STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/12/2023				
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 505 N GAVIN ST MUNCIE, IN 47303					
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR				
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
F 0000								
Bldg. 00	This visit was for IN00407659.	the Investigation of Complaint	F 0000					
	_	07659 - Federal/state deficiencies gations are cited at F600 and						
	Survey dates: Ma	y 11 and 12, 2023						
	Facility number: 0 Provider number: AIM number: 100	15E064						
	Census Bed Type: NF: 38 Total: 38							
	Census Payor Typ Medicaid: 37 Other: 1 Total: 38	e:						
	This deficiency re accordance with 4	flects State Findings cited in 10 IAC 16.2-3.1.						
	Quality review co	mpleted May 19, 2023.						
F 0600 SS=D Bldg. 00	Exploitation The resident has abuse, neglect, r property, and ex subpart. This incomplete the control of the co	e and Neglect on from Abuse, Neglect, and the right to be free from misappropriation of resident ploitation as defined in this cludes but is not limited to reporal punishment, sion and any physical or						
LABORATO	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	SIGNATURE	TITLE	(X6) DATE			
Derrek Ke	ith		HFA		06/18/2023			

Any defiency statement 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 disclosable

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.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE	3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU			LETED	
		15E064	B. W	ING		05/12	/2023
		1		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			GAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES			E, IN 47303		
(X4) ID	SUMMARV	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)	TE	DATE
		not required to treat the					
	resident's medical						
		, ,					
	§483.12(a) The fa	icility must-					
	. , , , ,	use verbal, mental, sexual,					
		, corporal punishment, or					
	involuntary seclus	The state of the s		600			07/10/2022
		on, interview, and record	F 00	500	F 600	··	07/10/2023
	1	failed to prevent physical			The filing of the plan of correc		
	_	nt resident (Resident E) by esident B) for 1 of 3 residents			does not constitute an admiss		
	reviewed for abuse.				that the alleged deficiency did fact exist. This plan of correcti		
	Teviewed for abuse.				is filed as evidence of the facil		
	Findings include:				desire to comply with the	ity S	
	i mamgs merade.				requirements and continue to		
	Review of a facility	self reportable, dated 5/7/2023			provide quality care.		
		ted Resident B was observed			The facility respectfully reques	sts	
		right hand and biting it,			paper review for compliance.		
	_	Resident E had been sitting in a			· ·		
	high-backed reclini	ng wheelchair. The altercation			What corrective action(s) will	be	
	was unprovoked. R				accomplished for those reside	ents	
		d care and placed on antibiotic			found to have been affected t	ру	
	therapy.				the deficient practice?		
		5/11/2022			Resident B's care was update		
	_	ion on 5/11/2023 at 10:27 a.m.,			5/8/2023, also Resident sent of	out	
		erved sitting in their			to in patient psych at Neuro	for	
		ng wheelchair in the common			Psych Hospital in Greenwood	ior	
	to the back of their	coloration and a scabbed area			evaluation. Resident E Nursing assessed	the	
	to the back of their	right hand.			resident with resident noted to		
	The clinical record	for Resident E was reviewed on			have a bruise to top of right ha		
		p.m. Diagnoses include, anxiety			and a skin tearX-ray of hand		
		e disorder, deaf, severe			ordered with no acute fracture		
	_	ation and mood disturbance.			dislocation note. Has not exhil		
					any s/sx of distress.		
	The current annual	MDS, dated 3/6/2023,			How will you identify other		
	indicated Resident	E required extensive assistance			residents having the potential	to	
	for bed mobility, to	ilet use, personal hygiene,			be affected by the same defic	ient	
	eating and dressing	. The resident had severe			practice and what corrective		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPL	COMPLETED	
		15E064	B. W	ING		05/12	/2023	
		1	<u> </u>	STREET 4	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	R			SAVIN ST			
BROOKS	SIDE CARE STRAT	FGIES			E, IN 47303			
				Wichton	2, 114 17 000		1	
(X4) ID	SUMMARY 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	
	cognitive impairme	nt.			action will be taken?			
		: 11/22/2010 : 1: 1			As outlined in the Care Strate	•		
	_	, revised 1/22/2019, indicated			Behavior Management Progra			
		ommunication problem related			(exhibit 1) all behaviors will be			
	_	The resident was legally deaf			referred to SSD by Social Ser	vices		
		sign language or understanding			form (exhibit 2), and will be			
	of written language	•			addressed in the weekly Beha	ivior		
	A	mated dated 5/0/2022 -t 1-27			meeting.	_		
		noted, dated 5/9/2023 at 1:27			What measures will be put into			
		ident E was bit by another thand. The on-call provider			place or what systemic change			
		he had, which was negative for			you will make to ensure that t			
		ic therapy was started on			deficient practice does not red	cui ?		
	5/8/2023.	te therapy was started on			Implementation of the undated	1		
	3/6/2023.				Implementation of the updated Care Strategies Behavior	ı		
	Daviesy of current r	physician orders indicated a			Management Program (exhibi	+ 1\		
		oxicillin-pot clavulanate			stating after the in-service on	ιι),		
		let 875-125 mg every 12 hours			6/8/2023.			
	, ,	pite treatment of the top of			How the corrective action(s) v	azill		
	their hand for 10 da				be monitored to ensure the	VIII		
		.,, .,			deficient practice will not recur	r		
	The clinical record	for Resident B was reviewed			i.e., what quality assurance	,		
		0 a.m. Diagnoses included			program will be put into place?	7.		
		ectable epilepsy with status			All behaviors will be referred to			
	_	ound intellectual disabilities.			SSD by Social Services form			
					(exhibit 2) and will be discusse	ed in		
	The current, quarter	rly Minimum Data Set (MDS)			the weekly Behavior meeting l			
	assessment, dated 3	1/16/2023, indicated the			the IDT members.	•		
	resident was moder	ately cognitively impaired.						
					The Weekly Behavior			
	A psychological Nu	arse Practitioner note, dated			Management Form will be fille	d		
		p.m., indicated Resident B was			out weekly by the SSD or			
	"	cute increase in physical			designee to ensure that behav	/ior		
		n, paranoia and delusions.			team discusses the reported			
	Re-direction of the	resident was difficult.			behaviors weekly and signed	off by		
					the DON weekly.			
		note, dated 5/6/2023,						
		B had been quietly walking			The results of these audits will			
		eas. Staff heard a female			reviewed in Quality Assurance	е		
	resident yell out (Resident E). Resident B was		1		Meeting Quarterly. The QA			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				JRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED B. WING 05/12/2023			ΓED	
		15E064	B. W	TNG		05/12/2	023
N. N. T. O. T. T.	NOTABLE OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF P	PROVIDER OR SUPPLIER	t			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	`	CY 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
	_	next to Resident E, who was			Committee will identify any tre	ends	
		acked reclining wheelchair.			or patterns and make	_	
	-	E's hand was bruised and			recommendations to revise th		
	E's hand in their mo	orted Resident B had Resident			plan of correction as indicated		
	Es nand in their inc	outn.					
	A current care plan.	, last revised on 5/8/2023,					
		nt had potential to be					
		ve to others related to poor					
		at others, or/and attempting to					
		entions included the					
	following: administ	er medications as ordered and					
	monitor/document f						
	· ·	s and address for contributing					
		sess and anticipate resident's					
		toileting needs, comfort level,					
	body positioning, pa						
		report any sign or symptom of					
		ger to self and others. When					
		es agitated: intervene before					
		guide away from source of					
		e calmly in conversation. If					
		ive, staff to walk calmly away,					
	and approach later.						
	The care plan lacke	d any interventions or					
	-	for biting behaviors.					
		.					
	During an interview	y on 5/11/2023 at 10:52 a.m.,					
	_	sident B had shown biting					
	behaviors in the pas	st. LPN 2 indicated the					
	resident had attemp	ted to bite her on the face.					
	_	give a specific date of the					
	_	nt it happened earlier this year.					
		ocumented the incident,					
	_	should be documented in the					
	clinical record.						
		5/11/2022 - 15 25					
		on 5/11/2023 at 11:25 a.m., the					
	Social Service Dire	ctor indicated the resident's					

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

Event ID:

TXQJ11 Facility ID: 000311

If continuation sheet Page 4 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER			JILDING	00	COMPI	
		15E064	B. W	ING		05/12	/2023
NAME OF I	PROVIDER OR SUPPLIER)	•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
					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		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		haviors had not been					
	addressed in the res	months ago, the resident had					
		member. All behaviors should					
		he clinical record and the SSD					
		ng during the MDS period.					
	Tevrewed the charth	ing during the WIDS period.					
	During an interview	v on 5/11/2023 at 1:34 p.m.,					
		on Aide (QMA) 1 indicated					
		when Resident B bit Resident E.					
	They had stepped a	way from the medication cart,					
	looked up and he (F	Resident B) had her (Resident					
		is mouth. QMA 1 stated					
		(Resident E) was mean to him,					
		her. Resident E was started on					
	antibiotic therapy in	mmediately.					
	Review of an untitle	ed document titled "Your					
		ons as a Nursing Home					
	_	from www.cms.gov indicated					
		ou have the right to be treated					
	_	spectYou have the right to be					
	free from verbal, se	exual, physical, and mental					
	abuse"						
	C	40					
	Cross reference F74	+∪.					
	This Federal tag rel	ates to complaint IN00407659.					
	3.1-27(a)(b)						
F 0740	483.40						
SS=D	Behavioral Health	Services					
Bldg. 00	§483.40 Behavior	al health services.					
	Each resident mu	st receive and the facility					
	must provide the r	necessary behavioral health					
		to attain or maintain the					
		e physical, mental, and					
		-being, in accordance with					
	the comprehensiv	e assessment and plan of					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLE			ETED		
		15E064	B. W	B. WING			05/12/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	8			SAVIN ST			
BB∪∪k¢	SIDE CARE STRAT	EGIES			E, IN 47303			
פאססאפ	NOT OWNE SIKAL	LOILO		MONCI	L, IIV +7 000			
(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 OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	care. Behavioral	health encompasses a						
		motional and mental						
	_	includes, but is not limited						
	-	and treatment of mental						
	and substance us							
		and record review, the facility	F 07	740	F740		07/03/2023	
		d implement a behavioral			The filing of the plan of correc			
		m to provide individualized			does not constitute an admiss			
	_	vent resident to resident			that the alleged deficiency did			
		enced by Resident B biting			fact exist. This plan of correcti			
		ack of the right hand, resulting			is filed as evidence of the facil	ity's		
	in broken skin and	antibiotic therapy.			desire to comply with the			
					requirements and continue to			
	Findings include:				provide quality care.			
					The facility respectfully reques	sts		
	I -	self reportable, dated 5/7/2023			paper review for compliance.			
		ted Resident B was observed						
	_	right hand and biting it,			What corrective action(s) will			
	_	Resident E had been sitting in a			accomplished for those reside			
	_	ng wheelchair. The altercation			found to have been affected b	ру		
	was unprovoked. R				the deficient practice?			
		d care and placed on antibiotic			Implementation of an updated			
	therapy.				Behavioral Management Plan			
					allow the facility to better man	_		
		for Resident B was reviewed			the specific needs of the resid	ent		
		0 a.m. Diagnoses included			population.			
		ctable epilepsy with status			How will you identify other	4-		
		ound intellectual disabilities.			residents having the potential			
		ecently been admitted to a			be affected by the same defic	ent		
		patient facility for evaluation			practice and what corrective			
	and treatment.				action will be taken?			
	The arrant	dy Minimum Data Sat (MDS)			As outlined in the Care Strate	-		
	1	rly Minimum Data Set (MDS)			Behavior Management Progra			
		/16/2023, indicated the stensive assistance for			(exhibit 1) all behaviors will be			
	_	and personal hygiene. They			referred to SSD by Social Ser	vices		
		n and set up for walking and			form (exhibit 2), and will be	wior		
		sident was moderately			addressed in the weekly Beha	IVIOI		
					meeting.	2		
	cognitively impaire	u.			What measures will be put into			
			1		place or what systemic change	es		

STATEMENT 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. W	ING		05/12/	/2023
				·			
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					GAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES		MUNCI	E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORREC		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΔTE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	A nursing progress	note, dated 2/12/2023 at 6:40			you will make to ensure that	the	
	p.m., indicated Res	ident B bit a CNA on the hand			deficient practice does not re	cur?	
	during a period of 1	behaviors when the CNA was					
	attempting to re-dir	rect the resident.			Implementation of the update	d	
					Care Strategies Behavior		
	A nursing progress	note, dated 2/12/2023 at 6:27			Management Program (exhibit	it 1),	
	a.m., indicated Res	ident B had attempted to bite			stating after the in-service on		
	an unknown female	e resident.			6/8/2023.		
					How the corrective action(s)	will	
	A psychological N	urse Practitioner note, dated			be monitored to ensure the		
	4/30/2023 at 12:09	p.m., indicated Resident B was			deficient practice will not recu	r,	
	being seen for an a	cute increase in physical			i.e., what quality assurance		
	aggression, agitation, paranoia and delusions.				program will be put into place	? ·	
	Re-direction of the	resident was difficult.			All behaviors will be referred t	to	
					SSD by Social Services form		
	A nursing progress	note, dated 5/6/2023,			(exhibit 2) and will be discuss	ed in	
	indicated Resident	B had been quietly walking			the weekly Behavior meeting	by	
	around common ar	eas. Staff heard a female			the IDT members.		
	resident yell out (R	esident E). Resident B was					
	observed standing	next to Resident E, who was			The Weekly Behavior		
	sitting in her high-l	packed reclining wheelchair.			Management Form will be fille	ed	
	The top of Residen	t E's hand was bruised and			out weekly by the SSD or		
	bleeding. Staff rep	orted Resident B had Resident			designee to ensure that beha	vior	
	E's hand in their me	outh.			team discusses the reported		
					behaviors weekly and signed	off by	
	_	, last revised on 5/8/2023,			the DON weekly.		
		ent had potential to be					
		ve to others related to poor			The results of these audits wi	ll be	
		at others, or/and attempting to			reviewed in Quality Assurance	e	
	hit at others. Interv	ventions included the			Meeting Quarterly. The QA		
		ter medications as ordered and			Committee will identify any tre	ends	
	monitor/document				or patterns and make		
		ss and address for contributing			recommendations to revise th		
		sess and anticipate resident's			plan of correction as indicated	d.	
		toileting needs, comfort level,					
	body positioning, p						
		report any sign or symptom of					
		nger to self and others. When					
		es agitated: intervene before					
	agitation escalates,	guide away from source of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/12/2023	
	ROVIDER OR SUPPLIER		505 N C	ADDRESS, CITY, STATE, ZIP COD GAVIN ST E, IN 47303	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION C calmly in conversation. If	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	response is aggressiand approach later.	ive, staff to walk calmly away,			
	documented review	d any interventions or for biting behaviors.			
	5//12/2023 at 12:09 anxiety disorder, de	for Resident E was reviewed on p.m. Diagnoses include, pressive disorder, deaf, severe tion and mood disturbance.			
	indicated Resident I for bed mobility, to	MDS, dated 3/6/2023, E required extensive assistance ilet use, personal hygiene, . The resident had severe nt.			
	the resident had a co to hearing deficit. T	revised 1/22/2019, indicated ommunication problem related the resident was legally deaf ign language or understanding .			
	p.m., indicated Resi resident on the righ ordered a x-ray of t	noted, dated 5/9/2023 at 1:27 ident E was bit by another t hand. The on-call provider he had, which was negative for c therapy was started on			
	5/8/23 order for am (antibiotic) oral tab	ohysician orders indicated a oxicillin-pot clavulanate let 875-125 mg every 12 hours pite treatment of the top of ys.			
	Resident E was obs	ion on 5/11/2023 at 10:27 a.m., erved sitting in their ng wheelchair in the common			

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

Event ID:

TXQJ11

Facility ID: 000311

If continuation sheet

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		15E064	B. W	ING		05/12/	/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	R			SAVIN ST			
BROOKS	SIDE CARE STRAT	FGIES			E, IN 47303			
DITOOITO	DINOGRAPIE OF WILL OF WITE COLOR			WIGHTON	L, II 47 000			
(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	ΓE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		coloration and a scabbed area						
	to the back of their	right hand.						
	D	5/11/2022 + 10.52						
	_	v on 5/11/2023 at 10:52 a.m.,						
		esident B had shown biting						
	_	st. LPN 2 indicated the						
	_	ted to bite her on the face. give a specific date of the						
		nt it happened earlier this year.						
	_	locumented the incident,						
		should be documented in the						
	clinical record.	should be documented in the						
	During an interview	v on 5/11/2023 at 11:25 a.m., the						
	_	ctor indicated the resident's						
		haviors had not been						
	addressed in the res							
	Approximately two	months ago, the resident had						
	tried to bite a staff i	member. All behaviors should						
	be documented in the	he clinical record and the SSD						
	reviewed the charting	ng during the MDS period.						
	_	v on 5/11/2023 at 1:34 p.m.,						
		on Aide (QMA) 1 indicated						
		vhen Resident B bit Resident E.						
		way from the medication cart,						
		Resident B) had her (Resident						
		s mouth. QMA 1 stated						
		(Resident E) was mean to him,						
		ner. Resident E was started on						
	antibiotic therapy in	nmediately.						
	Duning on the second	or on 5/12/2022 at 2:50						
		y on 5/12/2023 at 2:50 p.m.,						
		n event when Resident B was with two other residents. The						
		ing to argue and the QMA						
		nt B got up from the table and						
		elbow on the wall. The QMA						
		ident a key he had dropped on						
		was to a safe the resident kept						
	and Hoof. The key	was to a safe the resident kept						

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Event ID:

TXQJ11

Facility ID: 000311

If continuation sheet

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

PRINTED: 06/20/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED			ETED	
		15E064	B. WI	NG		05/12/	/2023
	ROVIDER OR SUPPLIER			505 N G	ADDRESS, CITY, STATE, ZIP COD BAVIN ST E, IN 47303		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
	in his room and staf	f used it as a distraction.					
	When the QMA trie	ed to give the key to Resident					
	B, the resident bit th	ne QMA's hand. The QMA					
	had a bruise, but the	bite did not break the skin.					
	4 indicated approxing Resident B attempted 4 believed she chart documentation of the clinical record. Behin the clinical record. During an interview Assistant Director of the following: "This has not really been a are trying to develop	on 5/12/2023 at 3:26 p.m., the f Nursing (ADON) indicated s is a behavioral facility. There a set program in place. But we p one. We educate on					
		ch. I do not believe we have ehaviors are monitored					
	through the charting						
	During an interview Administrator, Direct ADON indicated the facility and did not lead to the program in place. The facility had been we anticipated implement	on 5/12/2023 at 3:56 p.m., the ector of Nursing, and the efacility was a behavioral have a behavioral management. The Administrator indicated the orking on a program with entation in June 2023.					
	This Federal tag rela	ates to complaint IN00407659.					
	3.1-43(a)(1)						

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