STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKDALE GRANGER	430 CLEVELAND RD GRANGER, IN 46530

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R 0000 Bldg. 00	This visit was for the Investigation of Residential Complaint IN00408794. Complaint IN00408794 - No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: June 1 & 2, 2023 Facility number: 002656 Residential Census: 40 These State Residential Finding are cited in accordance with 410 IAC 16.2-5. Quality review completed 6/10/2023.	R 0000	The following is the Plan of Correction for Brookdale Granger regarding the Statement of Deficiencies dated June 2, 2023. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective. ="" span="">="" span="">="" span="">="" span="">="" p="">="" p="">="" span="">	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse;			

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

Tara Carney | Executive Director | 06/29/2023

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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	(2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review and interview, the facility failed ensure a resident was free from abuse for 1 of 2 incidents reviewed. (Resident C) Finding includes: A self-reported incident #121, dated 5/28/23, indicated Home Health Aide (HHA) 2 was observed being verbally and physically aggressive with Resident C. An Incident Investigation/Associate Interview, dated 5/31/23 at 10:00 A.M., indicated CNA 3 had asked HHA 2 for help with Resident C's shower. The resident wasn't in his apartment so CNA 3 and HHA 2 went to check in Resident B's room. Resident C was on the bed and HHA 2 " ...pulled the covers off [name of Resident C], shoved his glasses on his face, grabbed his arm, and forcefully escorted [name of Resident C] to his apartment...." An Incident Investigation/Associate Interview, dated 5/31/23 at 12:30 P.M., indicated HHA 2 had been asked by CNA 3 to assist her in providing Resident C a shower and indicated she could not find him. HHA 2 & CNA 3 went to Resident B's apartment and observed Resident C lying on Resident B's bed. The interview indicated HHA 2 had reported she had tapped on the bed and said "come on, you need to go to your apartment, your wife don't want you in here". HHA 2 indicated the resident then put on his glasses, stood up and followed HHA 2 & CNA 3 out of Resident B's room.	R 0052	R052 · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Executive Director conducted an investigation following notification of allegation, the investigation revealed no findings to substantiate allegation. MD and POA notified of allegation. Resident had no negative outcome. · How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have potential to be affected by alleged deficient practice. Dana Hakes, HWD, re-in-service associates on Brookdale abuse policy which was completed on 6/9/23. · What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; All abuse allegations to be reported to ED or designee immediately. New hires will be in-serviced on abuse prior to resident care and annually. · How the corrective action(s) will be monitored to ensure the	06/29/2023

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	On 6/1/23 at 3:45 P.M., an interview was conducted with HHA 2, the Regional Nurse, and the Executive Director (ED). HHA 2 indicated CNA 3 had come to her because she couldn't find Resident C, so she escorted CNA 3 to Resident B's room and found Resident C in Resident B's bed asleep. HHA 2 said she told Resident C he could not be in that room, so the resident put his glasses on and headed out of the room towards his own room. HHA 2 indicated Resident C came to nurse's station stating he could not get into his room, so she assisted him to his room. During an interview, on 6/2/23 at 11:45 A.M., CNA 3 indicated the incident started with HHA 2 opening Resident B's door with her key (didn't knock first). They both entered Resident B's room and found her, in a recliner asleep and Resident C was located in the bed asleep. CNA 3 indicated she heard HHA 2 say to Resident C "what are you doing in here, you're not supposed to be in here, you are a cheater". CNA 3 then observed HHA 2 shove glasses onto Resident C's face, then pulled on his arm to get him out of the bed. CNA 3 indicated the resident was half asleep stumbling around. She heard HHA 2 call Resident C a F------ cheater and sent him on his way down the hall. Resident C told HHA 2 he was going to sue her. When the resident was observed by RN 4, CNA 3 and HHA 2 going back towards Resident C's room, HHA 2 told him not to go into Resident B's room. CNA 3 indicated RN 4 spoke up and told HHA 2 and the resident it was ok for him to go into Resident B's room. During an interview, on 6/1/23 at 2:42 P.M., Resident B was alert to self only and could not remember an incident when staff entered her room and asked Resident C to leave.		deficient practice will not recur, i.e., what quality assurance program will be put into place; and ED or designee to complete rounds with resident/associates interviews 5 times weekly for 4 weeks, 1 time weekly for 2 month, 1 time monthly for 3 months · By what date the systemic changes will be completed. 6/29/23	

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	On 6/2/23 at 1:40 P.M., Resident C was observed in his room eating a snack, sitting on his bed. He was wearing his glasses. He was alert to self and indicated this was his room but had no knowledge of time or place. He indicated he didn't think anyone had ever abused him, hit him, yelled at him or cursed at him. A deep purple bruise was noted on his right forearm. On 6/2/23 at 1:54 P.M., a review of the clinical record was conducted. The resident's diagnoses included, but were not limited to: Alzheimer's Disease and anxiety. A Skin Observation Form, dated 5/30/23, indicated no bruises, redness and skin was intact. On 6/1/23 at 1:40 P.M., the ED provided a policy, "titled Abuse , Neglect & Exploitation Policy", dated 5/2001 and indicated the policy was the one currently used by the facility. The policy indicated "...Policy Overview [name of the facility] is committed to maintaining a safe environment for each resident, visitor and employee...Policy Detail 1. Definitions: a. "Abuse" is defined in Indiana as a willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, anguish, or deprivation by an individual of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well-being. Abuse may also include sexual abuse or verbal abuse...."			
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (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:			

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	(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 twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (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. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (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. (6) Maintaining reports of surveys conducted			

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	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 record review and interview, the facility failed to implement their abuse policy and notify the Administrator timely of an allegation of abuse for 1 of 2 incidents reviewed. (Resident C) Finding includes: A self-reported incident #121, dated 5/28/23, indicated Home Health Aide (HHA) 2 was observed being verbally and physically aggressive with Resident C. The report indicated the Executive Director (ED) had been notified, on 5/30/23 at 8:30 A.M. An Incident Investigation/Summary of Allegations indicated the following was reported by CNA 3, on the integrity line (a toll-free telephone hotline, for associates and other parties to report concerns). On May 28, 2023, around 8:50 P.M., CNA 3 asked HHA 2 where she thought Resident C could be located. Both CNA 3 and HHA 2 entered Resident B's apartment and found Resident B in a recliner and Resident C in bed asleep. "...[name of HHA 2] snatched the covers off [name of Resident C] and pulled him out the bed. [name of HHA 2] shoved [name of Resident C] glasses on his face and asked why he was in [name of Resident B] room. [name of HHA 2] called [name of Resident B] a "f------ cheater" and said that he knew that his wife (name unknown) didn't want him in [name of Resident B] room...." An Incident Investigation/Associate Interview, dated 5/30/23 at 11:00 A.M., between the Executive Director and RN 4 indicated, on 5/28/23 at approximately 8:00 P.M., CNA 3 reported HHA	R 0090	R090 · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Executive Director immediately, on 5.30.23, coached LPN to reporting policy upon notification of any abuse allegations. · How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have potential to be affected by alleged deficient practice. Dana Hakes, HWD, re-inservice associates on Brookdale reporting policy which was completed on 6/9/23. · What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Abuse allegations to be reported to ED or designee immediately. New hires will be in-serviced on abuse prior to resident care and annually. · 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; and ED or designee to complete rounds with resident/associates	06/29/2023

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	2 had forced Resident C out of Resident B's apartment. The interview indicated the ED then asked RN 4 why the allegation was not reported to her and RN 4 told the ED she had felt she had taken care of the situation and CNA 3 had reported to RN 4 she was going to contact the Executive Director. An Incident Investigation/Associate Interview, dated 5/31/23 at 10:00 A.M., indicated CNA 3 had asked HHA 2 for help with Resident C's shower. The resident wasn't in his apartment so CNA 3 and HHA 2 went to check in Resident B's room. Resident C was on the bed and HHA 2 " ...pulled the covers off [name of Resident C], shoved his glasses on his face, grabbed his arm, and forcefully escorted [name of Resident C] to his apartment ...." During an interview, on 6/1/23 at 1:10 P.M., the ED indicated she was not able to report nor investigate the allegation of abuse, timely, due to not being notified until 5/30/23. She indicated she was notified of a message, left on the integrity line, surrounding an incident with HHA 2 and Resident C. On 6/1/23 at 1:40 P.M., the ED provided a policy, "titled Abuse , Neglect & Exploitation Policy", dated 5/2001 and indicated the policy was the one currently used by the facility. The policy indicated "...3. Internal Reporting: a. Any associate who witnesses or becomes aware of alleged abuse, neglect or exploitation, should report such incident to the Administrator and or the Executive Director or supervisor on duty immediately...If an associate does not believe that appropriate action is being taken, the associate must report the alleged abuse, neglect or exploitation to the next level of supervisor...6. External		interviews 5 times weekly for 4 weeks, 1 time weekly for 2 month, 1 time monthly for 3 months By what date the systemic changes will be completed. 6/29/23	

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	Reporting/Notification c. Report to Indiana State Department of Health and Other Agencies (1) The Administrator and or Executive Director or designee should contact the ISDH [Indiana State Department of Health]...within 24 hours of determining a situation exists, or existed, that is reasonably believed to constitute abuse, neglect or exploitation...."			