm. to be affected by the alleged deficiency. Findings include: b. An audit of discharges/transfers as shown on Review of the Facility Assessment, dated 8/2/24 the monthly form for the State and provided by the Administrator on 8/21/24 at Ombudsman for the last 30 days 9:20 a.m., indicated the facility had an average will be completed and no further daily census of 26 and cared for residents with the issues noted. following needs: psychiatric/mood disorders including psychosis (hallucinations, delusions, 3. What measures will be put in etc.) impaired cognition, mental disorder, place and what systemic changes depression, mania/depression, schizophrenia, will be made to ensure that post-traumatic stress disorder (PTSD), anxiety deficient practice does not recur: disorder, and behavior plural? that needed a. An in-service was completed interventions. The facility's population included on 08/21/2024 for License Nurses five residents with behavioral symptoms and and the Interdisciplinary team for cognitive performance needs and ten with transfer/discharge procedures. behavioral/mental health needs. Services offered b. Any discharge from the facility by the facility included, but were not limited to, (whether resident-initiated or management of medical conditions and facility-initiated) will be addressed medication-related issues causing psychiatric to the Administration/designee to symptoms and behavior and implementation of confirm appropriate notification interventions to help support residents with and discharge planning has psychiatric diagnoses and intellectual or occurred. Should concerns be developmental disabilities. Discharge planning identified, the same shall be included assistance with financial implications, immediately addressed with referral to local contact agencies as needed, applicable staff members and discharge medication list, and assistance with corrective actions taken, as medical supplies. warranted to ensure compliance with facility policies and Resident C's clinical record was reviewed on procedures. 8/19/24 at 11:28 a.m. Diagnoses included mild Should a resident of the facility cognitive impairment, alcohol use, history of elect to leave Against Medical

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and epileptic syndrome.

cerebral infarction, mood disorder, cocaine abuse,

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Advice (AMA), said resident shall

be educated as to potential

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3		(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		15E064	B. W	ING		08/23/	2024
				CTREET	ADDRESS SITY STATE TIP SOD		
NAME OF	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
DDOOK	CIDE CADE CEDAT	TOICO			GAVIN ST		
BROOK	SIDE CARE STRAT	EGIES		MUNCI	E, IN 47303		
(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	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					negative outcomes of the deci	ision	
	A current, quarterly	y, Minimum Data Set			and the same shall be		
	assessment, dated 6	5/6/24, indicated the resident			documented. Should the resid	dent	
was cognitively intact. Behaviors were listed as:				have health needs susch that			
	Verbal behavioral s	symptoms directed towards			AMA discharge could place th	ie l	
	others occurred 1-3	days of the assessment			resident at risk applicable		
	period. Other beha	vioral symptoms not directed			agencies (e.g., Adult Protectiv	⁄e	
	towards others (e.g.	., physical symptoms such as			Services, Local Police		
		g self, pacing, rummaging,			Department, Ombudsman, etc	c.)	
	_	disrobing in public, throwing or			shall be notified of the residen	,	
	smearing food or bodily wastes, or verbal/vocal				decision and the concern(s) a		
	symptoms like screaming, disruptive sounds)				efforts of the facility.		
	occurred 1-3 days of the assessment period. He				,		
	used a cane or crutches for mobility. He was				4. How the corrective actions	will	
	occasionally incontinent of urine and required				be monitored to ensure the		
	1	or dressing the lower part of			deficient practices will not occ		
		lependent for bathing.			a. The Social Service and/or		
	·				Designee will complete audit f	form	
	Review of progress	notes indicated, on 8/15/24 at			with the information of the mo		
		p.m., Resident C physically			transfer/discharge Ombudsma	-	
		esident. The police were called			form and document findings o		
		s taken to the emergency			discharge/transfer paperwork		
	department for eval				regulation. This audit will be	•	
					completed 5 times a week for	30	
	Review of an Emer	gency Department Progress			days, then 3 times week for 30		
		at 10:23 p.m., indicated			days, then 2 times week for 30		
		en following an altercation. He			days at random for 30 days.		
		back, and was experiencing			monthly a review will be comp		
		rsing facility informed the			based on the transfer/discharge		
	_	nent the resident was not			Ombudsman form. If	,	
		re." The resident underwent			discrepamncies are noted, the	en	
	psychiatric and soc	ial work evaluations and was			immediate action will be trake		
		Brookside Care Strategies			correct.		
	_	anting to accept him back. No			b. Findings from review and a	anv	
	_	ral changes were noted.			corrective actions will be	,	
					discussed during QAPI meetir	าตร	
	An emergency dena	artment note, dated 8/16/24,			and the current plan revised a	-	
		C had received a psychiatric			warranted.	-	
		aluation. The resident was					
		the facility "despite them not					
		,r	1		i .		ī

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064		IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	_ COM	(X3) DATE SURVEY COMPLETED 08/23/2024	
	PROVIDER OR SUPPLIER		505 N C	ADDRESS, CITY, STATE, ZIP CO GAVIN ST E, IN 47303	OD		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)		(X5) COMPLETION	
TAG	wanting to accept h	R LSC IDENTIFYING INFORMATION im back."	TAG	DETCENCT)		DATE	
	Review of a hospital indicated the reside to the facility. The the facility for approximate to the facility for approximate the facility for approximate the facility for approximate the facility for a series of the facility for approximate facility facili	al nursing note, dated 8/16/24, nt verbalized a desire to return resident stated he had been at oximately one month and					
	11:18 a.m., indicate	hary Note, dated 8/16/2024 at and the resident was discharged medications, money, and					
	indicated Resident	ge Notice, dated 8/16/24, C was discharged to a downtown Indianapolis, 61 e facility.					
	transfer/discharge of 8/15/2024 through information to dete	ry, Social Service, and locumentation, dated from 8/16/2024, did not include rmine the facility provided a otice of impending discharge					
	the resident had ret room visit in a cond baseline that would discharge. The resi	did not contain documentation urned from the emergency dition that was different from warrant an emergency dent was not given an eal the transfer or make choices					

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

PRINTED: 10/07/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/23/2024	
NAME OF I	PROVIDER OR SUPPLIEI	· · · · · · · · · · · · · · · · · · ·			ADDRESS, CITY, STATE, ZIP COD		
BROOKS	SIDE CARE STRAT	EGIES			GAVIN ST E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI	BE PRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	_	v on 8/19/24 at 2:49 p.m., the					
		cated, on 8/16/24, the hospital					
	called and indicated the resident was being released back to the facility. The Administrator						
		table with the resident being					
		due to his behaviors. When					
		at the facility via ambulance,					
		net them in the parking lot. He					
		if he remembered what had					
	happened the night before. The resident						
	responded that he knew what he had done.						
	_	knew he was not wanted in the					
		ld sign any paperwork they					
	needed him to sign.						
		ninistrator asked the SSD					
	-	ector) to look for a homeless					
	shelter that could ta	ke the resident. The					
	Administrator indic	cated he gave the resident					
	\$20.00, a bag of foo	od, his belongings, and					
	cigarettes. The resi	ident told the Administrator he					
	did not have anyon	e and he did not need anyone.					
	The Administrator	transported the resident to the					
	homeless shelter in	his private car.					
	During an interview	v on 8/20/24 at 9:18 a.m., a					
		the named homeless shelter					
		C had not been admitted. No					
		nd date of birth had been in the					
	shelter for over a de						
	During an interview	v on 8/20/24 at 3:47 p.m., the					
		cated he had taken the resident					
		elter, but he did not feel it was					
		resident to another town (26					
		and paid for a two-night stay at					
		would provide the resident with					
		dent said he would contact his					
	brother.						
	The undated face sl	heet included but was not					

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

PRINTED: 10/07/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/23/2024		
	PROVIDER OR SUPPLIER SIDE CARE STRAT		505 N C	ADDRESS, CITY, STATE, ZIP COD GAVIN ST E, IN 47303		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
TAG	limited to, informat members in the eve members could not using the information. During the survey, resident could not be at 11:00 a.m., when referral sent from a for Resident C. The had arrived at the hadministrator indice had been picked up found lying on the shomeless shelter. Local police were count and an arrived at the hadministrator indice had been picked up found lying on the shomeless shelter. Local police were count and an arrived at the hospital for treatment kidney injury, and a after being found on shelter. The hospital dehydration with in resident continued to kinase (CK) levels to brain injury or exceen the facility dischares (CK) levels to brain injury or exceen the facility dischares (CK) levels to brain injury or an arrived at 11:05 a.m. partial copy of a Di was provided. The 8/21/24 at 11:05 a.m. the policy from the	24 emergency room report C was being admitted to the nt of dehydration, acute abnormal laboratory values in the sidewalk outside of a al was able to treat the travenous fluids, but the to have elevated creatine (indicative of heart, muscle, or ssive drug or alcohol use). ge policy was requested on and again at 10:10 a.m., when a scharge Policy dated 1/2023 Administrator indicated, on n., he was awaiting a copy of	TAG	DEPICIENCY		DATE
	provided by the DC	N on 8/21/24 at 11:45 a.m.,	1			

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PRINTED: 10/07/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/C		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		15E064	B. WI	NG		08/23/	/2024
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 505 N GAVIN ST MUNCIE, IN 47303				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	1	ID	DROVIDED'S BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
		y shall provide a thirty-day					
	written notice of an	impending transfer or					
		ce would be given as soon as					
	_	re the transfer or discharge:					
	_	necessary for the resident's					
		dent's needs cannot be met in					
	the facility;						
	c. The safety of ind	lividuals in the facility is					
	endangered:						
	5. The reasons for t	the transfer or discharge will					
	be documented in the	ne resident's medical record;					
	11. in determining	the transfer location for a					
	resident, the decisio	n to transfer to a particular					
	location will be dete	ermined by the needs, choices					
	and best interest of	the resident"					
	Review of a current	facility policy provided by the					
	Administrator on 8/	21/24 at 9:50 a.m., dated 1/2023					
	and titled "Resident	Discharge" indicated the					
	purpose was to prov	vide guidelines for discharging					
	a resident for includ	ling, but not limited to, needs					
	cannot be met or the	e resident's clinical and					
	behavioral status en	dangered the health and					
	safety of other resid	ents.					
	The immediate icon	pardy that began on 8/16/24					
		22/24, when the facility					
		to managers and nurses					
	regarding transfer a	_					
	10guiumg numbiel ai	na disenuige rights.					
	This citation relates	to Complaint IN00440457.					
	3.1-12(a)(4)(A)						
	3.1-12(a)(4)(C)						
	3.1-12(a)(4)(D)						

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