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	06/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENBRIAR VILLAGE	8800 SPOON DR INDIANAPOLIS, IN 46219

(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
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00409923. Complaint IN00409923 -- State deficiency related to the allegations is cited at R0052. Survey date: June 6, 2023 Facility number: 011799 Residential Census: 103 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on June 12, 2023	R 0000		
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; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to ensure 1 of 4 residents reviewed for abuse was not subjected to physical abuse by a staff member. (Resident B) Findings include: A facility-reportable incident, dated 6-2-23, indicated on 6-1-23 at an unspecified time, CNA 3 reported to a facility QMA and the Administrator that Resident B was aggressive with her when she	R 0052	**This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of Greenbriar Village as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also**	07/03/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dana Milner	Executive Director	06/23/2023

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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	attempted to re-direct him back to his room on 6-1-23 at approximately 12:30 a.m. During the investigation of this incident, the Administrator reviewed the facility's security video, as this was reported to have taken place in the facility's common area of the secured dementia care unit, and observed CNA 3 to physically strike Resident B on the back of his head and on his back with her right hand. During an observation of the security video in the presence of the facility's Director of Nursing (DON) and the Marketing Director, a female was observed to push on a 3-seat sofa with the female located at the far left hand side of sofa and a male seated on the far right side of sofa, with the female pushing the sofa towards a hallway entrance. The female was observed to stop pushing the sofa, then walk towards the male and take her right hand and push the male's back of head forward and push onto his upper mid-back area, then observed the female walk away, while the male stood up and began to walk around the sofa, the female walked away and out of the view of the camera. The DON identified the female as CNA 3 and the male as Resident B, a resident on the secured memory care unit. The DON indicated the videos are not time-stamped. In an interview with the DON on 6-6-23 at 3:05 p.m., she indicated the reason the abuse incident was discovered related to the investigation by the Administrator from CNA 3 calling the Administrator regarding Resident B being aggressive towards CNA 3. She indicated the facility does not often have reports about residents being aggressive towards staff. She indicated after the Administrator viewed the video, "she came and got me and asked me to review the video, also. My expectation was that I		**does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.** · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · 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; · What measures will be put into place or what systemic changes the facility will make to ensure	

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	would be seeing a resident towards staff event. Well, to say the least, I was shocked when I saw the aide pushing or shoving on the resident, the exact opposite of what I was expecting. Needless to say, that changed the entire focus of the investigation. The aide had gone so far as to write out a fairly detailed note for [name of Administrator] of the interaction. I can only say I was shocked and disappointed and felt very bad for the resident." She indicated the Administrator was able to get the facility reportable incident sent into State before the end of the day. The DON indicated CNA 3 was terminated immediately from employment. The DON indicated the facility did not have any prior issues with the work performance of CNA 3. In an interview on 6-6-23 at 2:03 p.m., with the Memory Care Unit Director, she indicated, "The only issue we had with [name of Resident B] was his insomnia, but not really any aggression. The week prior to the incident, we were aware of the same employee having to re-direct him and he did not like that. When we investigated, both the resident and employee said he yelled at her. Don't recall any negative reports in regards to the employee." "When I saw the video, all I can say is that I was shocked and surprised. I cannot say we have noticed any behavioral changes with the resident since the incident. He is still having problems with insomnia. The way we found out something was going on was the employee, I think, I could be wrong, [name of CNA 3] had called [name of the Administrator] during that night and said [name of Resident B] had swung at her, and I received the same report that morning in report. So, I was able to speak to [name of CNA 3] about this. She said he had struck at her. So, at that point, we decided to look at the security tape and that's when we found out the situation. We		that the deficient practice does not recur; · 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 · By the date, the systemic changes will be completed. R 052 1. The Executive Director (“ED”) reported alleged abuse by CNA 3 for Resident B to the Indiana Department of Health on 06/02/23. ED completed an investigation and determined that abuse had occurred. Employee CNA 3 was immediately suspended pending an investigation and later terminated based on the investigation’s findings. The Wellness Director completed a head-to-toe assessment of Resident B and no injuries or areas of concern. 2. The Community reviewed each resident’s record to determine which residents, if any, could be affected by the alleged deficient practice. 3. Executive Director or designee will conduct in-services to train all staff on abuse prevention, our Abuse Policy and	

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	were expecting to see where he hit her and then found out she hit him. [Name of the Administrator] told me that when she and [name of the Marketing Director spoke to her [CNA 3], she said she knew she was in full view of the camera because they were in the living room and she also told them that he [Resident B] hit her first. From what I saw, on the video, when she started to move the couch, he tried to swat at her while he was sitting on the sofa; it looked like to me that he might have come in actual contact, but I cannot say that for certain." The Memory Care Unit Director indicated the sofa normally is located in the center of the living room. A review of the employee record for CNA 3 on 6-6-23 at 10:35 a.m., indicated she has a current CNA certification and had begun employment with the facility on/after 10-19-22. A general orientation checklist indicated she had signed she had completed abuse and abuse reporting education and six (6) hours of dementia training on 10-25-22. A general orientation date of 10-25-22, included education on abuse identification and abuse prevention and reporting. Dementia training of 6 hours completed/signed 10-25-22. The facility's abuse policy signed by the employee on 10-25-22. There was an absence of any work performance concerns documentation. Her most recent abuse/abuse prohibition education/training's were documented as occurring on/about 3-15-23. On 6-6-23 at 10:15 a.m., the Director of Nursing provided a copy of a policy entitled, "Abuse Prevention Policy." This policy was indicated as the current policy utilized by the facility and had a "created" date of 8-10-2018. This policy indicated, "It is the policy of the Facility to protect residents		Reporting Guidelines, and our Memory Care Policies. Wellness Director or designee will train memory care staff on constructive ways to redirect and assist noncompliant memory care residents. 4. The Community will take the following steps to monitor for physical and mental abuse of memory care residents. The Wellness Director or designee will do random skin checks of 5 memory care residents each month for 3 months. The Wellness Director or designee will attempt to interview 5 memory care residents or their families each month for 3 months. Said interviews will attempt to determine if abuse has occurred or if there are specific concerns regarding potential mental or physical abuse. 5. Systemic Changes will be completed by July 3, 2023	

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	from abusive acts and to adequately train Facility personnel in methods of detection and prevention of abuse. The Facility will comply with state and federal regulations for reporting suspected or actual acts of abuse...The Facility enforces and protects all recognized rights of its Residents in compliance with 410 Indiana Code 16.2-5-1-1.2...Residents have the right to be from from...physical abuse...The Facility must report alleged violations, conduct an investigation of all alleged violations, report to proper authorities, and take necessary corrective actions. All Facility staff will be trained during initial orientation and an annual in-service program regarding the prevention and reporting of abuse, neglect, and misappropriation of resident property. Additional training programs may be implemented as part of corrective actions or in response to specific concerns...Any staff member who abuses a resident or permits to exist a situation which results in the abuse of a resident is subject to immediate dismissal in accordance with Facility's Employment policies. ..Complaints of abuse shall be promptly addressed by management staff...The Facility Administrator or designee is responsible for initiating interventions to protect the resident from any further acts of abuse while any incidents are being investigated...Any personnel must report the following: Knowledge of or reasonable cause to believe a resident has been or is being abused, mistreated, or neglected...The report must be made immediately to the Facility Administrator, the Director of Nursing or a direct supervisor. The initial report may be made orally, but must be followed by a written report within 24 hours. The Facility must report the incident to the ISDH within 24 hours of learning of the occurrence..." This Residential tag relates to Complaint IN00409923.			

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	2.5-1.2(v)(2)			