STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155814	A. BUILDING 00 B. WING	03/27/2025

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March 24, 25, 26 and 27, 2025. Facility number: 012901 Provider number: 155814 AIM number: 201215100 Census Bed Type: SNF/NF: 79 Total: 79 Census Payor Type: Medicare: 17 Medicaid: 53 Other: 9 Total: 79 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 10, 2025.	F 0000	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the Statement of Deficiencies. The Plan of Correction is prepared and submitted because of the requirement under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance. Please find enclosed this Plan of Correction for this survey. Due to the low scope and severity of the survey findings, the Facility respectfully requests the granting of paper compliance. Completed monitoring as per the plan of correction has been submitted to confirm implementation.	
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observations, interviews and record reviews, the facility failed to ensure residents had the right to privacy and dignity when staff failed to knock and announce themselves before entering the residents' room for 3 of 3 residents reviewed for dignity (Resident 25, 34, and 46), and for 1 of 1 resident council meeting (Residents 9, 20, 48, 11, and 43). Findings include:	F 0550	Applicable staff members were re-educated upon observation/notification of failure to knock prior to entering a resident's room. All staff shall receive inservice training as to the observing of resident privacy by knocking prior to entering the resident's room and/or bathroom. The facility shall	04/18/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jessica Wilson	HFA	04/17/2025

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	1. During an interview on 3/24/25 at 10:25 a.m. with Resident 25, an unknown staff member opened the door without knocking and entered the room. The staff member indicated she was looking for Resident 25's roommate and then left abruptly. Resident 25 indicated a lot of staff members did not knock before they entered the room or the bathroom. Staff would often make demeaning comments about the smell when she had a bowl movement. Resident 25 indicated when staff did not knock before coming into the room or bathroom it made her feel disrespected and undignified.2. During a random observation on 3/26/25 at 8:51 a.m., Certified Nursing Aide (CNA) 12 and another unidentified CNA rolled a hoyer lift to Resident 34's closed door. They opened the door and entered without knocking or identifying who they were and rolled the hoyer lift into the room. 3. On 3/26/25 at 1:00 p.m., a Resident Council Meeting was held with Residents 9, 20, 48, 11, and 43. They indicated, staff did not always knock and announce themselves before they entered the residents' rooms. Especially if the call light was already on, they would just walk into the rooms and say, "what do you need now?" The residents indicated when this happened, they did not feel like they were treated with respect or given privacy in their rooms. 4. On 3/26/25 at 1:54 p.m., CNA 14 was explaining how staff could tell if a resident was on enhanced barrier precautions (EBP) and as an example she indicated to Resident 46's room and walked in without knocking, or announcing herself to the resident who was in bed. On 3/27/25 at 10:50 a.m. the Regulatory Consultant		continue to address adherence to resident rights including, knocking and announcing self prior to entering a resident's room, and remaining respectful (i.e., not commenting on odors, etc.) as part of the orientation of newly hired staff. As a means to ensure ongoing compliance, administrative staff/designee shall conduct observations at random times on random shifts twice weekly for three months, then monthly for three months (thus six consecutive months). Should non-compliance be observed, corrective action shall be taken. As a means of Quality Assurance, results of the observations shall be provided to the Administrator and reported to the Quality Assurance Committee for review during quarterly meetings for the next six months. Should concern(s) be identified monitoring and reporting to the Committee shall be extended, as warranted.	

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	provided a copy of current facility policy title, "Residents Rights," reviewed January 2025. The policy indicated, "This facility shall treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life ... always knock and request permission before entering the room. The person entering should call out his/her name and wait slightly for the resident to respond to the individual prior to entering the room ...." 3.1-3(p)			
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination Based on observation, interview and record review, the facility failed to ensure the resident had the right to chose when he received routine lab draws that honored his preference not to be woken up too early for 1 of 1 residents reviewed for choices. Findings include: During an interview on 3/24/25 at 2:11 p.m., Resident 47 indicated, he was doing ok except he was tired of being woken up too early to keep getting blood draws. He indicated last time he woke up around 2:00 a.m. with a needle in his arm, it had startled him and made him mad. When they came that early to get his blood, they turned on the lights, jostle him in bed, stuck him and drew the blood, then he had a hard time falling back asleep. Resident 47 indicated he did not understand why he had to keep getting so much lab work done, and he wished they would do it later in the day.	F 0561	Resident 47 was interviewed as to his preference of time for lab(s) to be drawn and was reminded of his right to refuse. The medication-specific lab order shall be reviewed and the schedule altered to accommodate both the therapeutic draw time and resident preference. As all residents could be affected, residents will be addressed per the next Resident Council meeting and reminded of resident rights, including preference of time of services and of the right to refuse treatment. As a means to ensure ongoing compliance, nursing staff shall receive inservice training as to resident preference and the right to refuse treatment. As a means of quality assurance, Residents will be polled during	04/18/2025

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	During a follow up interview on 3/27/25 at 8:48 a.m., Resident 47 indicated he did not understand, "why they keep getting me up so D--- early for all this blood work." He couldn't go back to sleep then felt grumpy throughout the day. He indicated he told everyone and named three staff members. "I know I've told them, but nothing gets done about it." During an interview on 3/27/25 at 8:50 a.m., Certified Nursing Aide (CNA) 12 indicated Resident 47 did not like it when labs came in super early. CNA 12 tried to remind the resident, it was only once a week or so, and not every day, and encouraged him to take naps throughout the day. CNA 12 did notice a difference in Resident 47's attitude on the morning he was woken up too early. Resident 47 would be a little more grumpy than usual and short-tempered. During an interview on 3/27/25 at 9:00 a.m., Qualified Medication Aide (QMA) 11 indicated Residnet 47 hated it when labs came early for his bloodwork. QMA 11 worked night shift sometimes and indicated labs usually came around 3:00-4:00 in the morning for fasting blood draws. He usually had a hard time falling back asleep and would be grumpy later in the day. During an interview on 3/27/25 at 10:47 a.m., the Activity Director (AD) indicated she knew Resident 47 was not an early morning person. She knew he preferred to sleep in, and would often deliver his Daily Chronicle or other activities later in the morning after he had a chance to get up and eat breakfast. During an interview on 3/27/25 at 11:04 a.m., the Director of Nursing indicated, labs usually came early in the morning around 3:00-4:00 a.m., but		monthly Resident Council meetings for the next six months as to staff adherence with voiced preference and verbalized refusal. Should non-compliance be reported, the same shall be addressed with corrective action and reported back to the individual resident and to the Resident Council.	

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	resident's had the right to refuse, and the nurses at the facility could draw the labs later if needed. On 3/26/25 at 1:58 p.m., Resident 47 electronic and hard/paper charts were reviewed. He was a long-term care resident with diagnoses which included, but were not limited to, a history of a kidney transplant and insomnia. He had a standing lab order, dated 8/1/24, which indicated, "the above patient [Resident 47] had a kidney transplant ... and will be coming to your lab routinely for the following labs. This is a standing lab order. Expiration date of the order should be the maximum allowed time interval by your company policy." Resident 47 was instructed to receive monthly lab work, which included, but was not limited to a Prograf draw (Tacrolimus/Prograf is an immunosuppressant medication used along with other medications to prevent rejection in people who have received a liver, lung, or heart transplants) the order specified that the Prograf "must be 24 hr trough level," (Trough is the lowest level of a drug in a patient's body and blood should be drawn immediately before the next dose to assess drug concentrations during the trough phase). Resident 47 had a current physician's order for tacrolimus capsule; 0.5 milligrams (mg) administer 1 tablet every morning scheduled from 6:30 a.m. - 10:30 a.m. Resident 47's comprehensive care plans were reviewed and lacked implementation or revision to include goals/interventions for his routine recurring lab orders. Resident 47's labs were reviewed and revealed the			

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	following: On 11/4/24 at 3:14 a.m., blood was collected for his routine labs which included a draw for his Tacrolimus level. The medication was scheduled to be given the previous day as early as 6:30 a.m., so the lab would have been drawn too early. On 12/3/24 at 3:56 a.m., blood was collected for his routine labs which included a draw for his Tacrolimus level. The medication was scheduled to be given the previous day as early as 6:30 a.m., so the lab would have been drawn too early. On 12/5/24 at 2:41 a.m., blood was collected for his routine labs. On 1/7/25 at 3:56 a.m., blood was collected for his routine labs which included a draw for his Tacrolimus level. The medication was scheduled to be given the previous day as early as 6:30 a.m., so the lab would have been drawn too early. On 2/5/25 at 3:14 a.m., blood was collected for his routine labs which included a draw for his Tacrolimus level. The medication was scheduled to be given the previous day as early as 6:30 a.m., so the lab would have been drawn too early. In March 2025, Resident 47 had 5 early labs as follows: a. On 3/3/25 at 4:09 a.m. blood was collected for his routine labs which included a draw for his Tacrolimus level. The medication was scheduled to be given the previous day as early as 6:30 a.m., so the lab would have been drawn too early. b. On 3/5/25 at 3:21 a.m., he had a draw for magnesium. c. On 3/10/25 at 4:16 a.m., he had a draw for magnesium.			

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	d. On 3/14/25 at 4:21 a.m., he had blood work drawn for routine labs and a vitamin D level. e. On 3/24/25 at 3:34 a.m., he had a draw for magnesium. During an interview on 3/27/25 11:07 a.m., the Social Service Director (SSD) indicated she was not aware that Resident 47 did not like getting his labs draw too early, but she was told by nursing to make a new care plan that morning. The SSD reviewed his care plans and indicated he did not have one to address his routine labs, and she would add one. On 3/27/25 at 10:50 a.m., the Regulatory Consultant provided a copy of current facility policy titled, "Laboratory Orders, Timely Draws," reviewed January 2025. The policy indicated, "Laboratory testing shall be conducted in a timely manner per physician's orders. The facility shall ensure that physician's orders requesting laboratory services to be rendered are followed as specified in the order ...." On 3/27/25 at 10:50 a.m., the Regulatory Consultant provided a copy of current facility policy titled, "Resident Choice/Self-Determination," reviewed January 2025. The policy indicated, "This facility shall promote and facilitate resident self-determination through support of resident choice. The resident has the right to and this facility shall promote and facilitate self-determination through support of resident choice, including but not limited to ... a right to make choices about aspects of his or her life in the facility that are significant to the resident ... the resident/representative shall be interviewed following admission in an effort to identify resident choice/self-determination ... the resident/representative shall be encouraged to			

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	notify staff should a resident's choice change, in an effort the facility may support and accommodate said change, communicating the same to applicable caregivers ...." 3.1-3(u)			
F 0646 SS=D Bldg. 00	483.20(k)(4) MD/ID Significant Change Notification Based on record review and interviews, the facility failed to initiate a new PASARR (Preadmission Screening and Resident Review)screening after a new mental health diagnosis was added to the diagnosis listing for 1 of 1 resident reviewed for PASARR (Resident 3). Findings include: On 3/27/25 at 8:56 a.m., a record review was completed for Resident 3. She had the following diagnoses which included but were not limited to bi-polar , dementia, essential hypertension, chronic kidney disease, and major depressive disorder. Resident 3 had a level I (A Level 1 Screening involves completion of an evaluation to determine if an individual has, or is suspected of having, a PASRR condition, i.e., serious mental illness (SMI), intellectual disability (ID), developmental disability (DD), or related condition (RC) completed on 1/24/25. The diagnosis listed on her level I was major depression. On 4/15/24, Resident 3 had a new diagnosis of bi-polar added. Resident 3's record lacked documentation that a new PASRR screening was completed to determine if a level II was required.	F 0646	Resident 3 has been addressed per assessment with no additional services appropriate. In an effort to confirm all applicable residents have been identified who could warrant assessment, an audit for applicable diagnoses, including review of most recent mental health clinician notes has been completed and corresponding assessment review has been conducted, if warranted. As a means to ensure ongoing compliance, mental health clinician visits and subsequent note reviews shall be logged by the SSD and the mental health clinician notes and SSD log reviewed by the SS Consultant during weekly visits to the facility for the next six months. Should concerns be identified corrective action shall be taken, as warranted. As a means of quality assurance, compliance with the monitoring of notes and conducting of assessments if indicated shall be reported to the Quality Assurance Committee on a quarterly basis	04/18/2025

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	During an interview on 3/27/25 at 10:21 a.m., the Social Services and Activities Consultant indicated that Resident 3 had a diagnosis of dementia so it may not have triggered a level II. A policy titled, "PASARR Level II Referral" provided by the Regulatory Consultant on 3/27/25 at 1:01 p.m. It indicated, " ...The facility shall notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has a mental disorder or intellectual disability for resident review ....".		ongoing.	
F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary Based on record review and interview, the facility failed to ensure a comprehensive discharge plan was in place and implemented for 1 of 2 closed record reviewed (Resident 80). Findings include: On 3/26/25 at 8:46 a.m., Resident 80's closed record was reviewed. She had been a short-term resident who completed a rehabilitation stay from 12/17/24 - 12/29/24 for aftercare following a joint replacement surgery. Resident 80 had a comprehensive care plan, dated 12/18/24, which indicated her desire to discharge home, but her goal was "TBD" (to be determined). Interventions for this plan of care were not person centered and adaptive equipment needed was left blank as well as home services needed was left blank.	F 0661	Resident 80 has been reviewed as to comprehensive discharge planning and documentation in need of staff education/improvement. An audit of records of Residents discharged within the past 30 days has been conducted to identify any further concerns with comprehensive discharge/documentation. All applicable nursing and social service staff have received inservice education as to the completion of comprehensive discharge planning and necessary corresponding documentation. As a means to ensure ongoing compliance, administrative nursing staff shall be responsible to audit each prospective discharge for necessary planning and	04/18/2025

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	A Discharge Summary, dated 12/29/24, was reviewed. The recapitulation of the resident's stay was left blank. A summary at the time of her discharge was left blank. Her discharge plan of care indicated, "discharge hom and proceed with home health for nursing, physical and occupational therapy and home health aide." The Discharge summary lacked specification of which home health agency, physical therapy and/or occupation therapy contract service she might need, and did not include any contact information for any service. A copy of her "Home Discharge Instructions" form dated 12/29/24 was reviewed. The instructions lacked documentation for the following areas: a. A list of medications with instructions b. Dietary specifications c. Activity specifications d. Therapy specifications e. Referral documentation. The Discharge instructions for social services indicated, "seek assistance as needed ..." but did not specify who, or provide contact information. The record lacked documentation of reconciliation for all her medications at the time of her discharge. During an interview on 3/27/25 at 11:00 a.m., the Regional Nurse Consultant, (RNC) indicated she could not locate any documentation of Resident 80's medication reconciliation for the time of her discharge and reviewed the above Discharge summary and Home Instruction forms. She indicated the forms were minimally documented and should have included more information and details.		documentation prior to discharge and again review post discharge to confirm adherence with necessary planning and documentation thereof, including medication reconciliation/disposition ongoing for no less than six months. Should non-compliance be identified, corrective action shall be taken accordingly. As a means of quality assurance, results of the aforementioned audits shall be reported to the Quality Assurance Committee on a quarterly basis for no less than six months. Reporting will be extended should non-compliance be identified.	

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	On 3/27/25 at 8:15 a.m. the Regulatory Consultant provided a copy of current facility policy titled, "Discharge Planning," reviewed January 2025. The policy indicated, "The facility shall develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care and the reduction of factors leading to preventable readmissions ... The discharge planning process shall begin on admission and involve identifying each resident's discharge goals and needs, developing and implementing interventions to address the, and continuously evaluate them throughout the residents stay to ensure a successful discharge ... the discharge care plan is part of the comprehensive care plan and must: ... be re-evaluated regularly and updated when the resident's needs or goals change ... discharge planning must include: documentation of referral to local contact agencies ... documentation of the response to referrals ... the facility shall documents any referrals to local contact agencies or other appropriate entities made for this purpose ... this facility shall update the resident comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities ..." 3.1-36(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, record review, and interview, the facility failed to prevent the potential for accidents related to medications at bedside for 2 of 4 residents reviewed for accidents	F 0689	Residents 60 had no negative outcome as the result of the qualified personnel leaving the morning meds at bedside for later	04/18/2025

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	(Residents 60 and 33). Findings include: 1. On 3/26/25 at 1:30 p.m., a record review was completed for Resident 60. He had the following diagnoses which included but not limited to hypertension, arthritis, weakness, and anxiety. On 3/24/25 at 10:12 a.m., Resident 60 was sitting in his wheelchair with his back at the door. Behind him on a table was a cup of pills. The color of the pills was white, orange, and red. There were approximately 8 pills in the cup. On 3/25/25 at 1:58 p.m., the Regulatory Consultant indicated the Qualified Medication Assistant (QMA) was instructed not to leave Resident 60's medications at bedside unattended. On 3/27/25 at 10:21 a.m., the Director of Nursing (DON) indicated he was now allowed to have his medication at bedside.2. During a medication pass on 3/27/25 at 8:20 a.m. Resident 33 indicated to Licensed Practical Nurse (LPN) 13, there was a pill on the floor next to her bed that was there from night shift. LPN 13 walked over to where the Resident said the pill was picked up an unidentified, oblong shaped, tan pill off the ground next to the resident's bed. LPN 13 immediately disposed of the pill in the sharps container and continued with medication pass. A policy titled, "Medications, Self-Administration" was provided by the Regulatory Consultant on 3/25/25 at 1:35 p.m., It indicated, " ...Always observe the resident taking their medication(s). Never permit medication to remain in the resident's room. Residents may not self-administer medications unless specifically		consumption by the resident, as per the resident's request. Additionally, no other pills were observed on the floor of residents' rooms and Resident 33 exhibited no symptoms of an omitted dose. Following notification of the observation of pills at bedside, the applicable qualified staff member was provided immediate re-education as to the prohibition of leaving medications at bedside lacking an assessment and documented order for the resident to self-administer medication(s). In an effort to ensure ongoing compliance, all licensed/qualified staff shall receive inservice training regarding medication administration, including prohibition of leaving medications at the bedside, remaining with the resident until medications consumed (to ensure none are dropped on the floor and dose omitted) and the need to report to the IDT any desire of a resident to self-administer meds, to ensure necessary assessment is conducted to allow the resident to self-administer, if applicable. In an effort to ensure quality assurance, following education provided, administrative nursing shall conduct rounds following routine medication pass at random times on random shifts twice weekly for three months, then weekly for three months (thus, six consecutive months). Should	

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	155814	A. BUILDING 00 B. WING	03/27/2025

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	authorized in writing by the attending physician, and then only in accordance with facility procedures for self-administration ...." 3.1-45(a)		non-compliance be observed, corrective action shall be taken. Results of the observations shall be provided to the Administrator and reported to the Quality Assurance Committee for review during quarterly meetings for the next six months. Should concern be identified monitoring and reporting to the Committee shall be extended, as warranted.	
F 0699 SS=D Bldg. 00	483.25(m) Trauma Informed Care Based on observation, interview and record review, the facility failed to ensure residents with significant past trauma and/or post-traumic stress disorder (PTSD) received personalized care to address and avoid triggers for 2 of 2 residents reviewed for trauma informed care (Residents 25 and 65). Findings include: 1. During an interview on 3/24/25 at 10:25 a.m., Resident 25 indicated she regularly stayed up late at night because she couldn't shut her mind off and had trouble going to sleep and staying asleep. On 3/25/25 at 1:35 p.m., Resident 25's medical record was reviewed. She was a long-term care resident whose diagnoses included, but were not limited to Multiple Sclerosis (a chronic, autoimmune disease that affects the brain and spinal cord) and Major Depressive Disorder. A progress note, dated 1/1/2025 at 4:52 a.m., indicated Resident 25 was up in her wheelchair	F 0699	Residents 65 and 28 have been re-interviewed to confirm accuracy regarding identification of past trauma, potential triggers and personalized de-escalation interventions to be attempted by staff. CNA assignment sheets and careplans have been updated to ensure staff are knowledgeable of resident-specific personalized trauma informed care to be provided. All residents have been audited to identify those residents whose interviews indicated past trauma, with applicable residents re-interviewed to confirm accuracy regarding identification of past trauma, potential triggers and personalized de-escalation interventions to be attempted by staff. CNA assignment sheets and careplans have been updated to ensure staff are knowledgeable of resident-specific trauma informed	04/18/2025

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	awake. When the nurse asked the resident if she had slept any throughout the night the Resident indicated she had not because she had too much on her mind to sleep. A mood and behavior communication memo, dated 10/17/24, indicated between 10:00 p.m. and 6:00 a.m., Resident 25 was up in her wheelchair sleeping. The nurse asked the Resident to get in bed because she was sliding out of her wheelchair. The Resident agreed but at 2:00 a.m. when the nurse checked on the resident she had gotten back up out of bed and into her wheelchair. The resident was redirected four times to rest in bed. A psychology note, dated 11/7/24, indicated Resident 25 had a significant history of trauma which included but was not limited to, her father committing suicide in their backyard while she was home when the resident was 16 years old and the resident's father being an alcoholic and physically abusive to her and her mother. The note also indicated Resident 25 had experienced depression and PTSD her entire adult life and was facing current life challenges as she had to sell her home, had to have her cats adopted because she was unable to live on her own, and her long-time roommate was moving away with family. A trauma questionnaire, dated 10/7/23, indicated when asked, "have you ever had a close friend or family member murdered or killed by a drunk driver, substance abuse or suicide" the answer was no. The record lacked documentation that a new trauma-informed questionnaire/interview had been conducted after the Psych provider identified evidence of her past trauma.		care to be provided. As a means to ensure ongoing compliance, social service staff responsible to conduct initial interviews with residents have been re-educated as to policy and necessary communication to staff (via assignment sheets and careplans) to ensure staff are knowledgeable and uphold trauma informed care of the individual resident. Should concerns be identified corrective action shall be taken, as warranted. Additionally, mental health clinician visits and subsequent note reviews shall be reviewed by the SSD for any newly identified traumatic events to ensure interview, identification of triggers and personalized de-escalation interventions are communicated to staff/caregivers .The SSD shall be responsible to maintain a list of those residents identified as having experienced trauma and shall audit both assignment sheets and careplans on a monthly basis to ensure information remains available and current. As a means of quality assurance, the SSD/designee shall interview at least three staff on varied halls and on varied shifts weekly for three months, then one staff weekly for three months as to resident-centered trauma informed care for identified residents to confirm knowledge of interventions as listed on the assignment	

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	Resident 25's comprehensive care plans were reviewed and lacked documentation of implementation and/or revision of her plan of care to address her mental health and past trauma experiences. During an interview on 3/27/25 at 3:21 p.m., the Social Services Director (SSD) indicated she did the initial trauma questionnaire upon a resident's admission and was unaware that Resident 25 had past trauma. The SSD indicated that the Psychology group didn't usually talk or debrief with her after they talked to the Resident, she usually just read through the notes but she indicated she easily could have missed that information. The SSD indicated the notes from the psychology group should have prompted her to do a new trauma questionnaire for trauma informed care. 2. During an initial interview on 3/24/25 at 10:36 a.m., Resident 65 indicated she had severe PTSD related to her history. She shared openly, but became tearful as she explained she had been sexually assaulted so severely that her jaw was broken and she lost her ability to play the flute and lost a musical scholarship. She had to change her major to art and theatre, which she enjoyed, but felt a great loss that she could never play the flute again. Resident 65 also spent time as an Emergency Medical Technician (EMT) and experienced PTSD related to some horrible things she responded to. Resident 65 indicated she found ways to cope by learning new instruments, arts and crafts. Resident 65 indicated the best thing she could do when she felt triggered or overwhelmed was to talk with other people because it felt like she was in control and could help someone else. Resident 65 indicated she absolutely did not like to leave her room, and it made her anxious when she was		sheets and careplan.	

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	asked to go and do things because she did not want to upset anyone by saying "no," but she preferred to stay in her room. Resident 65 indicated she did not like to have male caregivers and it made her angry that she was told "she refused" showers because she didn't want to take them with a male caregiver. She did not want to be "labeled" as refusing care, just because she preferred only female staff. On 3/26/25 at 11:19 a.m., Resident 65's electronic medical record was reviewed. She was a long-term care resident who had diagnoses which included, but were not limited to, PTSD, anxiety and psychosis with hallucinations. The electronic record "Resident Profile" lacked documentation of her PTSD triggers and/or interventions. A copy of Resident 65's current Certified Nursing Aide (CNA) assignment sheet was provided by Licensed Practical Nurse (LPN) 13. The assignment sheet lacked documentation of her PTSD triggers and/or interventions. During an interview on 3/26/25 at 10:20 a.m., CNAs 14 and 15 indicated they worked with Resident 65 on a regular basis. They knew she had PTSD because she was pretty open about her past and shared with her female caregivers but did not like male caregivers. The CNAs did not know what her triggers were, or if she had other specific interventions other than just trying to talk to her and calm her down. The CNAs used their assignment sheets, but those mostly only indicated the resident's activities of daily living (ADL) requirements, like diet orders, side rails, transfer assistance etc. Information related to her mental illness would need to come from the nurse			

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	because the CNAs did not have time to go through folders of care plans. On 3/26/25 at 11:19 a.m., Resident 65's paper/hard chart was reviewed. She had a Pre-Admission Screen and Record Review (PASARR) level II dated 8/9/25 effective indefinitely which indicated she was considered to have a major mental illness. She had a physician's note from her long-standing psychiatric provider which indicated any attempt at gradual dose reductions (GDRs) for her psychiatric medications would likely cause instability and was contraindicated related to her history. Resident 65 had a " ...long-standing diagnosis of psychotic disorder and psychosis with hallucinations which is effectively managed .... [by her psychiatric medications]." Resident 65's folder of comprehensive care plans was reviewed. There were over 75 individual pages of care plans, and 14 pages related to mood/behavior/psychiatric disorder etc ... Care plans titled "Mood and Behavior" 1. "Delusions" revised 1/20/25, which indicated, " ...may exhibit any or all of the following mood and behavior challenges: (LIST) but none were listed. Interventions included, "encourage activities of interest such as: (LIST), but none were listed. 2. "Psychosis" revised 1/20/25. Interventions included, "encourage activities of interest such as: (LIST), but none were listed. 3. "PTSD," revised 1/25/25, indicated, " ...may exhibit any or all of the following mood and behavior challenges: "recent events, past events, sex abuse, verbal abuse. Interventions: listen to music, games on phone, play musical instruments. Additional care plans related to behaviors:			

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	4. "Rejection of care" revised 1/20/25, bathing and showers were circled, but lacked revision to include her preference for female caregivers. 5. "Non-Adherence" revised 1/20/25, which indicated, "the resident is non-adherent with: ... but was left blank. 6. "Verbal Behavior Symptoms Directed Towards Others," the list for interventions was left blank. 7. "False Allegations Against Staff," revised 1/20/25 which had check marks over "care or lack of care, abuse, neglect etc. Interventions were not individualized. 8. "Manipulative Behavior," revised 1/20/25, which indicated she voiced different stories and would tell her niece she showered when she had not. There were no individualized interventions listed. Additional care plans related to her mental health conditions: 9. "Hallucinations," revised 1/20/25 which indicated, "The resident has hallucinations as evidence by: previous nursing notes." There were no individualized interventions. 10. "Health Conditions," revised 1/2/25 which indicated she had PTSD disorder, she was easily startled, had anxiety and difficulty sleeping. There were no individualized interventions. 11. "Abuse," revised 1/20/25 which indicated, she had a history of sexual, physical, mental and verbal abuse and has PTSD with potential triggers: loud noises, loud voices, crowds and male caregivers. Interventions included, but were not limited to, "avoid triggers." 12. "Mental Health Services," revised 1/20/25 which indicated, "Outside Provider," but did not specify who the provider was or how often she was seen. 13. "Anxiety," revised 12/24/25 which indicated she had fatigue, irritability and racing thoughts.			

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	Interventions included, watching TV, playing on phone and talking to family. 14. "Fear and Anxiety- Potential For," revised 1/20/25, which indicated, she had anxiety due to past sexual, verbal, mental and physical abuse. Triggers: noises, loud voices, crowds, male caregivers. Interventions included, but were not limited to, "avoid triggers." Resident 65 had a "Trauma Questionnaire," dated 8/23/24 which indicated she had experienced verbal, mental and physical abuse and had attempted suicide in the past. A "De-Escelation Preference Interview," dated 8/24/24, indicated Resident 65 had the following triggers: being touched, being isolated, feeling rushed, preferences not being honored, unresolved pain, door remaining open, loud noises, yelling, crowded places, specific scents such as bleach, pesticides and perfumes ...." Resident 65's care plan did not include and/or were not revised to include documentation related to her suicide attempt in the past and/or being sensitive and/or triggered by certain scents. During an interview on 3/27/25 at 11:14 a.m., the Social Service Director, (SSD) indicated staff should have access to the care plan folders and could see that trying to flip through so many pages with different issues and interventions could be cumbersome. The SSD indicated the CNA assignment sheet would be the best place to put her triggers and interventions for Residents with PTSD and be updated as needed. The SSD indicated a lot of the times she was too busy to pick though each page of the care plans to find one to revise, so she would quickly print and date a new one to stick it in the folder.			

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	During an interview on 3/27/25 at 11:23 a.m. the Regional Nurse Consultant, (RNC) reviewed the 14 pages of care plans for Resident 65 and indicated they should be condensed down, and/or updated interventions that were most helpful could be added to the CNA assignments sheets for easier access to direct care staff. On 3/27/25 at 10:50 a.m. the Regulatory Consultant provided a copy of current facility policy titled, "Trauma Informed and Culturally Competent Care," revised January 2025. The policy indicated, "A trauma-informed, culturally competent approach to care acknowledges that caregivers have a complete picture of a resident's life situation - past and present - in order to provide effective healthcare services with a healing approach ...." On 3/27/25 at 10:50 a.m. the Regulatory Consultant provided a copy of current facility policy titled, "Care Plan development and Review," revised January 2025. The policy indicated, " ...the facility shall develop and implement a comprehensive person-centered care plan for each resident ... care plans shall be re-written as needed to maintain an up-to-date legible document ... care plan interventions specific to direct care personnel will be included on the direct caregiver's assignment sheet, or similar tool in use ...."			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On Based on record review and interview, the facility failed to follow up with pharmacy recommendations in a timely manner for 1 of 5 residents reviewed (Resident 69).	F 0756	Pharmacy recommendations for Resident 69 were reviewed by the prospective provider with response documented. Recommendations for past two	04/18/2025

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	Findings include: On 3/26/25 at 1:02 p.m., a record review was completed for Resident 69. He had the following diagnoses which included but were not limited to encounter for palliative care, hypertension, sleep apnea, and pain. He had a pharmacy recommendation on 2/5/25 for a reduction in the amount of aspirin he was receiving. The physician did not respond until 2/12/24, 7 days later. Resident 69 had a pharmacy recommendation on 2/5/25 for a reduction gabapentin and the current dosage. The physician did not respond until 2/12/25. On 3/26/25 at 1:32 p.m., the Regulatory Consultant indicated the facility's policy indicated they have 3 days to get pharmacy recommendations completed. On 3/27/25 at 10:09 a.m., The Director of Nursing (DON) indicated they send the recommendation to the physician and if there was no response in 3 days, she sent it again. She flagged the recommendations and when the physician responded, she pulled them back down in her binder. On 3/26/25 at 12:20 p.m., the Regulatory Consultant provided a policy titled, "Pharmacy Recommendations and Regimen Review." It indicated, "DON or designee, shall be responsible to monitor attending physician review/response. Recommendations of an emergent nature shall be communicated by the pharmacist immediately to the DON with a request for immediate attending physician review/response. For recommendations		monthly reviews have been audited to confirm provider response documented. In an effort to ensure ongoing compliance, the facility policy regarding pharmacy recommendations and response was reviewed with no revisions necessary. Licensed administrative staff responsible for ensuring compliance with communication of recommendations/irregularities to the provider again reviewed the policy and have implemented a system by which following notification should a provider fail to respond, on the third day, the provider will again be contacted and said contact shall be documented. Contact shall then occur daily on scheduled days of work until response is obtained and documented. In an effort to ensure quality assurance, the completed monthly report of pharmacy review/irregularities shall be provided to the Administrator and reported to the Quality Assurance Committee for review during at least quarterly meetings for the next six months. Should concerns be identified, reporting to the Committee shall be extended, as warranted.	

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	of a non-emergent nature, should response not received in three (3) physician office business days, DON or designee shall be responsible to ensure the attending physician is again contacted and response received and documented ...." 3.1-25(i)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to date medications when opened and label over the counter medications for 3 of 6 medication carts reviewed (Residents 34, 47, 5, 64, 49, 11, 44, and 59). Findings include: 1. Resident 34 had an insulin pen lispro in the cart dated 2/10/25. It expired 28 days after opening. 2. Resident 47 had latanoprost eye drops in the medication cart with no date to indicate when they were open for 2 of 2 bottles observed. 3. Resident 5 had a bottle of nasal deep-sea spray in the cart with no date to indicate when it was opened. 4. Resident 64 had a bottle of Tylenol in the medication cart, and it lacked a label. 5. Resident 49 had an insulin pen lantus in the medication cart dated 1/7/25. It expired 28 days after opening. 6. Resident 11 had a bottle of Tylenol in the medication cart with no label on the bottle. She had a nasal spray, nanogel, in the cart with no	F 0761	Medications lacking an appropriate label were addressed upon discovery. Expired medications (including pen, drops, vials, spray) and medications observed with no date indicating when opened were disposed upon discovery. All medication/treatment carts and rooms were observed to identify any further concerns with medication storage, labeling, expiration and/or date opened with corrective action taken, as necessary. As a means to ensure ongoing compliance, licensed/qualified staff shall receive inservice training addressing medication storage, labeling, dating vials/eye drops, etc., when opened, and disposal of expired medication as per facility policy. As a means of quality assurance, following the aforementioned training, administrative nursing shall conduct cart/medroom inspections twice weekly for three months, then weekly for three	04/18/2025

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	date to indicate when it was opened. 7. Resident 44 had a bottle of fish oil with no label on the bottle. 8. Resident 59 had fluticasone nasal spray in the medication cart. It lacked a date to indicate when it was opened. On 3/27/25 at 10:20 a.m., the Nurse Consultant indicated they attempted to manage medication storage, but it was a difficult task. She indicated the carts were correct now. A policy titled, "Medication Expiration" was provided by the Regulatory Consultant on 3/25/25 at 1:35 p.m. It indicated, " ...Opthalmic, otic, and nasal preparations will expire per the manufacturer expiration date unless otherwise noted on manufacturer packaging, e.g. refrigerate, discard any unused solution after 14 days. Multiple dose injections, such as insulin will expire 28 days after opening unless otherwise noted by manufacturer. Facility staff shall date the label of any multi-use vial when the vial is first accessed and access the vial in a dedicated medication preparation area ...." 3.1-25(j) 3.1-25(m) 3.1-25(n)		months (thus, six consecutive months). Should non-compliance be observed, corrective action shall be taken. Results of the observations shall be provided to the Administrator and reported to the Quality Assurance Committee for review during quarterly meetings for the next six months. Should concern be identified, monitoring and reporting to the Committee shall be extended, as warranted.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control A. Based on observations, interviews, and record reviews, the facility failed to ensure appropriate infection control measures were used during the administration of a nasal spray for a resident for 1 of 1 observation of a nasal spray administration (Resident 13).	F 0880	**RE: Nasal Spray** The staff member failing to wear gloves during the administration of nasal spray was re-educated. All licensed/qualified staff received inservice education as to correct	04/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155814	A. BUILDING 00 B. WING	03/27/2025

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

(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
	B. Based on observations, interviews, and record reviews, the facility failed to ensure consistent and effective infection control practices related to enhanced barrier precautions (EBP) to ensure staff and visitors were aware of who required EBP and that personal protective equipment (PPE) was readily accessible for 6 of 6 residents reviewed for EBP (Residents 44, 34, 41, 71, 15, and 46). Findings include: A. During a medication administration observation on 3/27/25 at 8:30 a.m., Licensed Practical Nurse (LPN) 13 was observed as she prepared a nasal spray for Resident 6. LPN 13 set and administered the resident's oral medications, then returned to the cart to prepare the resident's nasal spray. LPN 13 proceeded to administer the residents nasal spray without performing hand hygiene or donning gloves. After administering the nasal spray, LPN 13 left Resident 6's room and did not perform hand hygiene. On 3/27/25 at 1:21 p.m. the Regulatory Consultant, provided a copy of a current facility policy titled "Nasal Drops/Spray Instillation" reviewed January 2025. The policy indicated, " ... 1. Perform necessary initial steps ... 5. Perform necessary final steps ...". " ...procedure #1: initial steps ... 9. Wear gloves as indicated by standard precautions ...". " ...Procedure #2: final steps ... 1. Remove gloves if applicable and wash your hands ..." B1. On 3/26/25 at 1:50 p.m. Residents 44, 34, and 41's rooms were observed for Enhanced Barrier Precautions (EBP) and Personal Protective Equipment (PPE).		procedure for administration oof nasal spray, including the wearing of gloves. As a means to ensure ongoing compliance, following education provided, weekly observations of nasal spray administration shall be observed by administrative nursing staff for three months, and monthly for the subsequent three months. Should non-compliance be observed, additional training shall be conducted and observation frequency increased. As a means of quality assurance, results of the aforementioned observations and any corrective actions taken shall be reported to the Quality Assurance Committee on a quarterly basis. **RE: Enhanced Barrier Precautions** Administrative nursing staff identified all residents requiring Enhanced Barrier Precautions per facility policy based upon CMS guidance, including residents 44, 34, 41, 71,15 and 46. The CNA assignment sheets were updated to reflect the need for Enhanced Barrier Precautions and the basis for the need of precautions. The careplan of each resident identified was updated to address the need for Enhanced Barrier Precautions and the basis for the need of precautions. The resident representative of each resident identified was contacted to provide education as	

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	Resident 44, who required EPB related to her feeding tube, had a small EBP sign on her closet door and two packages of almost empty yellow isolation gowns stuffed into different corners of her closet, intermixed with the resident's personal clothing and items. Resident 34, who required EBP related to a below the knee amputation (BKA) and dialysis, had a small EBP sign on his closet door and one thin package of blue isolation gowns on the top shelf of his closet. Resident 41, who required EBP related to a pressure ulcer wound, had a small EBP sign on his closet door, but did not have any PPE in or around his closet. B2. On 3/24/25 at 10:45 a.m., Unit Manager 10 indicated she was preparing to complete the dressing changes for Resident 71 who had wounds on both of his feet. Resident 71's room had no indication via signage and/or available PPE that he required EBP as an extra precaution against the potential for infection related to his wounds. On 3/26/25 at 10:47 a.m., Certified Nursing Aide (CNA) 14 exited Resident 15's room with a trash bag. She indicated she had just changed the resident's brief for the morning, but had not donned any PPE because she only changed her brief and did not get near the resident's wound on her foot. On 3/26/25 at 1:43 p.m., Residents 15, 71 and 46 rooms were observed for EBP and PPE. Resident 15, who required EBP for a wound on her left foot had an EBP sign on her closet door, but there was no PPE in the closet, or elsewhere in her		to the need for Enhanced Barrier Precautions and the availability of PPE should the family desire the same due to assisting/providing direct caregiving. Carts with supply of gowns were placed in the applicable bathrooms, as well as a larger, color laminated sign placed on the closet for each resident requiring EBP. Carts will be monitored and replenished with supplies through 3x weekly observation. All staff received inservice training addressing adherence with EBP. As a means to ensure ongoing compliance with initiation and discontinuance of EBP as per policy, rationale for continued need will be addressed in morning meeting, and the list of residents on EBP updated/revised as warranted. Assignment sheets and careplans will be updated accordingly. Initiated 3/27/25 As a means of quality assurance, following education provided, administrative nursing shall conduct direct care observations at random times on random shifts three times per week for three months, then monthly for three months (thus six consecutive months). Should non-compliance be observed, corrective action shall be taken. Results of the observations shall be provided to the Administrator and reported to the Quality Assurance Committee for review during quarterly	

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	room. Resident 71, who required EBP for wound to both of his feet, had no indication of his requirement for EBP. There was no sign and no PPE. Resident 46, who required EBP for her use of a foley catheter, had a sign on her closet door. During an interview on 3/26/25 at 1:54 p.m., CNA 14 indicated staff should know if a resident required EPB because there should be a sign on the closet door and the PPE was stocked in each resident's closet. CNA 14 entered Resident 46's room (without knocking) and pointed to the EBP sign on her closet door and indicated, there should be PPE in the closet, but when she opened the closet to check, there was no PPE. On 3/25/25 at 1:35 p.m., the Regulatory Consultant provided a copy of current facility policy titled, "Enhanced Barrier Precautions (EBP)," reviewed January 2025. The policy indicated, " ...use of EBP is also indicated for residents with chronic wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO ... procedure: post signage within the resident room ... make PPE, including gowns and gloves available within the resident room ...."		meetings for the next six months. Should concern(s) be identified monitoring and reporting to the Committee shall be extended, as warranted. Additionally, the ongoing list of residents requiring EBP will be maintained and monitored by administrative nursing staff ongoing to ensure the above measures continue to be applied per facility policy. Continued compliance with policy shall be reported the Quality Assurance Committee during quarterly meetings ongoing.	