STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E064	A. BUILDING 00 B. WING	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE CARE STRATEGIES	505 N GAVIN ST MUNCIE, IN 47303

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00441003 and IN00440457. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. Complaint IN00441003 - Federal/State deficiencies related to the allegations are cited at F600. Complaint IN00440457 - Federal/State deficiencies related to the allegations are cited at F622 and F626 . Survey dates: August 19, 20, 21, 22, and 23, 2024 Facility number: 000311 Provider number: 15E064 AIM number: 100285520 Census Bed Type: NF: 32 Total: 32 Census Payor Type: Medicaid: 29 Other: 3 Total: 32 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 4, 2024.	F 0000	By submitting the following material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 09/18/2024 to the state findings of the recent complaint investigation. We are requesting paper compliance.	
F 0600 SS=G Bldg. 00	483.12(a)(1) Free from Abuse and Neglect Based on observation, record review and interview, the facility failed to ensure a cognitively	F 0600	Requesting IDR review as facility followed the Abuse policy and	09/18/2024

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

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	impaired resident who wandered (Resident D) was free from resident-to-resident physical abuse perpetrated by a resident known to be physically abusive towards others when approached (Resident C) for 1 of 3 residents reviewed for abuse. This deficient practice resulted in Resident D sustaining a head laceration and required emergent treatment at the hospital with six sutures to repair. Findings include: Review of an Incident Report sent to the Indiana Department of Health's reporting system indicated, on 8/15/24 at 9:01 p.m., Resident D was found lying on the floor in Resident C's room. Resident D had a laceration on the left side of his head and bruising to his chest and head. Resident C indicated there had been an altercation. A local police department's case report, dated 8/15/24 and provided by the Director of Nursing (DON) on 8/21/24 at 10:25 a.m., indicated as the officer got to the door of Resident C's room, blood was observed on the floor inside the entryway. Resident C was asked about what happened and he advised that Resident D had walked into his room while he was asleep. Resident C was unsure how many times he stomped on Resident D's head. Resident C also stated that he had thoughts of harming others. An employee had indicated to the officer they had not seen the incident, but witnessed Resident C standing over the top of Resident D while yelling. Resident C's clinical record was reviewed on 8/19/24 at 11:28 a.m. Diagnoses included mild cognitive impairment, alcohol use, history of cerebral infarction, mood disorder, cocaine abuse, and epileptic syndrome.		procedures. It is the practice of this facility to ensure residents are free from abuse, neglect, misappropriate of resident property, and exploitation. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice: a. Resident C is no longer a resident. b. The Resident D plan of care was reviewed and updated to reflect interventions as needed. c. Staff were educated 9/18/2024 on the location of interventions for each resident. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a. All residents have the potential to be affected by the alleged deficiency. b. An audit of residents that exhibit the wandering behavior has been completed and the plan of care updated with interventions. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur: a. An in-service was completed on 9/18/2024 for all staff on the Abuse policy and challenging	

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	A current care plan, revised on 5/3/24, indicated the resident had potential to be verbally aggressive and had threatening behaviors when others were loud, repetitive, or when there lacked space at a dining room table he wanted to sit. An intervention indicated the resident's triggers for verbal aggression were when others come too close to him. The behaviors were de-escalated by keeping wanderers away from him. The most recent quarterly Minimum Data Set (MDS) assessment, dated 6/6/24, indicated resident was cognitively intact, had verbal behaviors directed at others on one to three days during the assessment period and physical behaviors directed towards himself on one to three days during the assessment period. A current care plan, revised on 6/20/24, indicated the resident had potential to be physically aggressive to others, shoved others, and attempted to hit others. Interventions included intervene before agitation escalates, guide away from source of distress, engage in conversation, and if aggressive, walk away and approach later. The resident was to be encouraged to seek out a staff member when agitated. On 8/16/24, an intervention was added to this care plan to offer to take resident to the courtyard if agitated. A Behavior Management 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 report indicated the interventions were successful.		behaviors for direct care staff. b. An in-service was completed on 9/18/2024 for all staff on the location of interventions for each resident. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: a. The Interdisciplinary Team will review 5 residents' behavior care plans per week for the next 4 weeks. Then reviews will be completed for 5 residents 1 time every 4 weeks for the next quarter. If compliance is maintained for the next 6 months, then reviews will be completed during admission, quarterly, significant change, or as needed. If discrepancies are noted, then immediate action will be taken to correct. b. Findings from review and any corrective actions will be discussed during QAPI meetings and the current plan revised as warranted.	

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	A social services progress note, dated 8/12/24 at 10:54 a.m., indicated the resident had seen the mental health provider on 8/9/24. During the session, the resident had expressed to the clinician his frustration with loud peers. He wished he could live on his own. The clinician worked with the resident on positives of living in the facility and helped him identify ways to take breaks. A nurse's note, dated 8/15/24, indicated Resident C was in his room when he attacked another resident. Resident C indicated he had been trying to sleep. Resident C boasted about "stomping" on the other resident's head. The police removed Resident C from the facility and took him to the emergency department. The clinical record for Resident D was reviewed on 8/20/24 at 10:08 a.m. Diagnoses included mild neurocognitive disorder without behavioral disturbances, anxiety disorder, psychotic disorder, and insomnia. A current care plan, initiated on 9/5/23, indicated the resident had periods of restlessness. Interventions included to involve the resident in diversional activities as possible and to redirect the resident away from doors. A current care plan, revised on 1/10/24, indicated the resident was a wanderer related to impaired safety awareness, wandering up and down the halls. Interventions included to distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, a book, and to ensure safety with wandering. The care plans lacked a interventions regarding			

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	supervision to manage Resident D wandering and entering other resident rooms. A current care plan, revised 4/4/24, indicated the resident had potential to be physically aggressive and agitated and at times, felt he was protecting others. Interventions included to increase activities and one on one's (continuous supervision) when resident showed increased wandering behaviors and monitor and document signs and symptoms of the resident posing danger to self and others. A current care plan, revised 5/3/24, indicated the resident had impaired verbal communication as evidenced by absent speech, weak voice, problems finding correct words and decreased auditory comprehension. Interventions included to ask mostly "yes" or "no" questions, give him 5-10 seconds to respond, speak slowly and simply with a reassuring, calm tone, and use non-verbal gestures (i.e.: thumbs up, thumbs down, smile, etc.) An annual MDS assessment, dated 7/30/24, indicated the resident had a severe cognitive deficit and major mental illness. The resident had unclear speech and difficulty communicating some words or finishing thoughts. He usually understood others, but missed some part or intent of conversations. He had episodes of wandering on one to three days of the assessment period. He required substantial assistance for eating and was dependent on staff for hygiene, toileting, showering, and dressing. He was independent with ambulation. A progress note, dated 8/16/2024 at 3:15 a.m., indicated Resident D returned to the facility from the emergency room with six sutures to the left			

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	side of his forehead, with multiple scratches on his face, neck and chest. During an interview on 8/19/2024 at 2:49 p.m., CNA 1 indicated, on the evening of 8/15/24, staff heard someone yelling for help. CNA 1 found Resident D on the floor of Resident C's room. Resident C was standing over Resident D. Resident C appeared aggressive and Resident D was laying on the floor in a pool of blood. Resident C told CNA 1 he had beaten Resident D because he had woken him up. CNA 1 asked if he had kicked Resident D, and Resident C stated he had "stomped" him six to seven times. CNA 1 stayed with Resident C while other staff members removed Resident D from the room. During an interview on 8/19/2024 at 3:30 p.m., QMA 2 indicated she had heard a faint yell. CNA 1 had found Resident D on the ground, bloody, and Resident C was standing over him. QMA 2 and CNA 1 stood between the residents. QMA 2 indicated she went with Resident D and held pressure to his head until the ambulance arrived. She asked Resident C what he had done, and he indicated he had stomped on Resident D's head. During an interview on 8/19/24 at 3:46 p.m., the DON indicated the staff had heard someone yell out for help, and she observed Resident D in Resident C's room, laying on the floor. Resident D had blood on his head and on the floor. CNA 1 was trying to keep Resident C from Resident D. The DON indicated she left the room and called for more help. CNA 1 stayed with Resident C. The staff removed Resident D from the room while the DON called the police and the ambulance. During an interview on 8/20/2024 at 1:26 p.m., RN 3 indicated Resident C had a prior incident two			

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	months ago when he had shoved Resident D. RN 3 indicated she verbalized her concerns related to Resident C staying in the facility due to his behaviors. The staff asked Resident C if he wanted to go to go to a homeless shelter and he responded "no." On 8/22/24 at 9:29 a.m. CNA 4 indicated Resident C remained in his room much of the time, but when he was out, he had a flashy temper. Noise seemed to irritate him. The staff would try to redirect him to his room, which was mostly effective. She was not aware of any other interventions for his behaviors. The resident kept his blinds closed and just wanted to be left alone. On 8/22/24 at 9:41 a.m., Activity Aide 5 indicated Resident C kept to himself a lot. He would become verbally aggressive if someone got close to him. The Activity Aide calmed him down by talking with him and providing reassurance. She would talk with him when someone got close to him and reassure him, they were not approaching him. Sometimes he could not be calmed or redirected. She knew of no other interventions to try other than talking to him and redirecting him. On 8/22/24 at 9:54 a.m., QMA 6 indicated Resident C remained in his room most of the time. Noise bothered him and he would "go off". When a person got too close to him, he became agitated and would have behaviors. The QMA knew to move other resident's away from Resident C and redirect him to his room. She tried to assure when Resident C was seated with other residents to eat in the dining room that they were not loud. She was unaware of other interventions to manage the resident's behaviors. On 8/22/24 at 10:08 a.m., the Activities Director			

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	indicated a couple of months ago, she was assisting Resident D, who lacked balance, as he walked by Resident C's table in the main dining room. Resident C stood 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 down. During an interview on 8/22/24 at 9:32 a.m., CNA 4 indicated Resident D wandered up and down the hallways most of the day, every day. Resident D couldn't sit for any length of time. He went into other's rooms frequently and was easily redirected. She was unaware of other interventions for his wandering, but to redirect him to the hallway. During an interview on 8/22/24 at 9:42 a.m., Activity Aide 5 indicated Resident D was very sweet and wandered up and down the hallways. He would go into other resident's rooms. She indicated she would redirect him out of other's rooms when she saw him enter them or found him in someone else's room. During an interview on 8/22/24 at 9:47 a.m., QMA 6 indicated Resident D mostly walked up and down in the hallway and would go into other resident's rooms. He was easily redirected, but could become agitated at times. He would calm, and cooperated upon re-approaching. During an interview on 8/22/24 at 10:04 a.m., the Human Resources 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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	easily re-directed. During an interview on 8/20/24 at 1:03 p.m., CNA 21 indicated when Resident D returned to the facility from the emergency department, he was reluctant to leave his room. Staff encouraged him to continue his normal activities and assured him he was safe. During an observation on 8/22/24 at 10:30 a.m., Resident D was observed walking up and down the length of the hallway. The resident would stop occasionally and hold on the rail and adjust his shoe, then continue to ambulate in the hall. During an observation on 8/22/24 at 1:07 p.m., Resident D was ambulating in the hallway with an unsteady gait. He entered another resident's room, who was not in the room during the observation. The resident stood in the corner of the room and looked around and entered the bathroom. No staff were observed in the area. A current facility policy, revised 5/2024, titled, "Abuse Prevention, Identification, and Reporting Policy," provided by the Administrator on 8/2/24 at 9:24 a.m., indicated the following: "All residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms....It shall be the policy of the facility to follow the Indiana Department of Health Policies and Procedures for Long-term Care Abuse and Incident Reporting..." This citation relates to complaint IN00441003. 3.1-27(a)(1)			

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F 0622 SS=J Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements Based on record review and interview, the facility failed to honor a resident's right to return to the facility from an emergency room visit following a resident-to-resident altercation (Resident C). The facility failed to demonstrate inability to meet the resident's needs or that the resident was an immediate danger to others with interventions attempted. The Immediate Jeopardy began on 8/16/24 when the facility discharged the resident with his belongings to a hotel located 26 miles away from the facility, with a two-day paid stay. This deficient practice put the resident at risk for harm related to lack of a safe environment, placing the resident at risk of serious accidents. The Immediate Jeopardy was removed on 8/22/24, when the facility provided education to managers and nurses regarding transfer and discharge rights, but noncompliance remained at the lower scope and severity of harm that is not Immediate Jeopardy because the resident was found on a sidewalk by police back in the same city the facility is located in and was hospitalized for dehydration and acute kidney injury . Findings include: Review of the Facility Assessment, dated 8/2/24 and provided by the Administrator on 8/21/24 at 9:20 a.m., indicated the facility had an average daily census of 26 and cared for residents with the following needs: psychiatric/mood disorders including psychosis (hallucinations, delusions, etc.) impaired cognition, mental disorder, depression, mania/depression, schizophrenia, post-traumatic stress disorder (PTSD), anxiety	F 0622	Requesting IDR review as facility followed transfer/dicharge procedures. It is the practice of this facility to ensure transfer/discharge procedures are completed per regulation: 1. What correctived actions will be accomplished for those residents found to be affected by the deficient practice: a. Resident returned to the facility and was discharged per his request. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a. All residents have the potential to be affected by the alleged deficiency. b. An audit of discharges/transfers as shown on the monthly form for the State Ombudsman for the last 30 days will be completed and no further issues noted. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur: a. An in-service was completed	08/23/2024

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	disorder, and behaviors that needed interventions. The facility's population included five residents with behavioral symptoms and cognitive performance needs and ten with behavioral/mental health needs. Services offered by the facility included, but were not limited to, management of medical conditions and medication-related issues causing psychiatric symptoms and behavior and implementation of interventions to help support residents with psychiatric diagnoses and intellectual or developmental disabilities. Discharge planning included assistance with financial implications, referral to local contact agencies as needed, discharge medication list, and assistance with medical supplies. Resident C's clinical record was reviewed on 8/19/24 at 11:28 a.m. Diagnoses included mild cognitive impairment, alcohol use, history of cerebral infarction, mood disorder, cocaine abuse, and epileptic syndrome. Current medication orders at the time of discharge included acetaminophen (analgesic) 500 mg 2 by mouth every 8 hours as needed for pain, aspirin (antiplatelet) 81 mg by mouth every morning, atorvastatin calcium (for cholesterol) 20 mg by mouth at bedtime, cholecalciferol (Vitamin D 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 period. Other behavioral symptoms not directed		on 08/21/2024 for License Nurses and the Interdisciplinary team for transfer/discharge procedures. b. Any discharge from the facility (whether resident-initiated or facility-initiated) will be addressed to the Administration/designee to confirm appropriate notification and discharge planning has occurred. Should concerns be identified, the same shall be immediately addressed with applicable staff members and corrective actions taken, as warranted to ensure compliance with facility policies and procedures. Should a resident of the facility elect to leave Against Medical Advice (AMA), said resident shall be educated as to potential negative outcomes of the decision and the same shall be documented. Should the resident have health needs such that AMA discharge could place the resident at risk, applicable agencies (e.g., Adult Protective Services, Local Police Departmetn, Ombudsman, 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 with the information of the monthly	

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	towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) occurred 1-3 days of the assessment period. He used a cane or crutches for mobility. He was occasionally incontinent of urine and required assistance of one for dressing the lower part of his body. He was dependent for bathing. A current care plan, dated 3/9/24, indicated Resident C wished to remain at the facility for long term care, and to only be asked about discharge plans on comprehensive assessments. Interventions included: 1. The facility will contact appropriate community agencies if needed. Date Initiated: 3/9/24. 2. Encourage the resident to discuss feelings and concerns about remaining in the facility. Date Initiated: 3/9/24. 3. Observe for and address episodes of anxiety, fear and/or distress. Date Initiated: 3/9/24. 4. Resident will be asked about returning to the community with each full assessment and as needed. Date Initiated: 3/9/24. A current care plan, dated 3/13/24, indicated Resident C had a mood problem related to mood disorder, was being seen by mental health services, and may express the following: trouble concentrating some days, verbal aggression, feeling hopeless at times, missing their independence, feeling like no one cared about them, struggling with conflict and getting along with peers, increased depression, frustration due to having a roommate, and being easily annoyed by peers. Interventions included the following: 1. Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 3/13/24. 2. Assist		transfer/discharge Ombudsman form and document findings on discharge/transfer paperwork per regulation. This audit will be completed 5 times week for 30 days, then 3 times week for 30 days, then 2 times week for 30 days at random for 30 days. Then monthly a review will be completed based on the transfer/discharge Ombudsman form. If discrepancies are noted, then immediate action will be taken to correct. b. Findings from review and any corrective actions will be discussed during QAPI meetings and the current plan revised as warranted.	

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	the resident, family, caregivers to identify strengths, positive coping skills and reinforce these. Date Initiated: 3/13/24. 3. Behavioral health consults as needed (psycho-geriatric team, psychiatrist etc.). Date Initiated: 3/13/24. 4. Educate the resident/family/caregivers regarding expectations of treatment, concerns with side effects and potential adverse effects, evaluation, maintenance. Date Initiated: 3/13/24. 5. Mental health clinician will work with resident on building rapport with roommate and help identify ways to experience joy in facility. Date Initiated: 7/22/24. 6. Mental health clinician will work with resident on negative thought no one care and helping identify supports. Date Initiated: 5/20/24. 7. Mental health clinician will work with resident on negative thought of hopelessness/helplessness and identifying strengths. Date Initiated: 3/26/24. 8. Mental health clinician will work with resident on negative thought of loss of control and help identify things in his life he has control over. Date Initiated: 4/30/24. 9. Mental health clinician will work with resident on negative thought of loss of control and identify thing in his control. Date Initiated: 6/17/24. 10. Mental health clinician will work with resident on positive peer interactions and identify ways to take breaks. Date Initiated: 5/27/24. 11. Mental health clinician will work with resident on positives of facility and identify ways to take breaks. Date Initiated: 8/12/24. 12. Mental health clinician will work with resident on ways he contributes to conflict and deep breathing. Date Initiated: 7/29/24. 13. Mental health clinician will work with resident on ways to use compromise and explores ways to use "I" statements. Date Initiated: 6/10/24. 14. Monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a			

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	note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. Date Initiated: 3/13/24. 15. Monitor/record mood to determine if problems seem to be related to external causes, i.e. medications, treatments, concern over diagnosis. Date Initiated: 3/13/24. 16. Monitor/record/report to MD prn risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons. Date Initiated: 3/13/24. 17. Monitor/report to Nurse any risk for harm to self or suicidal idealization. Date Initiated: 3/13/24. 18. Observe for signs and symptoms of mania or hypomania racing thoughts or euphoria; increased irritability; frequent mood changes; pressured speech; flight of ideas; marked change in need for sleep; agitation or hyperactivity. Date Initiated: 3/13/24. A current care plan, dated 3/19/24, indicated the resident had the potential to be verbally aggressive with threatening behavior. Interventions included the following: 1. Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 3/19/24. 2. Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document. Date Initiated: 3/19/24. 3. Assess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain etc. Date Initiated: 3/19/24. 4. Assess resident's coping skills and support system. Date Initiated: 5/3/24. 5. Assess resident's understanding of the situation. Allow time for the resident to express self and feelings towards the situation. Date Initiated: 3/19/24. 6.			

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	Monitor behaviors. Document observed behavior and attempted interventions. Date Initiated: 6/21/24. 7. Offer to take resident for a walk, etc. Date Initiated: 8/5/24. 8. Provide positive feedback for good behavior. Emphasize the positive aspects of compliance. Date Initiated: 3/19/24. 9. Psych NP/Psychiatric/Psychogeriatric consult as indicated. Date Initiated: 3/19/24. 10. The resident's triggers for verbal aggression are others getting close to him. The resident's behaviors is de-escalated by keeping wanderers away from him. Date Initiated: 4/29/24. 11. When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Date Initiated: 3/19/24. A current care plan, dated 4/1/24, indicated the resident had the potential to be physically aggressive to others, shoving others, attempting to hit others, and hitting others. Interventions included the following: 1. Psychiatric/Psychogeriatric consult as indicated. Date Initiated: 6/20/24. 2. When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Date Initiated: 4/1/24. 3. Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 4/1/24. 4. Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. Date Initiated: 4/1/24. 5. Assess and address for contributing sensory deficits. Date Initiated: 4/1/24. 6. Assess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain etc. Date Initiated: 4/1/24. 7.			

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	COMMUNICATION: Encourage seeking out of staff member when agitated. Date Initiated: 4/1424. 8. COMMUNICATION: provide physical and verbal cues to alleviate anxiety. Date Initiated: 4/14/24. 9. Encourage resident to verbalize source of agitation. Date Initiated: 5/23/24. 10. Monitor/document/report PRN any signs or symptoms of resident posing danger to self and others. Date Initiated: 4/1/24. 11. Notify Psych NP of behaviors. Date Initiated: 4/1/24. 12. Offer to take resident to enclosed court yard as/if able when he exhibits any agitation, etc. Date Initiated: 8/16/24. Review of progress notes indicated, on 8/15/24 at approximately 9:35 p.m., Resident C physically assaulted another resident. The police were called and Resident C was taken to the emergency department for evaluation. A police report, dated 8/15/24 at approximately 9:12 p.m., indicated the police were called to the facility in regards to a fight. Staff informed the police that Resident C had "stomped" on another resident's head (Resident D). The police observed blood on the floor of Resident C's room. When asked, Resident C told the police he had "beat his a_ _" and was unsure of how many times he stomped on the other resident's head. The resident told the police he had been woken up by the other resident when they walked into his room. Staff told the police Resident C knew right from wrong and provided statements about what they had witnessed. The police also visited the other resident (Resident D) while they were being seen in the emergency room. The police documented a "large gash" on the resident's forehead. Resident D remained non-verbal. Review of an emergency department progress			

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	note, dated 8/15/24 at 10:23 p.m., indicated Resident C was seen following an altercation. He had been hit in the 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. Resident C was to proceed back to Brookside Care Strategies, despite them not wanting to accept him back. Review of a hospital nursing note, dated 8/16/24, indicated the resident verbalized a desire to return to the facility. The resident stated he had been at the facility for approximately one month and considered the facility his home. An emergency department note, dated 8/16/24, indicated Resident C had received a psychiatric and social work evaluation. The resident was being sent back to the facility "despite them not wanting to accept him back." The resident had no behavioral changes. A Social Service note, dated 8/16/2024 at 11:03 a.m., indicated the resident was discharged to a homeless shelter located 61 miles from the facility. The resident was given all of his belongings, medications, $20.00 cash, a lighter, and a pack of cigarettes. A Discharge Summary Note, dated 8/16/2024 at 11:18 a.m., indicated the resident was discharged with his face sheet, medications, money, and cigarettes. A Transfer/Discharge Notice, dated 8/16/24, indicated Resident C was discharged to a homeless shelter in downtown Indianapolis, 61			

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	miles away from the facility. The Interdisciplinary, Social Service, and transfer/discharge documentation, dated from 8/15/2024 through 8/16/2024, did not include information to determine the facility provided a thirty-day written notice 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 location. During an interview on 8/19/24 at 2:49 p.m., the Administrator indicated, on 8/16/24, the hospital called and indicated the resident was being released back to the facility. The Administrator did not feel comfortable with the resident being back in the facility due to his behaviors. When the resident arrived at the facility via ambulance, the Administrator met them in the parking lot. He asked the resident if he remembered what had happened the night before. The resident responded that he knew what he had done. Resident C said he knew he was not wanted in the facility and he would sign any paperwork they needed him to sign. He just wanted his cigarettes. The Administrator asked the SSD (Social Service Director) to look for a homeless shelter that could take the resident. The Administrator indicated he gave the resident $20.00, a bag of food, his belongings, and cigarettes. The resident told the Administrator he did not have anyone and he did not need anyone. The Administrator transported the resident to the homeless shelter in his private car.			

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	During an interview on 8/20/24 at 9:18 a.m., a representative from the named homeless shelter indicated Resident C had not been admitted. No one by that name and 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 Administrator indicated he had taken the resident to the homeless shelter, but he did not feel it was safe. He took the resident to another town (26 miles from facility) 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. The undated face sheet, included, but was not limited to, information to contact two family members in the event of an emergency. The family members could not be contacted for interview using the information on the face sheet. During the survey, the whereabouts of the resident could not be determined until on, 8/22/24 at 11:00 a.m., when the Administrator provided a referral sent from a local hospital requesting a bed for Resident C. The referral indicated the resident had arrived at the hospital on 8/18/24. The Administrator indicated he was told the resident had been picked up by the police after being found lying on the sidewalk in front of a local homeless shelter. Local police were contacted during the survey and no report was available. Review of an 8/18/24 emergency room report indicated Resident C was being admitted to the hospital for treatment of dehydration, acute kidney injury, and abnormal laboratory values			

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	after being found on the sidewalk outside of a shelter. The hospital was able to treat the dehydration with intravenous fluids, but the resident continued to have elevated creatine kinase (CK) levels (indicative of heart, muscle, or brain injury or excessive drug or alcohol use). The facility discharge policy was requested on 8/21/24 at 9:50 a.m. and again at 10:10 a.m., when a partial copy of a Discharge Policy dated 1/2023 was provided. The Administrator indicated, on 8/21/24 at 11:05 a.m., he was awaiting a copy of the policy from the corporate offices. Review of a facility policy, dated December 2016, and titled "Transfer or Discharge Notice," provided by the DON on 8/21/24 at 11:45 a.m., indicated the facility shall provide a thirty-day written notice of an impending transfer or discharge. The notice would be given as soon as practicable but before the transfer or discharge: "a. The transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility; .... c. The safety of individuals in the facility is endangered: .... 5. The reasons for the transfer or discharge will be documented in the resident's medical record; .... 11. in determining the transfer location for a resident, the decision to transfer to a particular location will be determined 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 provide guidelines for discharging a resident for including, but not limited to, needs cannot be met or the resident's clinical and behavioral status endangered the health and			

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	safety of other residents. The immediate jeopardy that began on 8/16/24 was removed on 8/22/24, when the facility provided education to managers and nurses regarding transfer and discharge rights, but noncompliance remained at the lower scope and severity of harm that is not Immediate Jeopardy because the resident was found on a sidewalk by police back in the city the facility is located in and was hospitalized for dehydration and acute kidney injury. This citation relates to Complaint IN00440457. 3.1-12(a)(3) 3.1-12(a)(4)			
F 0626 SS=J Bldg. 00	483.15(e)(1)(2) Permitting Residents to Return to Facility Based on record review and interview, the facility failed to ensure facility policies were implemented to allow a resident to return to the facility for care following an emergency room visit. The resident was not provided adequate notice to appeal the discharge prior to being transported to and left at a hotel 26 miles away from the facility. The Immediate Jeopardy that began on 8/16/24, when the facility failed to allow a resident to return to the facility after a hospital visit per facility policy. This deficient practice put the resident at risk for harm related to lack of a safe environment, placing the resident at risk of serious accidents. The Administrator, Social Services Director (SSD), and the Housekeeping Supervisor were notified of the Immediate Jeopardy on 8/20/24 at 4:37 p.m. The Immediate Jeopardy was removed when the facility	F 0626	Request IDR as the facility follows the policy and procedure on readmitting residents. It is the practice of this facility to 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 be accomplished for those residents found to be affected by the deficient practice: a. Resident returned to the facility and was discharged per his request. 2. How other residents having the	08/23/2024

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	completed education of management and nurses regarding discharge rights and the facility policy for resident discharge on 8/22/24, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm. Findings include: Review of the Facility Assessment, dated 8/2/24 and provided by the Administrator on 8/21/24 at 9:20 a.m., indicated the facility had an average daily census of 26 and cared for residents with the following needs: psychiatric/mood disorders including psychosis (hallucinations, delusions, etc.) impaired cognition, mental disorder, depression, mania/depression, schizophrenia, post-traumatic stress disorder (PTSD), anxiety disorder, and behavior plural? that needed interventions. The facility's population included five residents with behavioral symptoms and cognitive performance needs and ten with behavioral/mental health needs. Services offered by the facility included, but were not limited to, management of medical conditions and medication-related issues causing psychiatric symptoms and behavior and implementation of interventions to help support residents with psychiatric diagnoses and intellectual or developmental disabilities. Discharge planning included assistance with financial implications, referral to local contact agencies as needed, discharge medication list, and assistance with medical supplies. Resident C's clinical record was reviewed on 8/19/24 at 11:28 a.m. Diagnoses included mild cognitive impairment, alcohol use, history of cerebral infarction, mood disorder, cocaine abuse, and epileptic syndrome.		potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a. All residents have the potential to be affected by the alleged deficiency. b. An audit of discharges/transfers as shown on the monthly form for the State Ombudsman for the last 30 days will be completed and no further issues noted. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur: a. An in-service was completed on 08/21/2024 for License Nurses and the Interdisciplinary team for transfer/discharge procedures. b. Any discharge from the facility (whether resident-initiated or facility-initiated) will be addressed to the Administration/designee to confirm appropriate notification and discharge planning has occurred. Should concerns be identified, the same shall be immediately addressed with applicable staff members and corrective actions taken, as warranted to ensure compliance with facility policies and procedures. Should a resident of the facility elect to leave Against Medical Advice (AMA), said resident shall be educated as to potential	

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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 period. Other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) occurred 1-3 days of the assessment period. He used a cane or crutches for mobility. He was occasionally incontinent of urine and required assistance of one for dressing the lower part of his body. He was dependent for bathing. Review of progress notes indicated, on 8/15/24 at approximately 9:35 p.m., Resident C physically assaulted another resident. The police were called and Resident C was taken to the emergency department for evaluation. Review of an Emergency Department Progress note, dated 8/15/24 at 10:23 p.m., indicated Resident C was seen following an altercation. He had been hit in the 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 was to proceed back to Brookside Care Strategies despite them not wanting to accept him back. No significant behavioral changes were noted. An emergency department note, dated 8/16/24, indicated Resident C had received a psychiatric and social work evaluation. The resident was being sent back to the facility "despite them not		negative outcomes of the decision and the same shall be documented. Should the resident have health needs susch that AMA discharge could place the resident at risk applicable agencies (e.g., Adult Protective Services, Local Police Department, Ombudsman, 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 with the information of the monthly transfer/discharge Ombudsman form and document findings on discharge/transfer paperwork per regulation. This audit will be completed 5 times a week for 30 days, then 3 times week for 30 days, then 2 times week for 30 days at random for 30 days. Then monthly a review will be completed based on the transfer/discharge Ombudsman form. If discrepamncies are noted, then immediate action will be traken to correct. b. Findings from review and any corrective actions will be discussed during QAPI meetings and the current plan revised as warranted.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	wanting to accept him back." Review of a hospital nursing note, dated 8/16/24, indicated the resident verbalized a desire to return to the facility. The resident stated he had been at the facility for approximately one month and considered the facility his home. A Social Service note, dated 8/16/2024 at 11:03 a.m., indicated the resident was discharged to a homeless shelter located 61 miles from the facility. The resident was given all of his belongings, medications, $20.00 cash, a lighter, and a pack of cigarettes. A Discharge Summary Note, dated 8/16/2024 at 11:18 a.m., indicated the resident was discharged with his face sheet, medications, money, and cigarettes. A Transfer/Discharge Notice, dated 8/16/24, indicated Resident C was discharged to a homeless shelter in downtown Indianapolis, 61 miles away from the facility. The Interdisciplinary, Social Service, and transfer/discharge documentation, dated from 8/15/2024 through 8/16/2024, did not include information to determine the facility provided a thirty-day written notice 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 location.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E064	A. BUILDING 00 B. WING	08/23/2024

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	During an interview on 8/19/24 at 2:49 p.m., the Administrator indicated, on 8/16/24, the hospital called and indicated the resident was being released back to the facility. The Administrator did not feel comfortable with the resident being back in the facility due to his behaviors. When the resident arrived at the facility via ambulance, the Administrator met them in the parking lot. He asked the resident if he remembered what had happened the night before. The resident responded that he knew what he had done. Resident C said he knew he was not wanted in the facility and he would sign any paperwork they needed him to sign. He just wanted his cigarettes. The Administrator asked the SSD (Social Service Director) to look for a homeless shelter that could take the resident. The Administrator indicated he gave the resident $20.00, a bag of food, his belongings, and cigarettes. The resident told the Administrator he did not have anyone and he did not need anyone. The Administrator transported the resident to the homeless shelter in his private car. During an interview on 8/20/24 at 9:18 a.m., a representative from the named homeless shelter indicated Resident C had not been admitted. No one by that name and 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 Administrator indicated he had taken the resident to the homeless shelter, but he did not feel it was safe. He took the resident to another town (26 miles from facility) 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. The undated face sheet, included, but was not			

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	limited to, information to contact two family members in the event of an emergency. The family members could not be contacted for interview using the information on the face sheet. During the survey, the whereabouts of the resident could not be determined until on, 8/22/24 at 11:00 a.m., when the Administrator provided a referral sent from a local hospital requesting a bed for Resident C. The referral indicated the resident had arrived at the hospital on 8/18/24. The Administrator indicated he was told the resident had been picked up by the police after being found lying on the sidewalk in front of a local homeless shelter. Local police were contacted during the survey and no report was available. Review of an 8/18/24 emergency room report indicated Resident C was being admitted to the hospital for treatment of dehydration, acute kidney injury, and abnormal laboratory values after being found on the sidewalk outside of a shelter. The hospital was able to treat the dehydration with intravenous fluids, but the resident continued to have elevated creatine kinase (CK) levels (indicative of heart, muscle, or brain injury or excessive drug or alcohol use). The facility discharge policy was requested on 8/21/24 at 9:50 a.m. and again at 10:10 a.m., when a partial copy of a Discharge Policy dated 1/2023 was provided. The Administrator indicated, on 8/21/24 at 11:05 a.m., he was awaiting a copy of the policy from the corporate offices. Review of a facility policy, dated December 2016, and titled "Transfer or Discharge Notice," provided by the DON on 8/21/24 at 11:45 a.m.,			

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	indicated the facility shall provide a thirty-day written notice of an impending transfer or discharge. The notice would be given as soon as practicable but before the transfer or discharge: "a. The transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility; .... c. The safety of individuals in the facility is endangered: .... 5. The reasons for the transfer or discharge will be documented in the resident's medical record; .... 11. in determining the transfer location for a resident, the decision to transfer to a particular location will be determined 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 provide guidelines for discharging a resident for including, but not limited to, needs cannot be met or the resident's clinical and behavioral status endangered the health and safety of other residents. The immediate jeopardy that began on 8/16/24 was removed on 8/22/24, when the facility provided education to managers and nurses regarding transfer and discharge 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)			