PRINTED: 02/08/2023

	T OF HEALTH AND HI R MEDICARE & MEDI					RM APPROVED 1B NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E064	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/03/2023		
	PROVIDER OR SUPPLIE		505 N (ADDRESS, CITY, STATE, ZIP COD GAVIN ST E, IN 47303			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3 RIATE	(X5) COMPLETION DATE	
F 0000							
Bldg. 00		a Post Survey Revisit (PSR) to of Complaint IN00393778 rember 15, 2022.	F 0000				
	Complaint IN0039 Survey date: Janua	93778 - Not corrected.					
	Facility number: 0 Provider number: AIM number: 100	000311 15E064					
	Census Bed Type: NF: 38 Total: 38						
	Census Payor Typ Medicaid: 37 Other: 1 Total: 38	e:					
	These deficiencies accordance with 4	reflect State Findings cited in 10 IAC 16.2-3.1.					
	Quality review co	mpleted January 6, 2023.					
F 0600 SS=D Bldg. 00	Exploitation The resident has abuse, neglect, r property, and ex subpart. This incomplete freedom from controluntary sectors.	e and Neglect in from Abuse, Neglect, and the right to be free from misappropriation of resident ploitation as defined in this cludes but is not limited to rporal punishment, ision and any physical or int not required to treat the					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Derrek Keith **HFA** 01/31/2023

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: YKZR12 Facility ID: 000311 If continuation sheet Page 1 of 15

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		15E064	B. W	NG		01/03	/2023
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			GAVIN ST		
BBUUKS	SIDE CARE STRAT	FGIES			E, IN 47303		
שאטטאם	DIDE OAKE STRAT	LOILO		WIGING	L, IIV 47 000		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	resident's medical	symptoms.					
	§483.12(a) The fa	cility must-					
		use verbal, mental, sexual,					
		, corporal punishment, or					
	involuntary seclus						
		and record review, the facility	F 06	500	The filing of the plan of correc		02/13/2023
		the plan of correction from the			does not constitute an admiss		
	_	esident on October 30, 2022, in			that the alleged deficiency did		
		ther physical and emotional			fact exist. This plan of correcti		
	abuse of residents.				is filed as evidence of the facil	ity's	
					desire to comply with the		
	Findings include:				requirements and continue to		
					provide quality care.		
		ff in-service information on			The facility respectfully reques	sts	
		/22 and included in the facility's			paper review for compliance.		
	1 ~	ocuments, indicated lack of					
	_	se policy review, or education			It is the policy of this provider		
		g a resident's plan of care for			each resident has the right to	be	
	individual needs on	the attached agenda.			free from abuse, neglect,		
	D . C4 C 11				misappropriation of resident		
		ty's plan of correction			property, and exploitation.		
		ving: "Staff members have 1/18/22 and 11/21/22 by the			What corrective action(s) will be		
		d following a resident's plan of			accomplished for those reside		
		vidual needsStaff have been			found to have been affected b	y trie	
		7/22 on reporting suspected			deficient practice?		
		The Abuse QAPI audit tool			Resident was assessed for psychosocial distress, none no		
	I -	weekly for four weeks, and			and is free from abuse.	Jieu	
	_	nths by the Executive			How will you identify other		
		Abuse QAPI tool will be			residents having the potential	to	
		by the QAPI team for six			be affected by the same defici		
	months"				practice and what corrective a		
					will be taken?		
	During an interview	, at the time of the review, the			Residents that reside at the		
	_	e staff had completed			facility may be affected by the		
		the presentation, and she had			alleged deficient practice.		
		and reporting abuse, but she			Staff members have been		
	could not locate the				educated on 11/17/22 by the		

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE COMPI 01/03	LETED
	PROVIDER OR SUPPLIER		505 N	ADDRESS, CITY, STATE, ZIP C GAVIN ST CIE, IN 47303	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
	During an interview interim Administra: 24-hour reports eac change of condition abuse were present, audit tool to docum assurance and perfeteam had not had a Review of a current "Abuse Prohibition" "Procedure 2. Should an occurr reported or witness notified immediate! 4. The staff who with abusive incident with protect the involved including verbal/mental/phys seclusion and/or extinclude, but are not a. Physically removabusive environments. Physically removabuse from the environments. This Federal Tag re IN00393778. This of 11/15/22. The facility of the second interview of the control of th	to, on 1/3/23 at 1:35 p.m., the tor indicated he reviewed the h morning to see if any type of a or signs and symptoms of. He had not completed an ent his findings. The quality ormance improvement (QAPI) meeting since the incident. It, undated policy, titled, "indicated the following: The administrator shall be ty It these or was made aware of the ll take immediate steps to the resident from further abuse, incal/neglect/involuntary ploitation. Such steps could limited to: fring the resident(s) from the int.		ADON on abuse and for resident's plan of care individual needs. What measures will be place or what systemic you will make to ensure deficient practice does reoccur. Staff have been re-edu 11/17/22 on reporting abuse immediately. Special clothing was presidents remandled in the common area to be monitored for disrobing On 11/29/22 the Ombustone of the common area to be monitored for disrobing On 11/29/22 the Ombustone of the common area to be monitored for disrobing On 11/29/22 the Ombustone of the corrective action and Administrator on a neglect. (Exhibit 1&2) How the corrective action monitored to ensure the practice will not recurred, quality assurance progent into place? The Abuse audit tool we completed weekly for for and monthly for six monitored to the current facility policy indicated, "Our provided by the Administrator. The current facility policy indicated, "Our not condone any form abuse or neglect. (Exhibit policy indicated, "Our not condone any form abuse or neglect. (Exhibit policy will have an in set 1/23/23.	regarding a put into a changes be that the not ucated on suspected urchased to in covered. seated in be better d. ddsman be to the Staff abuse and ion(s) will be be deficient i.e., what iram will be four weeks, which by the cy titled N AND Y" with a ry 2023, was istrator. The r facility will of resident ibit 3) ed abuse	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		15E064	B. WI	NG		01/03/	2023
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
BROOKS	SIDE CARE STRATE	EGIES			GAVIN ST E, IN 47303		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0607 SS=D Bldg. 00	§483.12(b)(1) Profined and support and support and explosing procedures to invest allegations, and §483.12(b)(2) Esta procedures to invest allegations, and §483.12(b)(3) Incluparagraph §483.98 §483.12(b)(4) Esta QAPI program required facilities in accordate Act. The polici include but are not elements. §483.12(b)(5)(ii) Finotice of employee section 1150B(d)(3) §483.12(b)(5)(iii) Include but are not elements.	at Abuse/Neglect Policies cility must develop and policies and procedures and procedures and procedures and prevent abuse, itation of residents and of resident property, ablish policies and estigate any such added training as required at 5, ablish coordination with the uired under §483.75. The second of the					
	and (2) of the Act. Based on interview failed to implement alleged lack of imm	and record review, the facility the plan of correction from the ediate reporting of abuse of a 30, 2022, in order to prevent	F 06	607	The filing of the plan of correct does not constitute an admissi that the alleged deficiency did fact exist. This plan of correction	on in	02/13/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YKZR12 Facility ID: 000311

If continuation sheet Page 4 of 15

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE SU	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLET	TED
		15E064	B. WI	NG		01/03/2	023
			'	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8			GAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES			E, IN 47303		
	Т			ID	<u> </u>	Т	(V5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE '	DATE
TAG		d emotional abuse of residents.		IAU	is filed as evidence of the facil	litv'c	DATE
	Turtifer physical and	emotional aduse of residents.			desire to comply with the	iity S	
	Findings include:				requirements and continue to		
	i manigs merade.				provide quality care.		
	Review of the facili	ity's plan of correction			The facility respectfully reques	ete	
		ving: "Training included Staff			paper review for compliance.		
		for difficult residents and			paper review for compliance.		
	residents with behav				What corrective action(s) will be	_{oe}	
		gnee will complete 10			accomplished for those reside		
		a combination of both			found to have been affected b		
	_	dents, regarding abuse and the			deficient practice.	,	
		.The Administrator/Human			Upon notification the administ	rator	
		will present a summary of the			immediately suspended Staff		
		to the Quality Assurance			members and initiated an		
	committee monthly	for three months1			investigation. The local police		
	Administrator and/o	or Director of Nursing will			department was immediately		
	audit documentation	n of clinical staff as needed for			notified of the allegation, if		
	any documentation	of abuse or suspicious abuse.			appropriately needed.		
	Unit Managers and	Social Services will audit staff			How the facility will identify oth	ner	
	documentation of al	buse/neglect. 2. Audits will be			residents having the potential	to	
	performed by Socia	l Services/Unit			be affected by the same defici	ient	
	Manger/Director of	Nursing and/or Administrator			practice and what corrective a	ction	
	5 x weekly x 4 week	ks, then monthly x 3 months. PIP			will be taken.		
		JAPI by Administrator of			All facility residents have the		
	Designee, updated i	monthly"			potential to be affected by the		
					same alleged deficiency. Wha		
		d on 1/3/23 of the staff			measures will be put into place		
		ion, dated 11/17/22 and			what systemic changes will be	;	
		lity's plan of correction			made to ensure that the defici	ent	
		ed a lack of abuse training,			practice does not recur.		
		, or education regarding			The facility immediately upon		
		t's plan of care for individual			notification of the allegation		
	needs on the attache	ed agenda.			initiated in servicing. This was		
					completed on 11/29/22 by the		
	During an interview, at the time of the review, t				Ombudsman.		
	ADON indicated the staff had completed				The		
		the presentation, and she had			Administrator/designee/DON/	ADO	
	_	and reporting abuse, but she			N will complete 10 resident		
	could not locate the	documentation.			interviews weekly for a month		
1	I		ı		regarding abuse and neglect	After	

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		15E064	B. W	ING		01/03/	2023
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER						
BBOOKS	NDE CADE CEDAT	E01E0			GAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES		MUNCI	E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	A review of the resi	dent interview log, provided			1 month the facility will intervie	ew 5	
		inistrator on 1/3/23 at 4:05 p.m.,			residents weekly regarding ab		
	-	nt interviews had not started			and neglect for an additional 3		
		ecord lacked any staff			months.		
	interviews.				The facility will follow the abus	ie.	
					policy related to reporting. In		
	During an interview	y, on 1/3/23 at 3:53 p.m., the			addition, the facility put up		
	_	e had not completed staff			postings in prominent staff are	284	
		g abuse. She was unsure why			as visual reminders to report	uo	
		ws were started on the actual			abuse.		
	plan of correction d				How the corrective action(s) w	ill he	
	plan of correction a	are and not prior to.			monitored to ensure the deficient		
	During an interview	y, on 1/3/23 at 1:35 p.m., the			practice will not recur, i.e., wha		
		or indicated he reviewed the			quality assurance programs w		
		h morning to see if any type of			put into place.	III DE	
	-	or signs and symptoms of			Education:		
	-	He had not completed an			All Abuse/Neglect policies h	2010	
	-	ent his findings. The quality			been reviewed and updated if		
		rmance improvement (QAPI)			needed.		
	_	meeting since the incident. He			2. All staff have been re-educa	atod	
		rted his revision of the			on Abuse/Neglect clinical	ileu	
		ect policy, but had not			protocol, reporting requiremen	ıte.	
	completed the revis				for any suspicion of abuse or	ເວ	
	completed the revis	ion.			neglect, Abuse Investigation a	und	
	Review of a current	undated policy titled " Abuse			Reporting and Abuse Preventi		
	Prohibition" indicat				Audits:	OH.	
	"Procedure	od the following.			2. Clinical Documentation Aud	lite	
		ence of abusive behavior be			will be performed by Social	າເວ	
		the Administrator shall be			Services/or Administrator 5 x		
	notified immediatel				weekly x 4 weeks, then month	dv v	
		tness or was made aware of the			3 months.	ıy A	
		Il take immediate steps to			o monuis.		
		d resident from further abuse,			The Administrator will present	3	
	including	a resident from further abuse,			summary of the findings to the		
	_	cal/neglect/involuntary					
		oloitation. Such steps could			committee monthly for the nex		
	include, but are not				six months, adjusting the PIP	a 5	
					needed.		
		ing the resident(s) from the					
	abusive environmer						
	b. Physically remov	ing the perpetrator of the					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		15E064	B. W	ING		01/03/	/2023
NAME OF B	DOLUDED OD GLIDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P.	ROVIDER OR SUPPLIER				SAVIN ST		
BROOKS	IDE CARE STRATI	EGIES	•	MUNCI	E, IN 47303		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓΕ	COMPLETION DATE
TAG	abuse from the envi			IAG			DATE
	douse from the chivi	Tomicit					
	Review of a current	policy, dated 12/1/2021, titled					
		to State Agencies and Other					
	Entities/Individuals	" indicated the following:					
	"POLICY:						
	-	ions and all substantiated					
		vill be immediately reported to					
	individuals as may l	encies and other entities or					
	Interpretation and In	-					
	-	otices to agencies will be made					
		s of occurrence if event					
	involved abuse or re	esults in serious injury, or					
	•	(24) hours if the allegation					
		use and does not result in					
	bodily injury"						
		lates to complaint number					
		deficiency was cited on					
		ty failed to implement a					
	systemic plan of cor	rrection to prevent recurrence.					
	3.1-28(c)						
F 0609	483.12(b)(5)(i)(A)(B)(c)(1)(4)					
SS=D	Reporting of Alleg						
Bldg. 00		onse to allegations of					
	-	ploitation, or mistreatment,					
	the facility must:						
	§483.12(c)(1) Ens	ure that all alleged					
	violations involving						
	exploitation or mis	treatment, including					
injuries of unknown source and							
misappropriation of resident property, are							
	reported immediately, but not later than 2						
		egation is made, if the the allegation involve abuse					
		s bodily injury, or not later					
		,, , ,	1				I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YKZR12 Facility ID: 000311

If continuation sheet Page 7 of 15

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		15E064	B. W	ING		01/03	/2023
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			GAVIN ST		
BBUUK	SIDE CARE STRAT	ECIES			E, IN 47303		
BROOKS	SIDE CARE STRAT	EGIES		MONCI	E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	than 24 hours if th	e events that cause the					
	allegation do not i	nvolve abuse and do not					
	result in serious be	odily injury, to the					
		e facility and to other					
		to the State Survey					
		protective services where					
		for jurisdiction in long-term					
		ccordance with State law					
	through established						
		sa procodarco.					
	8483 12(c)(4) Ren	oort the results of all					
		ne administrator or his or					
	_	presentative and to other					
		ance with State law,					
		ate Survey Agency, within					
	_	the incident, and if the					
		s verified appropriate					
	corrective action r						
		and record review, the facility	F 0	600	The filing of the plan of correc	tion	02/13/2023
		the plan of correction from the	FU	009	does not constitute an admiss		02/13/2023
		orting of abuse of a resident to					
		n October 30, 2022, in order to			that the alleged deficiency did		
		sical and emotional abuse of			fact exist. This plan of correcti		
	residents.	sical and emotional abuse of			is filed as evidence of the facil	iity S	
	residents.				desire to comply with the		
	Findings in ded.				requirements and continue to		
	Findings include:				provide quality care.		
	D:	(4-d1 £4)			The facility respectfully reques	SIS	
		ty's plan of correction			paper review for compliance.		
		ving: "All residents will be					
	I	. 5th,2022 for Abuse and			What corrective action(s) will		
		ations arise, will be reported to			accomplished for those reside		
		D or DON will meet with			found to have been affected to	ру	
		ith invitation from Resident			the deficient practice?		
		o review Abuse Prohibition,			Resident allegations of abuse	have	
Reporting and Investigation Policy and ProceduresThe Administrator will be responsible for the completion of the Abuse Prohibition and Investigation QA tool weekly			been reported to ISDH.				
			How will you identify other				
			residents having the potential				
			be affected by the same defic	cient			
		thly times 6 months, and			practice and what corrective		
	quarterly thereafter	for one year. The results of			action will be taken?		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YKZR12 Facility ID: 000311

If continuation sheet Page 8 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 01/03/2023 15E064 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 505 N GAVIN ST **BROOKSIDE CARE STRATEGIES** MUNCIE, IN 47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE these audits will be All residents have the potential to reviewed by the QAPI committee overseen by the be affected by the alleged deficient ED...." practice. · All residents will be interviewed by A review completed on 1/3/23 of the staff February 3rd,2023 for Abuse and in-service information, dated 11/17/22, indicated neglect, if any allegations arise, lack of abuse training, abuse policy review, or will be reported to ISDH per policy. education regarding following a resident's plan of care for individual needs on the attached agenda. If any allegations of abuse will be reported to the Executive Director During an interview, at the time of the review, the immediately, reported to ISDH, ADON indicated the staff had completed and investigated. What measures post-tests following the presentation, and she had will be put into place or what spoken about abuse and reporting abuse, but she systemic changes you will make could not locate the documentation. to ensure that the deficient practice does not recur? During an interview, on 1/3/23 at 1:35 p.m., the All staff in-serviced by the ADON interim Administrator indicated he reviewed the by January 23, 2023, on the 24-hour reports each morning to see if any type of Abuse Prohibition, Reporting and change of condition or signs and symptoms of Investigation Policy and abuse were present. He had not completed an Procedures · audit tool to document his findings. The quality Reporting pending investigation assurance and performance improvement (QAPI) immediately and at the conclusion team had not had a meeting since the incident. He of the investigation will be reported was not aware of any staff meeting with the to the following agencies when resident council. applicable: ISDH, APS, Ombudsman, Licensing/Certification Agency, During an interview, on 1/3/22 at 1:52 p.m., CNA 5 indicated she had received training regarding Local Police. resident abuse. She indicated she would make How the corrective action(s) will sure the resident(s) were safe and notify the be monitored to ensure the charge nurse, if she witnessed any resident abuse. deficient practice will not recur, i.e., what quality assurance During an interview, on 1/3/22 at 1:57 p.m., LPN 6 program will be put into place? · indicated she had participated in the abuse and The Abuse audit tool will be reporting education. She indicated she would completed weekly for four weeks, report any witnessed abuse to the Administrator and monthly for six months by the or Director of Nursing. If abuse was reported to Administrator. her, as acting charge nurse, she would assess the situation and report to the Administrator or Inservice on Resident rights was

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 01/03/2023							
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CO	D				
BROOKS	SIDE CARE STRAT	EGIES	505 N GAVIN ST MUNCIE, IN 47303						
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRE					
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE COMPLETION DATE				
	Director of Nursing			conducted on 1/23/2023	3				
	7 indicated she had resident abuse and r would intervene and	w, on 1/3/22 at 1:59 p.m., CNA received education on reporting. She indicated she d separate resident(s)/staff and nurse who would report to		The Administrator will pr summary of the findings committee monthly for the six months, adjusting the needed.	to the QA he next				
	Resident Council Pr member had reques	r, on 1/3/23 at 3:45 p.m., the resident indicated no staff ted to meet with the resident 1 had not met for several							
	Prohibition," indica "Procedure 2. Should an occurr reported or witness, notified immediatel 4. The staff who wir abusive incident wir protect the involved including verbal/mental/physi seclusion and/or exp include, but are not a. Physically remov abusive environment b. Physically remov abuse from the environment	ence of abusive behavior be the Administrator shall be y tness or was made aware of the ll take immediate steps to l resident from further abuse, cal/neglect/involuntary ploitation. Such steps could limited to: ing the resident(s) from the int. ing the perpetrator of the							
	"Reporting Abuse to Entities/Individuals "POLICY: All sus substantiated incide immediately reported	o State Agencies an Other " indicated the following: spected violations and all							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064			JILDING	nstruction <u>00</u>	(X3) DATE COMPL 01/03/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 505 N GAVIN ST MUNCIE, IN 47303					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 0867 SS=D Bldg. 00	required by law. Interpretation and In 2. Verbal/written no within two (2) hours involved abuse or rowithin twenty-four does not include abbodily injury" This Federal Tag re IN00393778. This of 11/15/22. The facility systemic plan of consistency of the facility systemic plan of consistency of the facility systemic plan of consistency of the facility must estawritten policies and data collections syincluding adverse policies and proceed minimum, the follows 483.75(c)(1) Face effective systems feedback and input other staff, resider representatives, in information will be that are high risk, problem-prone, an improvement. §483.75(c)(2) Face effective systems	mplementation: prices to agencies will be made s of occurrence if event esults in serious injury, or (24) hours if the allegation use and does not result in lates to complaint number deficiency was cited on ty failed to implement a rection to prevent recurrence. (2)(i)(ii) rement Activities um feedback, data systems ablish and implement d procedures for feedback, restems, and monitoring, event monitoring. The dures must include, at a swing: illity maintenance of to obtain and use of at from direct care staff, nts, and resident including how such used to identify problems						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YKZR12 Facility ID: 000311

If continuation sheet

Page 11 of 15

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		15E064	B. W	ING		01/03	/2023
	ROVIDER OR SUPPLIER		•	505 N G	ADDRESS, CITY, STATE, ZIP COD SAVIN ST E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	assessment requi including how suc to develop and mo indicators. §483.75(c)(3) Fac	•					
	indicators, includir	valuation of performance ng the methodology and h development, monitoring,					
	monitoring, includ the facility will sys track, investigate, information relatin facility, including h	cility adverse event ing the methods by which stematically identify, report, analyze and use data and ing to adverse events in the now the facility will use the ctivities to prevent adverse					
	§483.75(d) Progra systemic action.	am systematic analysis and					
	aimed at performatimplementing those	e facility must take actions ance improvement and, after se actions, measure its k performance to ensure s are realized and					
	implement policies (i) How they will use to determine under impacting larger s (ii) How they will of that will be design systems level to p	se a systematic approach erlying causes of problems					

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15E064	B. W	ING		01/03/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			SAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES			E, IN 47303		
(VA) ID	CUMMADY	CTATEMENT OF DEFICIENCIE	1	ID			(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
IAG	(iii) How the facilit		+	IAG			DATE
	` '	s performance improvement					
		e that improvements are					
	sustained.	s that improvements are					
	§483.75(e) Program activities.						
	\$483.75(e)(1) The	facility must set priorities					
	- , , , ,	e improvement activities					
		-risk, high-volume, or					
	problem-prone are	eas; consider the incidence,					
	•	everity of problems in those					
	· ·	nealth outcomes, resident					
	safety, resident autonomy, resident choice,						
	and quality of care	9.					
	8483 75(e)(2) Per	formance improvement					
	- , , , ,	ck medical errors and					
		events, analyze their					
		ement preventive actions					
	•	that include feedback and					
	learning throughor	ut the facility.					
	§483.75(e)(3) As i	part of their performance					
	. , , ,	vities, the facility must					
	•	erformance improvement					
		ber and frequency of					
		ects conducted by the					
		t the scope and complexity					
	of the facility's ser	vices and available					
	resources, as refle	ected in the facility					
	assessment requi	red at §483.70(e).					
		ects must include at least					
		that focuses on high risk or					
		eas identified through the					
		d analysis described in					
	paragraphs (c) an	d (d) of this section.					
	8492 75/a) Ouglit	v accomment and					
	§483.75(g) Quality	y assessificiti aliu					
	assurance.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YKZR12 Facility ID: 000311

If continuation sheet Page 13 of 15

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED		
		15E064	B. WING			01/03/2023		
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	R			GAVIN ST			
BROOKSIDE CARE STRATEGIES				MUNCIE, IN 47303				
			1		· 			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
IAG	REGULATORY OR LSC IDENTIFYING INFORMATION			IAG	BLITCHNOT	DATE		
	§483.75(g)(2) The quality assessment and assurance committee reports to the facility's							
		or designated person(s)						
		overning body regarding its						
		g implementation of the						
_		quired under paragraphs (a)						
	through (e) of this section. The committee							
	must:							
	(ii) Develop and implement appropriate plans						1	
	of action to correct identified quality							
	deficiencies;							
	(iii) Regularly review and analyze data,							
	including data coll	lected under the QAPI						
		resulting from drug regimen						
	i i	on available data to make						
	improvements.							
		view and interview, the facility	F 08	367	The filing of the plan of correc		02/13/2023	
		ues identified in which quality			does not constitute an admission			
		urance activities were			that the alleged deficiency did			
		nced by the severity and			fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the			
		nd to ensure quality assurance						
1 -		llowed and plans of action						
re-occurring.		vent deficiencies from			requirements and continue to provide quality care.			
	10-0ccurring.				The facility respectfully reques	ete		
	Cross reference F60	00			paper review for compliance.	ວເວ		
	C1033 Telefelice F0(What corrective action(s) will be	ne		
	Cross reference F60	07.			accomplished for those reside			
					found to have been affected by the			
	Cross reference F60	09.			deficient practice.	,		
					It is the goal of Brookside Car	ıl of Brookside Care		
	During an interview, on 1/3/23 at 1:35 p.m., the				Strategies to provide a place f			
	-	tor indicated he reviewed the			from abuse and neglect for the			
	24-hour reports eac	h morning to see if any type of			residents. Also to ensure the b			
	-	or signs and symptoms of			quality of life can be provides	to	1	
	~	. He had not completed an			our resident population.			
audit tool to document his findings. The quality								
	assurance and perfo	ormance improvement (QAPI)			How the facility will identify oth	ner		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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CE. TERSTON	THE CONTENTS	1 0211.1020				•	21101070000		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED			
	15E064		B. WI	NG		01/03	/2023		
		- 19 - 1		_		1 ., 50,	- 		
NAME OF D	DONIDED OD GUDDI IED	<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD				
NAME OF PROVIDER OR SUPPLIER				505 N GAVIN ST					
BROOKSIDE CARE STRATEGIES			MUNCIE, IN 47303						
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG				TAG	DEFICIENCY)	VIE.	DATE		
	team had not had a meeting since the incident (in				residents having the potential	to			
	October 2022).				be affected by the same defic				
					practice and what corrective action				
	3.1-52(b)(2)				uill be taken.				
	5.1 52(5)(2)				All facility residents have the				
				potential to be affected by the					
				same alleged deficiency. What					
				measures will be put into place or					
				what systemic changes will be					
				made to ensure that the deficient					
				practice does not recur.					
				How the corrective action(s) will be					
					monitored to ensure the defici				
				practice will not recur, i.e., what					
					1 · ·				
					quality assurance programs w	ill be			
					put into place.	200			
			See Plans of correction for			ouu,			
			F607, and F609			4:			
				Along with the Plans of col					
				for the above deficient prac					
				the Administrator will at the					
				QAPI meeting on February 3rd,					
			2023 review the findings from the						
			last month of January findings						
			related to the POC for the three						
			related F-tags. The QAPI team will						
					initiate a PIP relating to ongoi	-			
					monitoring for abuse and neg	lect.			
					Also the Administrator will coll	lect			
					and store the related POC for	ms			
					in a binder titled "POC" to ens	ure			
					all forms are done and accour	nted			
					for.				

Event ID: $YKZR12 \qquad {\rm Facility\ ID:} \quad 000311$ Page 15 of 15 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet