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	05/12/2023

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

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00407659. Complaint IN00407659 - Federal/state deficiencies related to the allegations are cited at F600 and F740. Survey dates: May 11 and 12, 2023 Facility number: 000311 Provider number: 15E064 AIM number: 100285520 Census Bed Type: NF: 38 Total: 38 Census Payor Type: Medicaid: 37 Other: 1 Total: 38 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 19, 2023.	F 0000		
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Derrek Keith	HFA	06/18/2023

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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	chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, interview, and record review, the facility failed to prevent physical abuse of a dependent resident (Resident E) by another resident (Resident B) for 1 of 3 residents reviewed for abuse. Findings include: Review of a facility self reportable, dated 5/7/2023 at 9:01 a.m., indicated Resident B was observed taking Resident E's right hand and biting it, breaking the skin. Resident E had been sitting in a high-backed reclining wheelchair. The altercation was unprovoked. Resident E had to be administered wound care and placed on antibiotic therapy. During an observation on 5/11/2023 at 10:27 a.m., Resident E was observed sitting in their high-backed reclining wheelchair in the common area. They had discoloration and a scabbed area to the back of their right hand. The clinical record for Resident E was reviewed on 5/12/2023 at 12:09 p.m. Diagnoses include, anxiety disorder, depressive disorder, deaf, severe dementia with agitation and mood disturbance. The current annual MDS, dated 3/6/2023, indicated Resident E required extensive assistance for bed mobility, toilet use, personal hygiene, eating and dressing. The resident had severe	F 0600	F 600 The filing of the plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and continue to provide quality care. The facility respectfully requests paper review for compliance. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident B's care was updated on 5/8/2023, also Resident sent out to in patient psych at Neuro Psych Hospital in Greenwood for evaluation. Resident E Nursing assessed the resident with resident noted to have a bruise to top of right hand and a skin tear. .X-ray of hand ordered with no acute fracture or dislocation note. Has not exhibited any s/sx of distress. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective	07/10/2023

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	cognitive impairment. A current care plan, revised 1/22/2019, indicated the resident had a communication problem related to hearing deficit. The resident was legally deaf and did not utilize sign language or understanding of written language. A nursing progress noted, dated 5/9/2023 at 1:27 p.m., indicated Resident E was bit by another resident on the right hand. The on-call provider ordered a x-ray of the had, which was negative for fractures. Antibiotic therapy was started on 5/8/2023. Review of current physician orders indicated a 5/8/23 order for amoxicillin-pot clavulanate (antibiotic) oral tablet 875-125 mg every 12 hours by mouth for post-bite treatment of the top of their hand for 10 days. The clinical record for Resident B was reviewed on 5/11/2023 at 9:50 a.m. Diagnoses included schizophrenia, intractable epilepsy with status epilpticus, and profound intellectual disabilities. The current, quarterly Minimum Data Set (MDS) assessment, dated 3/16/2023, indicated the resident was moderately cognitively impaired. A psychological Nurse Practitioner note, dated 4/30/2023 at 12:09 p.m., indicated Resident B was being seen for an acute increase in physical aggression, agitation, paranoia and delusions. Re-direction of the resident was difficult. A nursing progress note, dated 5/6/2023, indicated Resident B had been quietly walking around common areas. Staff heard a female resident yell out (Resident E). Resident B was		action will be taken? · As outlined in the Care Strategies Behavior Management Program (exhibit 1) all behaviors will be referred to SSD by Social Services form (exhibit 2), and will be addressed in the weekly Behavior meeting. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Implementation of the updated Care Strategies Behavior Management Program (exhibit 1), stating after the in-service on 6/8/2023. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · All behaviors will be referred to SSD by Social Services form (exhibit 2) and will be discussed in the weekly Behavior meeting by the IDT members. The Weekly Behavior Management Form will be filled out weekly by the SSD or designee to ensure that behavior team discusses the reported behaviors weekly and signed off by the DON weekly. The results of these audits will be reviewed in Quality Assurance Meeting Quarterly. The QA	

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	observed standing next to Resident E, who was sitting in her high-backed reclining wheelchair. The top of Resident E's hand was bruised and bleeding. Staff reported Resident B had Resident E's hand in their mouth. A current care plan, last revised on 5/8/2023, indicated the resident had potential to be physically aggressive to others related to poor impulse, grabbing at others, or/and attempting to hit at others. Interventions included the following: administer medications as ordered and monitor/document for side effects and effectiveness, assess and address for contributing sensory deficits, assess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain, etc., monitor/document/report any sign or symptom of resident posing danger to self and others. When the resident becomes agitated: intervene before agitation escalates, guide away from source of distress, and engage calmly in conversation. If response is aggressive, staff to walk calmly away, and approach later. The care plan lacked any interventions or documented review for biting behaviors. During an interview on 5/11/2023 at 10:52 a.m., LPN 2 indicated Resident B had shown biting behaviors in the past. LPN 2 indicated the resident had attempted to bite her on the face. She was unable to give a specific date of the incident, but thought it happened earlier this year. She may not have documented the incident, although behaviors should be documented in the clinical record. During an interview on 5/11/2023 at 11:25 a.m., the Social Service Director indicated the resident's		Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	history of biting behaviors had not been addressed in the resident's care plan. Approximately two months ago, the resident had tried to bite a staff member. All behaviors should be documented in the clinical record and the SSD reviewed the charting during the MDS period. During an interview on 5/11/2023 at 1:34 p.m., Qualified Medication Aide (QMA) 1 indicated they were present when Resident B bit Resident E. They had stepped away from the medication cart, looked up and he (Resident B) had her (Resident E) whole hand in his mouth. QMA 1 stated Resident B said she (Resident E) was mean to him, so he was mean to her. Resident E was started on antibiotic therapy immediately. Review of an untitled document titled "Your Rights and Protections as a Nursing Home Resident," retrieved from www.cms.gov indicated the following: "...You have the right to be treated with dignity and respect...You have the right to be free from verbal, sexual, physical, and mental abuse...." Cross reference F740. This Federal tag relates to complaint IN00407659. 3.1-27(a)(b)			
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of			

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	care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on interview and record review, the facility failed to develop and implement a behavioral management program to provide individualized interventions to prevent resident to resident altercations, as evidenced by Resident B biting Resident E on the back of the right hand, resulting in broken skin and antibiotic therapy. Findings include: Review of a facility self reportable, dated 5/7/2023 at 9:01 a.m., indicated Resident B was observed taking Resident E's right hand and biting it, breaking the skin. Resident E had been sitting in a high-backed reclining wheelchair. The altercation was unprovoked. Resident E had to be administered wound care and placed on antibiotic therapy. The clinical record for Resident B was reviewed on 5/11/2023 at 9:50 a.m. Diagnoses included schizophrenia, intractable epilepsy with status epilpticus, and profound intellectual disabilities. The resident had recently been admitted to a neuropsychiatric inpatient facility for evaluation and treatment. The current, quarterly Minimum Data Set (MDS) assessment, dated 3/16/2023, indicated the resident required extensive assistance for transfers, toilet use, and personal hygiene. They required supervision and set up for walking and locomotion. The resident was moderately cognitively impaired.	F 0740	F740 The filing of the plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and continue to provide quality care. The facility respectfully requests paper review for compliance. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Implementation of an updated Behavioral Management Plan will allow the facility to better manage the specific needs of the resident population. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · As outlined in the Care Strategies Behavior Management Program (exhibit 1) all behaviors will be referred to SSD by Social Services form (exhibit 2), and will be addressed in the weekly Behavior meeting. What measures will be put into place or what systemic changes	07/03/2023

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	A nursing progress note, dated 2/12/2023 at 6:40 p.m., indicated Resident B bit a CNA on the hand during a period of behaviors when the CNA was attempting to re-direct the resident. A nursing progress note, dated 2/12/2023 at 6:27 a.m., indicated Resident B had attempted to bite an unknown female resident. A psychological Nurse Practitioner note, dated 4/30/2023 at 12:09 p.m., indicated Resident B was being seen for an acute increase in physical aggression, agitation, paranoia and delusions. Re-direction of the resident was difficult. A nursing progress note, dated 5/6/2023, indicated Resident B had been quietly walking around common areas. Staff heard a female resident yell out (Resident E). Resident B was observed standing next to Resident E, who was sitting in her high-backed reclining wheelchair. The top of Resident E's hand was bruised and bleeding. Staff reported Resident B had Resident E's hand in their mouth. A current care plan, last revised on 5/8/2023, indicated the resident had potential to be physically aggressive to others related to poor impulse, grabbing at others, or/and attempting to hit at others. Interventions included the following: administer medications as ordered and monitor/document for side effects and effectiveness, assess and address for contributing sensory deficits, assess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain, etc., monitor/document/report any sign or symptom of resident posing danger to self and others. When the resident becomes agitated: intervene before agitation escalates, guide away from source of		you will make to ensure that the deficient practice does not recur? · Implementation of the updated Care Strategies Behavior Management Program (exhibit 1), stating after the in-service on 6/8/2023. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · All behaviors will be referred to SSD by Social Services form (exhibit 2) and will be discussed in the weekly Behavior meeting by the IDT members. The Weekly Behavior Management Form will be filled out weekly by the SSD or designee to ensure that behavior team discusses the reported behaviors weekly and signed off by the DON weekly. The results of these audits will be reviewed in Quality Assurance Meeting Quarterly. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	distress, and engage calmly in conversation. If response is aggressive, staff to walk calmly away, and approach later. The care plan lacked any interventions or documented review for biting behaviors. The clinical record for Resident E was reviewed on 5//12/2023 at 12:09 p.m. Diagnoses include, anxiety disorder, depressive disorder, deaf, severe dementia with agitation and mood disturbance. The current annual MDS, dated 3/6/2023, indicated Resident E required extensive assistance for bed mobility, toilet use, personal hygiene, eating and dressing. The resident had severe cognitive impairment. A current care plan, revised 1/22/2019, indicated the resident had a communication problem related to hearing deficit. The resident was legally deaf and did not utilize sign language or understanding of written language. A nursing progress noted, dated 5/9/2023 at 1:27 p.m., indicated Resident E was bit by another resident on the right hand. The on-call provider ordered a x-ray of the had, which was negative for fractures. Antibiotic therapy was started on 5/8/2023. Review of current physician orders indicated a 5/8/23 order for amoxicillin-pot clavulanate (antibiotic) oral tablet 875-125 mg every 12 hours by mouth for post-bite treatment of the top of their hand for 10 days. During an observation on 5/11/2023 at 10:27 a.m., Resident E was observed sitting in their high-backed reclining wheelchair in the common			

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	area. They had discoloration and a scabbed area to the back of their right hand. During an interview on 5/11/2023 at 10:52 a.m., LPN 2 indicated Resident B had shown biting behaviors in the past. LPN 2 indicated the resident had attempted to bite her on the face. She was unable to give a specific date of the incident, but thought it happened earlier this year. She may not have documented the incident, although behaviors should be documented in the clinical record. During an interview on 5/11/2023 at 11:25 a.m., the Social Service Director indicated the resident's history of biting behaviors had not been addressed in the resident's care plan. Approximately two months ago, the resident had tried to bite a staff member. All behaviors should be documented in the clinical record and the SSD reviewed the charting during the MDS period. During an interview on 5/11/2023 at 1:34 p.m., Qualified Medication Aide (QMA) 1 indicated they were present when Resident B bit Resident E. They had stepped away from the medication cart, looked up and he (Resident B) had her (Resident E) whole hand in his mouth. QMA 1 stated Resident B said she (Resident E) was mean to him, so he was mean to her. Resident E was started on antibiotic therapy immediately. During an interview on 5/12/2023 at 2:50 p.m., QMA 3 indicated an event when Resident B was in the common area with two other residents. The residents were starting to argue and the QMA intervened. Resident B got up from the table and started banging his elbow on the wall. The QMA tried to give the resident a key he had dropped on the floor. The key was to a safe the resident kept			

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	in his room and staff used it as a distraction. When the QMA tried to give the key to Resident B, the resident bit the QMA's hand. The QMA had a bruise, but the bite did not break the skin. During an interview on 5/12/2023 at 3:46 p.m., LPN 4 indicated approximately one month prior, Resident B attempted to bite her on the arm. LPN 4 believed she charted the incident, but no documentation of the incident was found in the clinical record. Behaviors should be documented in the clinical record. During an interview on 5/12/2023 at 3:26 p.m., the Assistant Director of Nursing (ADON) indicated the following: "This is a behavioral facility There has not really been a set program in place. But we are trying to develop one. We educate on re-direction, approach. I do not believe we have any written plan. Behaviors are monitored through the charting." During an interview on 5/12/2023 at 3:56 p.m., the Administrator, Director of Nursing, and the ADON indicated the facility was a behavioral facility and did not have a behavioral management program in place. The Administrator indicated the facility had been working on a program with anticipated implementation in June 2023. This Federal tag relates to complaint IN00407659. 3.1-43(a)(1)			