| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 08/01/2023 |

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| BROOKDALE GRANGER | 430 CLEVELAND RD<br>GRANGER, IN 46530 |

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| R 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00413497.<br><br>Complaint IN00413497 - State deficiencies related to the allegations are cited at R0052 and R0090.<br><br>Survey date: July 31 & August 1, 2023<br><br>Facility number: 002656<br><br>Residential Census: 46<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed 8/9/2023. | R 0000 | | |
| R 0052<br><br>Bldg. 00 | 410 IAC 16.2-5-1.2(v)(1-6)<br>Residents' Rights - Offense<br>(v) Residents have the right to be free from:<br>(1) sexual abuse;<br>(2) physical abuse;<br>(3) mental abuse;<br>(4) corporal punishment;<br>(5) neglect; and<br>(6) involuntary seclusion.<br><br>Based on record review and interview, the facility failed ensure a resident was free from abuse for 1 of 2 incidents reviewed. (Resident D)<br><br>Findings include:<br><br>On 7/31/23 at 1:00 P.M., during an observation and interview Resident D was observed in her room sitting in a chair. Resident D was noted to have a swollen, black and blue bruised area to the | R 0052 | ; 1 resident affected. Community has notified MD of alleged abuse and will continue to follow MD orders. Resident F was referred to geri psych. It has been determined that resident F is no longer appropriate for AL setting. Resident F will be admitted to memory care when placement is secured. All residents have the potential to be affected by | 09/15/2023 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Ashley Woodcox | Area Director | 09/08/2023 |

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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| | right leg approximately 5 cm wide by 10 cm long. Upon palpitation, the area was hard and warm to the touch. The resident indicated the area was painful. Resident D indicated on 7/26/23 in the evening, Resident F attempted to enter her room multiple times and reported the attempts to the nurses. Resident D indicated Resident F came to her door and she told him to go away. Resident D indicated he returned and opened the door and let himself into her room, closed the door and attempted to lock it. Resident D indicated she was in her wheelchair at the time and wheeled over to door to open it to get Resident F out, attempted to push him, and began yelling at the resident and yelling for help. Resident D indicated Resident F who was also in a wheelchair, was beside her table and got angry when he lifted up her white wooden dining chair and threw it at her hitting her on the head and then on the right leg. Resident D indicated one of the nurses came to the room shortly after and removed Resident F from her room. Resident D indicated no one witnessed Resident F throw the chair, but did see the resulting injury. Resident D indicated the nursing staff wanted her to go to the Emergency Room due to the injury to her leg, but she refused. Resident D indicated the facility did not notify her family of the incident but that her daughter came to the facility the next day and saw the injury. Resident D indicated she had severe arthritis to her hands and locking and unlocking her door is very difficult, but after the incident she began keeping her door locked. Resident D indicated she was afraid of Resident F and was afraid he might return to her room, felt unsafe, and felt the facility was not doing anything to keep her safe.<br><br>On 7/31/23 at 1:11 P.M., during an interview with the Administrator, she indicated on 7/26/23, Resident F went into Resident D's room 2 times | | alleged deficient practice.<br>Resident F will move to memory care community when placement is secured.<br>Associates will be in-serviced on abuse. Resident F will move to memory care community.<br>ED or designee to complete rounds at community and will complete interviews 5 x weekly for 4 weeks, 1 x weekly for 2 months, 1x monthly for 3 months. | |

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| | back to back. The Administrator indicated the 2nd time he entered the room, Resident D was telling him to get out and he went over to a chair, turned it over as if to fix it and hit Resident D in the knee. The Administrator indicated she did not report the incident to the State Agency because there were no serious injuries. The administrator indicated she completed an interfacility incident investigation interviewing Resident D and LPN 2, but no further investigation was completed.<br><br>On 7/31/23 at 1:20 P.M., during an interview with Resident D's Family Member 1, she indicated she received a missed call from the facility on 7/26/23 and a second call later in the evening requesting she call the facility. Family Member 1 indicated she did not get the message until the next day. Family Member 1 indicated the facility never made another attempt to notify her of her mother's injury and learned of the injury on 7/27/23 around 1:00 P.M. when she came to visit her mother.<br><br>On 7/31/23 at 2:00 P.M., during an interview with Licence Practical Nurse (LPN) 2, she indicated she was directed to Resident D's room because the resident was yelling. LPN 2 indicated when she went in the room she saw Resident F pick up a chair and she took the chair away. LPN 2 indicated Resident F may have thrown the chair at Resident D before she arrived, but did not witness it. LPN 2 indicated after she left the room, Resident D wheeled herself to the nurses station and instructed her to document the incident. LPN 2 indicated she notified the administrator, physician, and family at that time. LPN 2 indicated she attempted to call Resident D's family member but did not get an answer so then called a second time and left a message requesting a return call. LPN 2 indicated she did not attempt to call the family again but instructed day shift to call. | | | |

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| | On 8/1/23 at 10:26 A.M., during an interview with Resident F's Family Member 2, he indicated the resident was admitted to the facility due to wandering at home. Family Member 2 indicated the facility called him on 7/31/23 to notify him that his father threw a chair at another resident. Family Member 2 indicated he was not notified of the incident when it occurred.<br><br>On 8/1/23 at 11:09 A.M., the clinical record for resident D was reviewed. Resident D was admitted to the facility with diagnoses that included dementia. Review of the Physician/Healthcare Provider Plan of Care dated 5/13/23, indicated Resident D required a wheelchair for locomotion. Review of the Personal Service Plan dated 5/13/23 indicated the resident required physical assistance with bathing, and toileting. The resident required assistance going to and from the dining room and community activities. Resident D was oriented to person, place, and time and was able to communicate needs and preferences.<br><br>Review of Resident D's Progress note indicated on 7/26/23 at 7:32 P.M., "Resident yelling down the hallway. When entering resident room this nurse saw another resident in her room which was a male. Resident was yelling 'get him out my room.' The Male was escorted out of resident room after helping the male resident place down a chair that was seen picking it up to try and fix it. After escorting the male resident out of the room. This nurse checked resident out to which she said she was ok and to shut her door.<br><br>Progress note dated 7/26/2023 at 8:00 P.M., "Resident wheeled herself down the hall from her room and said that the Male resident that was in her room injured her with the chair that was in her | | | |

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| | room. when assessing area there was red area noted to the left bottom knee. Called md [Medical Doctor] to inform her of the situation and MD gave an order to send resident out to the ER [Emergency Room] for Eval [evaluation] and treatment, to which the resident started yelling and refused on several different attempts by staffing and this nurse. Resident stated she only wanted ice pack to which was given to her. Resident then stated she wanted the Male resident to go to Jail and commanded me to call the police now because she was hit with a chair. Resident then with the ice wheeled herself back to her room. POA [Power Of Attorney] was called on 2 different attempts and left voice message for her to call the facility. ED {Executive Director] was called and main [made] know of the situation."<br><br>On 8/1/23 at 11:23 A.M., the clinical record for Resident F was reviewed. Resident F was admitted to the facility with diagnoses that included dementia and depression. Review of the Physician/Healthcare Provider Plan of Care dated 4/26/23, indicated Resident F utilizes a walker or cane for locomotion. Review of the Personal Service Plan dated 7/11/23 indicated the resident was independent for dressing, grooming, toileting, and was independent going to and from the dining room and community activities. Resident F wandered and required redirection, was not always oriented to person, and was able to communicate needs and preferences.<br><br>A Progress Note dated 7/25/2023 at 5:21 A.M., indicated, "Resident [Resident F] wandering halls and into other residents rooms."<br><br>A Progress Note dated 7/26/2023 at 7:16 P.M., indicated, "Resident [Resident F] was in another | | | |

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| | resident room and had her chair in his hand. Resident was escorted out of resident room and one on one was provided for him until he went to bed. No c/o pain or discomfort."<br><br>A Progress Note dated 7/31/2023 at 3:38 P.M. indicated, "Great Lake psych [psychiatric] NP [Nurse Practitioner] notified of resident roaming in and out of resident rooms, this writer asked if resident can be sent to pysch hospital to be evaluated and treated. Received new orders for referral to pysch hospital. Son aware and is in agreeance to send out for evaluation. Referral sent to local psychiatric hospital..."<br><br>On 7/31/23 at 3:00 P.M., a document titled "Incident Investigation," dated 7/27/23, no time documented, indicated an interview summary with Resident D, "...Resident stated [Resident F] entered her apartment 2 times. The first time she was yelling at him to get out, she stated that she was yelling because he can't hear. He left her apartment without further incident. A little bit later he came back to the apartment. He had turned his wheelchair around and was messing with the door. She went closer and was telling him to get out. He picked up her chair and turned it over. The chair did hit her but [Resident D] cannot remember where it hit. The nurse took [Resident F] out of the apartment." "Incident Investigation," dated 7/26/23, no time documented, indicated an interview summary with LPN 2, "[LPN 2] stated that [Resident F] was in [Resident D's] apartment and she had to redirect him out. [LPN 2] heard [Resident D] yelling so she went done [down] to her apartment. this [she] found [Resident F] at the door. She was redirecting [Resident F]. [Resident F] picked up the dining chair near the door and turned it over. [LPN 2] stated that [Resident F] was talking about fixing it. When [Resident F] | | | |

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| | turned the chair over, the top if the chair hit [Resident D] on the leg."<br><br>On 7/31/23 at 12:45, the policy, "Abuse, Neglect & Exploitation," dated 5/21, indicated, "...[Facility] is committed to maintaining a safe environment for each resident...Abuse is the willful infliction of injury...resulting in physical harm, pain, or mental anguish...Resident on Resident altercations (physical, mental, or verbal) shall be reported to the [State Agency] within 24-hours if an injury occurs...Upon receipt of an allegation of abuse...the Executive Director...should conduct a confidential internal investigation of the incident...The investigation should include interviews with potential witnesses, which may include the alleged perpetrator, the alleged victim, associates, other residents...Notifying Responsible Party. The Executive Director or supervisor on duty should notify the resident's legally responsible party, if there is an allegation of abuse..."<br><br>This Residential tag relates to complaint IN00413497. | | | |
| R 0090<br><br>Bldg. 00 | 410 IAC 16.2-5-1.3(g)(1-6)<br>Administration and Management - Deficiency<br>(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:<br>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the | | | |

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| | twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:<br>(A) epidemic outbreaks;<br>(B)poisonings;<br>(C) fires; or<br>(D) major accidents.<br>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.<br>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.<br>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.<br>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:<br>(A) employee's full name; and<br>(B) dates and hours worked during the past twelve (12) months.<br>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.<br>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request | | | |
| | Based on observation, interview, and record review, the facility failed to implement their policy in regard to reporting, thoroughly investigating, | R 0090 | 1 resident affected by deficient practice. MD of resident notified. Community will follow MD orders. All residents have the potential to | 08/29/2023 |

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| | and notifying resident's responsible when an allegation of resident to resident physical abuse resulted in injury, for 2 of 2 residents reviewed for abuse, (Resident D and Resident F).<br><br>Findings include:<br><br>On 7/31/23 at 1:00 P.M., during an observation and interview Resident D was observed in her room sitting in a chair. Resident D was noted to have a swollen, black and blue bruised area to the right leg approximately 5 cm wide by 10 cm long. Upon palpitation, the area was hard and warm to the touch. The resident indicated the area was painful. Resident D indicated on 7/26/23 in the evening, Resident F attempted to enter her room multiple times and reported the attempts to the nurses. Resident D indicated Resident F came to her door and she told him to go away. Resident D indicated he returned and opened the door and let himself into her room, closed the door and attempted to lock it. Resident D indicated she was in her wheelchair at the time and wheeled over to door to open it to get Resident F out, attempted to push him, and began yelling at the resident and yelling for help. Resident D indicated Resident F who was also in a wheelchair, was beside her table and got angry when he lifted up her white wooden dining chair and threw it at her hitting her on the head and then on the right leg. Resident D indicated one of the nurses came to the room shortly after and removed Resident F from her room. Resident D indicated no one witnessed Resident F throw the chair, but did see the resulting injury. Resident D indicated the nursing staff wanted her to go to the Emergency Room due to the injury to her leg, but she refused. Resident D indicated the facility did not notify her family of the incident but that her daughter came to the facility the next day and saw the injury. | | be affected by alleged deficient practice<br>Community will report abuse allegations to POA, MD, executive director, and Indiana Department of Health immediately and then complete investigation per community policy. | |

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| | Resident D indicated she had severe arthritis to her hands and locking and unlocking her door is very difficult, but after the incident she began keeping her door locked. Resident D indicated she was afraid of Resident F and was afraid he might return to her room, felt unsafe, and felt the facility was not doing anything to keep her safe.<br><br>On 7/31/23 at 1:11 P.M., during an interview with the Administrator, she indicated on 7/26/23, Resident F went into Resident D's room 2 times back to back. The Administrator indicated the 2nd time he entered the room, Resident D was telling him to get out and he went over to a chair, turned it over as if to fix it and hit Resident D in the knee. The Administrator indicated she did not report the incident to the State Agency because there were no serious injuries. The administrator indicated she completed an interfacility incident investigation interviewing Resident D and LPN 2, but no further investigation was completed.<br><br>On 7/31/23 at 1:20 P.M., during an interview with Resident D's Family Member 1, she indicated she received a missed call from the facility on 7/26/23 and a second call later in the evening requesting she call the facility. Family Member 1 indicated she did not get the message until the next day. Family Member 1 indicated the facility never made another attempt to notify her of her mother's injury and learned of the injury on 7/27/23 around 1:00 P.M. when she came to visit her mother.<br><br>On 7/31/23 at 2:00 P.M., during an interview with Licence Practical Nurse (LPN) 2, she indicated she was directed to Resident D's room because the resident was yelling. LPN 2 indicated when she went in the room she saw Resident F pick up a chair and she took the chair away. LPN 2 indicated Resident F may have thrown the chair at Resident | | | |

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| | D before she arrived, but did not witness it. LPN 2 indicated after she left the room, Resident D wheeled herself to the nurses station and instructed her to document the incident. LPN 2 indicated she notified the administrator, physician, and family at that time. LPN 2 indicated she attempted to call Resident D's family member but did not get an answer so then called a second time and left a message requesting a return call. LPN 2 indicated she did not attempt to call the family again but instructed day shift to call.<br><br>On 8/1/23 at 10:26 A.M., during an interview with Resident F's Family Member 2, he indicated the resident was admitted to the facility due to wandering at home. Family Member 2 indicated the facility called him on 7/31/23 to notify him that his father threw a chair at another resident. Family Member 2 indicated he was not notified of the incident when it occurred.<br><br>On 8/1/23 at 11:09 A.M., the clinical record for resident D was reviewed. Resident D was admitted to the facility with diagnoses that included dementia. Review of the Physician/Healthcare Provider Plan of Care dated 5/13/23, indicated Resident D required a wheelchair for locomotion. Review of the Personal Service Plan dated 5/13/23 indicated the resident required physical assistance with bathing, and toileting. The resident required assistance going to and from the dining room and community activities. Resident D was oriented to person, place, and time and was able to communicate needs and preferences.<br><br>Review of Resident D's Progress note indicated on 7/26/23 at 7:32 P.M., "Resident yelling down the hallway. When entering resident room this nurse saw another resident in her room which was a male. Resident was yelling 'get him out my room.' | | | |

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| | The Male was escorted out of resident room after helping the male resident place down a chair that was seen picking it up to try and fix it. After escorting the male resident out of the room. This nurse checked resident out to which she said she was ok and to shut her door.<br><br>Progress note dated 7/26/2023 at 8:00 P.M., "Resident wheeled herself down the hall from her room and said that the Male resident that was in her room injured her with the chair that was in her room. when assessing area there was red area noted to the left bottom knee. Called md [Medical Doctor] to inform her of the situation and MD gave an order to send resident out to the ER [Emergency Room] for Eval [evaluation] and treatment, to which the resident started yelling and refused on several different attempts by staffing and this nurse. Resident stated she only wanted ice pack to which was given to her. Resident then stated she wanted the Male resident to go to Jail and commanded me to call the police now because she was hit with a chair. Resident then with the ice wheeled herself back to her room. POA [Power Of Attorney] was called on 2 different attempts and left voice message for her to call the facility. ED {Executive Director] was called and main [made] know of the situation."<br><br>On 8/1/23 at 11:23 A.M., the clinical record for Resident F was reviewed. Resident F was admitted to the facility with diagnoses that included dementia and depression. Review of the Physician/Healthcare Provider Plan of Care dated 4/26/23, indicated Resident F utilizes a walker or cane for locomotion. Review of the Personal Service Plan dated 7/11/23 indicated the resident was independent for dressing, grooming, toileting, and was independent going to and from the | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 08/01/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BROOKDALE GRANGER | 430 CLEVELAND RD<br>GRANGER, IN 46530 |

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| | dining room and community activities. Resident F wandered and required redirection, was not always oriented to person, and was able to communicate needs and preferences.<br><br>A Progress Note dated 7/25/2023 at 5:21 A.M., indicated, "Resident [Resident F] wandering halls and into other residents rooms."<br><br>A Progress Note dated 7/26/2023 at 7:16 P.M., indicated, "Resident [Resident F] was in another resident room and had her chair in his hand. Resident was escorted out of resident room and one on one was provided for him until he went to bed. No c/o pain or discomfort."<br><br>A Progress Note dated 7/31/2023 at 3:38 P.M. indicated, "Great Lake psych [psychiatric] NP [Nurse Practitioner] notified of resident roaming in and out of resident rooms, this writer asked if resident can be sent to pysch hospital to be evaluated and treated. Received new orders for referral to pysch hospital. Son aware and is in agreeance to send out for evaluation. Referral sent to local psychiatric hospital..."<br><br>On 7/31/23 at 3:00 P.M., a document titled "Incident Investigation," dated 7/27/23, no time documented, indicated an interview summary with Resident D, "...Resident stated [Resident F] entered her apartment 2 times. The first time she was yelling at him to get out, she stated that she was yelling because he can't hear. He left her apartment without further incident. A little bit later he came back to the apartment. He had turned his wheelchair around and was messing with the door. She went closer and was telling him to get out. He picked up her chair and turned it over. The chair did hit her but [Resident D] cannot remember where it hit. The nurse took [Resident F] out of | | | |

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| | the apartment." "Incident Investigation," dated 7/26/23, no time documented, indicated an interview summary with LPN 2, "[LPN 2] stated that [Resident F] was in [Resident D's] apartment and she had to redirect him out. [LPN 2] heard [Resident D] yelling so she went done [down] to her apartment. this [she] found [Resident F] at the door. She was redirecting [Resident F]. [Resident F] picked up the dining chair near the door and turned it over. [LPN 2] stated that [Resident F] was talking about fixing it. When [Resident F] turned the chair over, the top if the chair hit [Resident D] on the leg."<br><br>On 7/31/23 at 12:45, the policy, "Abuse, Neglect & Exploitation," dated 5/21, indicated, "...[Facility] is committed to maintaining a safe environment for each resident...Abuse is the willful infliction of injury...resulting in physical harm, pain, or mental anguish...Resident on Resident altercations (physical, mental, or verbal) shall be reported to the [State Agency] within 24-hours if an injury occurs...Upon receipt of an allegation of abuse...the Executive Director...should conduct a confidential internal investigation of the incident...The investigation should include interviews with potential witnesses, which may include the alleged perpetrator, the alleged victim, associates, other residents...Notifying Responsible Party. The Executive Director or supervisor on duty should notify the resident's legally responsible party, if there is an allegation of abuse..."<br><br>This Residential tag relates to complaint IN00413497. | | | |