STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E064	A. BUILDING 00 B. WING	01/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE CARE STRATEGIES	505 N GAVIN ST MUNCIE, IN 47303

(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
F 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00393778 completed on November 15, 2022. Complaint IN00393778 - Not corrected. Survey date: January 3, 2023 Facility number: 000311 Provider number: 15E064 AIM number: 100285520 Census Bed Type: NF: 38 Total: 38 Census Payor Type: Medicaid: 37 Other: 1 Total: 38 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 6, 2023.	F 0000		
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint 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.

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	resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to implement the plan of correction from the alleged abuse of a resident on October 30, 2022, in order to prevent further physical and emotional abuse of residents. Findings include: A review of the staff in-service information on 1/3/23, dated 11/17/22 and included in the facility's plan of correction documents, indicated lack of abuse training, abuse policy review, or education regarding following a resident's plan of care for individual needs on the attached agenda. Review of the facility's plan of correction indicated the following: "...Staff members have been educated on 11/18/22 and 11/21/22 by the ADON on abuse and following a resident's plan of care regarding individual needs...Staff have been re-educated on 11/17/22 on reporting suspected abuse immediately...The Abuse QAPI audit tool will be completed weekly for four weeks, and monthly for six months by the Executive Director/Designee...Abuse QAPI tool will be reviewed monthly by the QAPI team for six months...." During an interview, at the time of the review, the ADON indicated the staff had completed post-tests following the presentation, and she had spoken about abuse and reporting abuse, but she could not locate the documentation.	F 0600	The filing of the plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and continue to provide quality care. The facility respectfully requests paper review for compliance. It is the policy of this provider that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident was assessed for psychosocial distress, none noted and is free from abuse. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents that reside at the facility may be affected by the alleged deficient practice. Staff members have been educated on 11/17/22 by the	02/13/2023

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	During an interview, on 1/3/23 at 1:35 p.m., the interim Administrator indicated he reviewed the 24-hour reports each morning to see if any type of change of condition or signs and symptoms of abuse were present. He had not completed an audit tool to document his findings. The quality assurance and performance improvement (QAPI) team had not had a meeting since the incident. Review of a current, undated policy, titled, "Abuse Prohibition," indicated the following: " ...Procedure... 2. Should an occurrence of abusive behavior be reported or witness, the Administrator shall be notified immediately... 4. The staff who witness or was made aware of the abusive incident will take immediate steps to protect the involved resident from further abuse, including verbal/mental/physical/neglect/involuntary seclusion and/or exploitation. Such steps could include, but are not limited to: a. Physically removing the resident(s) from the abusive environment. b. Physically removing the perpetrator of the abuse from the environment...." This Federal Tag relates to complaint number IN00393778. This deficiency was cited on 11/15/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-28(c)		ADON on abuse and following a resident's plan of care regarding individual needs. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not reoccur. Staff have been re-educated on 11/17/22 on reporting suspected abuse immediately. Special clothing was purchased to ensure residents remain covered. Residents will now be seated in the common area to be better monitored for disrobing. On 11/29/22 the Ombudsman presented an in-service to the Staff and Administrator on abuse and neglect. (Exhibit 1&2) 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? The Abuse audit tool will be completed weekly for four weeks , and monthly for six months by the Administrator. The current facility policy titled "ABUSE PREVENTION AND PROHIBITION POLICY" with a revision date of January 2023, was provided by the Administrator. The policy indicated, "...Our facility will not condone any form of resident abuse or neglect. (Exhibit 3) Inservice on the updated abuse policy will have an in service on 1/23/23.	

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F 0607 SS=D Bldg. 00	483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. Based on interview and record review, the facility failed to implement the plan of correction from the alleged lack of immediate reporting of abuse of a resident on October 30, 2022, in order to prevent	F 0607	The filing of the plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction	02/13/2023

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	further physical and emotional abuse of residents. Findings include: Review of the facility's plan of correction indicated the following: "...Training included Staff stress when caring for difficult residents and residents with behaviors...The Administrator/designee will complete 10 interviews weekly, a combination of both employees and residents, regarding abuse and the reporting of abuse...The Administrator/Human Resource Director will present a summary of the interview findings to the Quality Assurance committee monthly for three months...1 Administrator and/or Director of Nursing will audit documentation of clinical staff as needed for any documentation of abuse or suspicious abuse. Unit Managers and Social Services will audit staff documentation of abuse/neglect. 2. Audits will be performed by Social Services/Unit Manger/Director of Nursing and/or Administrator 5 x weekly x 4 weeks, then monthly x 3 months. PIP will be added to QUAPI by Administrator of Designee, updated monthly...." A review completed on 1/3/23 of the staff in-service information, dated 11/17/22 and included in the facility's plan of correction documents, indicated a lack of abuse training, abuse policy review, or education regarding following a resident's plan of care for individual needs on the attached agenda. During an interview, at the time of the review, the ADON indicated the staff had completed post-tests following the presentation, and she had spoken about abuse and reporting abuse, but she could not locate the documentation.		is filed as evidence of the facility's desire to comply with the requirements and continue to provide quality care. The facility respectfully requests paper review for compliance. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Upon notification the administrator immediately suspended Staff members and initiated an investigation. The local police department was immediately notified of the allegation, if appropriately needed. 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 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. The facility immediately upon notification of the allegation initiated in servicing. This was completed on 11/29/22 by the Ombudsman. The Administrator/designee/DON/ADON will complete 10 resident interviews weekly for a month, regarding abuse and neglect. After	

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	A review of the resident interview log, provided by the interim Administrator on 1/3/23 at 4:05 p.m., indicated the resident interviews had not started until 12/2/22. The record lacked any staff interviews. During an interview, on 1/3/23 at 3:53 p.m., the ADON indicated she had not completed staff interviews regarding abuse. She was unsure why the resident interviews were started on the actual plan of correction date and not prior to. During an interview, on 1/3/23 at 1:35 p.m., the interim Administrator indicated he reviewed the 24-hour reports each morning to see if any type of change of condition or signs and symptoms of abuse were present. He had not completed an audit tool to document his findings. The quality assurance and performance improvement (QAPI) team had not had a meeting since the incident. He indicated he had started his revision of the facilities abuse/neglect policy, but had not completed the revision. Review of a current undated policy titled " Abuse Prohibition" indicated the following: "...Procedure ... 2. Should an occurrence of abusive behavior be reported or witness, the Administrator shall be notified immediately. ... 4. The staff who witness or was made aware of the abusive incident will take immediate steps to protect The involved resident from further abuse, including verbal/mental/physical/neglect/involuntary seclusion and/or exploitation. Such steps could include, but are not limited to: a. Physically removing the resident(s) from the abusive environment. b. Physically removing the perpetrator of the		1 month the facility will interview 5 residents weekly regarding abuse and neglect for an additional 3 months. The facility will follow the abuse policy related to reporting. In addition, the facility put up postings in prominent staff areas as visual reminders to report abuse. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place. Education: 1. All Abuse/Neglect policies have been reviewed and updated if needed. 2. All staff have been re-educated on Abuse/Neglect clinical protocol, reporting requirements for any suspicion of abuse or neglect, Abuse Investigation and Reporting and Abuse Prevention. Audits: 2. Clinical Documentation Audits will be performed by Social Services/or Administrator 5 x weekly x 4 weeks, then monthly x 3 months. The Administrator will present a summary of the findings to the QA committee monthly for the next six months, adjusting the PIP as needed.	

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	abuse from the environment...." Review of a current policy, dated 12/1/2021, titled " Reporting Abuse to State Agencies and Other Entities/Individuals" indicated the following: "...POLICY: All suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities or individuals as may be required by law. Interpretation and Implementation: ... 2. Verbal/written notices to agencies will be made within two (2) hours of occurrence if event involved abuse or results in serious injury, or within twenty-four (24) hours if the allegation does not include abuse and does not result in bodily injury...." This Federal Tag relates to complaint number IN00393778. This deficiency was cited on 11/15/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-28(c)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later			

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	than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interview and record review, the facility failed to implement the plan of correction from the alleged lack of reporting of abuse of a resident to the State Agency on October 30, 2022, in order to prevent further physical and emotional abuse of residents. Findings include: Review of the facility's plan of correction indicated the following: "...All residents will be interviewed by Dec. 5th,2022 for Abuse and neglect, if any allegations arise, will be reported to ISDH per policy...ED or DON will meet with Resident Council with invitation from Resident Council President to review Abuse Prohibition, Reporting and Investigation Policy and Procedures...The Administrator will be responsible for the completion of the Abuse Prohibition and Investigation QA tool weekly times 4 weeks, monthly times 6 months, and quarterly thereafter for one year. The results of	F 0609	The filing of the plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and continue to provide quality care. The facility respectfully requests paper review for compliance. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident allegations of abuse have been reported to ISDH. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ·	02/13/2023

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	these audits will be reviewed by the QAPI committee overseen by the ED...." A review completed on 1/3/23 of the staff in-service information, dated 11/17/22, indicated lack of abuse training, abuse policy review, or education regarding following a resident's plan of care for individual needs on the attached agenda. During an interview, at the time of the review, the ADON indicated the staff had completed post-tests following the presentation, and she had spoken about abuse and reporting abuse, but she could not locate the documentation. During an interview, on 1/3/23 at 1:35 p.m., the interim Administrator indicated he reviewed the 24-hour reports each morning to see if any type of change of condition or signs and symptoms of abuse were present. He had not completed an audit tool to document his findings. The quality assurance and performance improvement (QAPI) team had not had a meeting since the incident. He was not aware of any staff meeting with the resident council. During an interview, on 1/3/22 at 1:52 p.m., CNA 5 indicated she had received training regarding resident abuse. She indicated she would make sure the resident(s) were safe and notify the charge nurse, if she witnessed any resident abuse. During an interview, on 1/3/22 at 1:57 p.m., LPN 6 indicated she had participated in the abuse and reporting education. She indicated she would report any witnessed abuse to the Administrator or Director of Nursing. If abuse was reported to her, as acting charge nurse, she would assess the situation and report to the Administrator or		All residents have the potential to be affected by the alleged deficient practice. · All residents will be interviewed by February 3rd,2023 for Abuse and neglect, if any allegations arise, will be reported to ISDH per policy. · If any allegations of abuse will be reported to the Executive Director immediately, reported to ISDH, and investigated. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · All staff in-serviced by the ADON by January 23, 2023, on the Abuse Prohibition, Reporting and Investigation Policy and Procedures · Reporting pending investigation immediately and at the conclusion of the investigation will be reported to the following agencies when applicable: ISDH , APS , Ombudsman , Licensing/Certification Agency , Local Police. 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? · The Abuse audit tool will be completed weekly for four weeks , and monthly for six months by the Administrator. Inservice on Resident rights was	

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	Director of Nursing if needed. Durinng an interview, on 1/3/22 at 1:59 p.m., CNA 7 indicated she had received education on resident abuse and reporting. She indicated she would intervene and separate resident(s)/staff and report to the charge nurse who would report to the Administrator. During an interview, on 1/3/23 at 3:45 p.m., the Resident Council President indicated no staff member had requested to meet with the resident council. The council had not met for several months. Review of a current undated policy titled "Abuse Prohibition," indicated the following: "...Procedure ... 2. Should an occurrence of abusive behavior be reported or witness, the Administrator shall be notified immediately. ... 4. The staff who witness or was made aware of the abusive incident will take immediate steps to protect the involved resident from further abuse, including verbal/mental/physical/neglect/involuntary seclusion and/or exploitation. Such steps could include, but are not limited to: a. Physically removing the resident(s) from the abusive environment. b. Physically removing the perpetrator of the abuse from the environment...." Review of a current policy, dated 12/1/2021, titled "Reporting Abuse to State Agencies an Other Entities/Individuals," indicated the following: "...POLICY: All suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities or individuals as may be		conducted on 1/23/2023 The Administrator will present a summary of the findings to the QA committee monthly for the next six months, adjusting the PIP as needed.	

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	required by law. Interpretation and Implementation: ... 2. Verbal/written notices to agencies will be made within two (2) hours of occurrence if event involved abuse or results in serious injury, or within twenty-four (24) hours if the allegation does not include abuse and does not result in bodily injury...." This Federal Tag relates to complaint number IN00393778. This deficiency was cited on 11/15/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-28(c)			
F 0867 SS=D Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments,			

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	including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and			

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(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
	(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E064	A. BUILDING 00 B. WING	01/03/2023

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	§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.			
	Based on record review and interview, the facility failed to ensure issues identified in which quality assessment and assurance activities were necessary as evidenced by the severity and deficiencies cited and to ensure quality assurance procedures were followed and plans of action implemented to prevent deficiencies from re-occurring. Cross reference F600. Cross reference F607. Cross reference F609. During an interview, on 1/3/23 at 1:35 p.m., the interim Administrator indicated he reviewed the 24-hour reports each morning to see if any type of change of condition or signs and symptoms of abuse were present. He had not completed an audit tool to document his findings. The quality assurance and performance improvement (QAPI)	F 0867	The filing of the plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and continue to provide quality care. The facility respectfully requests paper review for compliance. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. It is the goal of Brookside Care Strategies to provide a place free from abuse and neglect for the residents. Also to ensure the best quality of life can be provides to our resident population. How the facility will identify other	02/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	team had not had a meeting since the incident (in October 2022). 3.1-52(b)(2)		residents having the potential to be affected by the same deficient practice and what corrective action will be taken. 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 deficient practice will not recur, i.e., what quality assurance programs will be put into place. See Plans of correction for F600, F607, and F609 Along with the Plans of correction for the above deficient practices the Administrator will at the next 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 ongoing monitoring for abuse and neglect. Also the Administrator will collect and store the related POC forms in a binder titled “POC” to ensure all forms are done and accounted for.	