STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENTWOOD AT LAPORTE	2002 ANDREW AVE, LA PORTE, , 46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00374578, IN00374674, IN00374823, IN00374827, and IN00374830 Complaint IN00374578 - Substantiated. State deficiencies related to the allegations are cited at R0241 and R0268. Complaint IN00374674 - Substantiated. State deficiencies related to the allegations are cited at R0090, R0240, R0241, R0268, and R0349. Complaint IN00374823 - Substantiated. State deficiencies related to the allegations are cited at R0241 and R0268. Complaint IN00374827 - Substantiated. State deficiencies related to the allegations are cited at R0241. Complaint IN00374830 -	R 0000		

	Substantiated. State deficiencies related to the allegations are cited at R0241 and R0268. Survey dates: March 8 and 9, 2022 Facility number: 010890 Residential Census: 88 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/14/22.			
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (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: (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;	R 0090	Executive Director will adhere to State Reportable guidelines found at https://www.in.gov/health/files/IncidentReportingPolicy-Final.pdf. 2. Incident must be reported within 24 hours of discovery of the incident. Follow up report will be completed within five business days after the initial report submission if not included with initial report. 3. Team educated on ISL policy GP19 Internal and State Incident Reporting HOW WILL YOU ENSURE ONGOING COMPLIANCE, INCLUDE TIMEFRAMES, DEADLINES	04/25/2022

	(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 by the division in each		1.Clinical Staff will Utilize the When to Call Protocol call tree to communicate any unusual occurrence to based on the type of occurrence who will be contacted will be in Medication Rooms to ensure proper reporting is performed immediately. It will be monitored at the Daily Clinical meetings and will be an immediate and ongoing monitoring by the Nursing and ED or designated representative. 2. Team Members will be in-serviced to report incidents immediately to supervisor. 3. Supervisor to immediately notify ED of any incident requiring state reportable. 4. Executive Director will adhere to State Reportable guidelines found at https://www.in.gov/health/files/IncidentReportingPolicy-Final.pdf. 5. Incident must be reported within 24 hours of discovery of the incident. 6. Follow up report will be completed within five business days after the initial report submission if not included with initial report. 7. RELIAS TRAINING & SELF STUDY ABUSE AND OTHER INCIDENTS IN-SERVICE. New associates upon hire and	

	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 ensure a resident elopement was reported to the State Agency for 1 of 3 residents reviewed for accidents. (Resident D) Finding includes: The record for Resident D was reviewed on 3/8/22 at 9:55 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, hallucinations, anxiety, major depression, and restlessness and agitation. Nurses' Notes, dated 12/11/21 at 7:31 a.m., indicated on 12/10/21 at approximately 6:45 p.m., the facility had received a phone call from the long term care (LTC) facility next door indicating the resident was at their facility stating she had been kicked out of the building and she was waiting for her son and husband to pick her up. Staff were sent to the LTC facility to assist the resident back to the building, the resident refused to leave stating she was waiting for her son and husband to pick her up. The Executive Director and the resident's son were notified.		ongoing for current associates will complete resident rights training. Within 30 days of POC and on-going 8. Elopement drills will be held at least every three months on each shift. A record will be kept with the dates and times these drills were held. PERSON RESPONSIBLE FOR IMPLEMENTING THE ACTION PLAN AND ENSURING COMPLIANCE Executive Director or designated community representative. Date of implementation 03/09/22 and/04/30/22	

Shortly afterwards, the resident and staff returned to the facility. No injuries were noted and the resident was provided with one to one care until her son arrived. The resident was placed on 30 minute checks and her son stayed with her until 9:30 p.m.

There was no documentation indicating the incident had been reported to the State Agency.

Interview with the Resident Care Director from a sister facility on 3/9/22 at 12:08 p.m., indicated the elopement had not been reported to the State Agency and it should have been.

This State Residential finding relates to Complaint IN00374674.

Based on record review and interview, the facility failed to ensure a resident elopement was reported to the State Agency for 1 of 3 residents reviewed for accidents. (Resident D)

Finding includes:

The record for Resident D was reviewed on 3/8/22 at 9:55 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, hallucinations, anxiety, major depression, and restlessness and agitation.

Nurses' Notes, dated 12/11/21

	at 7:31 a.m., indicated on 12/10/21 at approximately 6:45 p.m., the facility had received a phone call from the long term care (LTC) facility next door indicating the resident was at their facility stating she had been kicked out of the building and she was waiting for her son and husband to pick her up. Staff were sent to the LTC facility to assist the resident back to the building, the resident refused to leave stating she was waiting for her son and husband to pick her up. The Executive Director and the resident's son were notified. Shortly afterwards, the resident and staff returned to the facility. No injuries were noted and the resident was provided with one to one care until her son arrived. The resident was placed on 30 minute checks and her son stayed with her until 9:30 p.m. There was no documentation indicating the incident had been reported to the State Agency. Interview with the Resident Care Director from a sister facility on 3/9/22 at 12:08 p.m., indicated the elopement had not been reported to the State Agency and it should have been. This State Residential finding relates to Complaint IN00374674.			

R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, record review, and interview, the facility failed to ensure a resident with a history of falling down the stairs was provided adequate supervision to prevent further falls for 1 of 3 residents reviewed for accidents. (Resident G) Finding includes: On 3/8/22 at 7:20 a.m., Resident G was observed walking down the stairs with bare feet and in his boxer shorts. His legs were unsteady and wobbly as he held onto one of the handrails. Staff were overheard yelling at the resident to go back upstairs, so the resident turned himself around on the stair step and started to climb back up the stairs. No staff got up to assist the resident back to his apartment.	R 0240	IDENTIFY THE PLAN OF ACTION TO CORRECT THE PROBLEM(S) INCLUDE TIMEFRAME 1. Resident G was moved permanently to MC on 3/9/22 to ensure adequate supervision. 2. Fall risk assessment was completed 3/22/22 for Resident G 3. Team members educated on service plans and fall risk assessments per ISL policy “GP05 Resident Assessment and Service Plans” HOW WILL YOU ENSURE ONGOING COMPLIANCE, INCLUDE TIMEFRAMES, DEADLINES 1. Service Plan Binder will be readily available to care staff with resident service plans 2. Care team will be educated on where to find service plan binder and how to read service plans 3. Fall risk assessments will be reviewed and updated on first fall, repeated falls and falls with injury requiring medical intervention/treatment. PERSON RESPONSIBLE FOR	04/25/2022

	At 7:25 a.m., the resident was observed standing in front of the nurses' station in his bare feet and boxer shorts. He came downstairs via the elevator. A CNA redirected the resident back to the elevator and took him to his room to get dressed. The record for Resident G was reviewed on 3/8/22 at 10:00 a.m. Diagnoses included, but were not limited to, dementia, COPD, diabetes, high blood pressure, osteoarthritis, gout, and glaucoma. A Level of Care Assessment, dated 2/24/22, indicated Transport/Escort: required staff to escort up to 3 times daily, may be a fall risk and had no behaviors. The resident had memory impairment, was forgetful, and required occasional/frequent reminders and cueing. A Fall Risk assessment, dated 11/10/21, indicated the resident's score was a 4. A score of 4 or more was considered at risk for falling. Nurses' Notes, dated 2/16/22 at 11:27 a.m., indicated "notified that resident fell, vitals signs taken. Skin and ROM (range of motion) checked. Small abrasion to top of head. Notified daughter [name] that resident was sent to via ambulance to the hospital [name]. Notified		IMPLEMENTING THE ACTION PLAN AND ENSURING COMPLIANCE Executive Director or representative. DATE OF IMPLEMENTATION AND FOLLOW UP 03/09/2022 and completion by 4/30/202	

doctor office."

Nurses' Notes, dated 2/16/22 at 6:23 p.m., indicated the hospital was called to find out the status of the resident. The resident was being admitted with the diagnoses of urinary retention, fall, rug burn, and head injury.

The resident returned from the hospital on 2/17/22.

A Resident Incident Report, dated 2/16/22 and provided by the Memory Care Director, indicated the resident fell down the stairs and was found sitting on his buttocks on the landing of the stairs. There were no witnesses or apparent injuries. The resident did complain of pain to his buttocks. The resident had a history of falls in the past. The follow up and prevention to be provided was frequent checks.

Nurses' Notes, by the Memory Care Director on 2/16/22 at 9:29 p.m., indicated the Executive Director and herself had a meeting with the resident's daughter regarding his level of care. It was suggested the resident transfer to the memory care. The daughter agreed to ease the transition and have the resident participate in week day programming from 11:00 a.m., to 4:00 p.m., on the memory care unit.

There was no plan to move the

resident to another apartment and off of the second floor at that time.

Nurses' Notes, dated 2/22/22 at 10:35 a.m., indicated the resident had another fall and was found sitting on the dining room floor.

Nurses' Notes, dated 2/28/22 at 11:12 p.m., indicated the resident was found on the floor by the front office. He was unable to say how he fell.

The resident still resided in an apartment on the second floor.

On 3/9/22 the resident was permanently transferred to the memory care unit.

Interview with CNA 1 on 3/8/22 at 10:30 a.m., indicated the resident walked down the stairs all the time, and then staff help him back upstairs via the elevator.

Interview with Memory Care Director on 3/8/22 at 10:40 am. indicated the resident slid down the stairs in the main lobby. He now goes to the Memory care unit during the day and will be moving over there soon. She indicated the daughter did not want to move the resident 2 times due to his confusion. She was unsure if the daughter was informed of the need for extra supervision to ensure no other falls while walking up and down

the stairs.

This State Residential finding relates to Complaint IN00374674.

Based on observation, record review, and interview, the facility failed to ensure a resident with a history of falling down the stairs was provided adequate supervision to prevent further falls for 1 of 3 residents reviewed for accidents. (Resident G)

Finding includes:

On 3/8/22 at 7:20 a.m., Resident G was observed walking down the stairs with bare feet and in his boxer shorts. His legs were unsteady and wobbly as he held onto one of the handrails. Staff were overheard yelling at the resident to go back upstairs, so the resident turned himself around on the stair step and started to climb back up the stairs. No staff got up to assist the resident back to his apartment.

At 7:25 a.m., the resident was observed standing in front of the nurses' station in his bare feet and boxer shorts. He came downstairs via the elevator. A CNA redirected the resident back to the elevator and took him to his room to get dressed.

The record for Resident G was reviewed on 3/8/22 at 10:00

	a.m. Diagnoses included, but were not limited to, dementia, COPD, diabetes, high blood pressure, osteoarthritis, gout, and glaucoma. A Level of Care Assessment, dated 2/24/22, indicated Transport/Escort: required staff to escort up to 3 times daily, may be a fall risk and had no behaviors. The resident had memory impairment, was forgetful, and required occasional/frequent reminders and cueing. A Fall Risk assessment, dated 11/10/21, indicated the resident's score was a 4. A score of 4 or more was considered at risk for falling. Nurses' Notes, dated 2/16/22 at 11:27 a.m., indicated "notified that resident fell, vitals signs taken. Skin and ROM (range of motion) checked. Small abrasion to top of head. Notified daughter [name] that resident was sent to via ambulance to the hospital [name]. Notified doctor office." Nurses' Notes, dated 2/16/22 at 6:23 p.m., indicated the hospital was called to find out the status of the resident. The resident was being admitted with the diagnoses of urinary retention, fall, rug burn, and head injury.			

The resident returned from the hospital on 2/17/22.

A Resident Incident Report, dated 2/16/22 and provided by the Memory Care Director, indicated the resident fell down the stairs and was found sitting on his buttocks on the landing of the stairs. There were no witnesses or apparent injuries. The resident did complain of pain to his buttocks. The resident had a history of falls in the past. The follow up and prevention to be provided was frequent checks.

Nurses' Notes, by the Memory Care Director on 2/16/22 at 9:29 p.m., indicated the Executive Director and herself had a meeting with the resident's daughter regarding his level of care. It was suggested the resident transfer to the memory care. The daughter agreed to ease the transition and have the resident participate in week day programming from 11:00 a.m., to 4:00 p.m., on the memory care unit.

There was no plan to move the resident to another apartment and off of the second floor at that time.

Nurses' Notes, dated 2/22/22 at 10:35 a.m., indicated the resident had another fall and was found sitting on the dining room floor.

	Nurses' Notes, dated 2/28/22 at 11:12 p.m., indicated the resident was found on the floor by the front office. He was unable to say how he fell. The resident still resided in an apartment on the second floor. On 3/9/22 the resident was permanently transferred to the memory care unit. Interview with CNA 1 on 3/8/22 at 10:30 a.m., indicated the resident walked down the stairs all the time, and then staff help him back upstairs via the elevator. Interview with Memory Care Director on 3/8/22 at 10:40 am. indicated the resident slid down the stairs in the main lobby. He now goes to the Memory care unit during the day and will be moving over there soon. She indicated the daughter did not want to move the resident 2 times due to his confusion. She was unsure if the daughter was informed of the need for extra supervision to ensure no other falls while walking up and down the stairs. This State Residential finding relates to Complaint IN00374674.			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1)	R 0241	Campus is advertising on multiple websites, social media and through	04/25/2022

	(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to ensure medications were given as ordered and blood sugars were obtained as ordered for 6 of 7 residents reviewed for medication administration. The lack of medication administration and blood sugar monitoring resulted in elevated blood sugars and a resident being sent to the hospital for evaluation. (Residents B, L, K, G, J, and H) Findings include: 1. Interview with Resident B on 3/8/22 at 7:45 a.m., indicated she did not receive her medications several times last week and over the weekend due to no staff. The record for Resident B was reviewed on 3/8/22 at 7:14 a.m. Diagnoses included, but were not limited to, stage 3 chronic kidney disease, hypertension, hypothyroidism, high		other resources to hire additional nurses and/or med techs 2. Campus is using contracted labor from multiple agency contracts to assist with staffing appropriately 3. Campus has hired agency recruiting firm to fill interim RCD position to lead clinical team and is capable of administering medications in emergency situations. 4. ISL uses a consultant group (Allen Flores Consulting Group) to support the team at the campus level and has a compact license capable of administering medications in emergency situations. HOW WILL YOU ENSURE ONGOING COMPLIANCE, INCLUDE TIMEFRAMES, DEADLINES 1. Facilitate Daily clinical meeting to review care staff assignment, open shifts and address any staffing needs immediately. Institute on-call Resident Care Director that will cover any medication administration needs for the last minute. 2. Plan developed with agency to ensure proper follow up with any call offs and contact director	

	cholesterol, atrial fibrillation (an irregular heartbeat), type 2 diabetes, and adjustment disorder with mixed anxiety. The March 2022 Medication Administration Record (MAR), indicated the resident did not receive her medications on the following dates: - Atorvastatin (a medication for high cholesterol) 10 milligrams (mg) at 5:00 p.m. was not administered on 3/4 and 3/6/22. - Furosemide (a diuretic) 20 mg at 8:00 a.m. was not administered on 3/5/22. - Glimepiride (a diabetic medication) 2 mg at 8:00 a.m. was not given on 3/5 and her 5:00 p.m. dose was not given on 3/4 and 3/6/22. - Levothyroxin (a thyroid medication) 50 micrograms (mcg) was not given at 8:00 a.m. on 3/5/22. - Magnesium Oxide 400 mg at 8:00 a.m. was not given on 3/5 and her 5:00 p.m. dose was not given on 3/4 and 3/6/22. - Meloxicam (an anti-inflammatory) 15 mg was not given on 3/5/22 at 8:00 a.m. - Metformin (a diabetic medication) 850 mg at 8:00 a.m. was not given on 3/5 and her 5:00 p.m. dose was not given		supervisor or on-call nurse to institute the plan for coverage. 3. Communication information clearly posted with phone numbers to contact when call off occurs 4. Team educated on how to handle a call off and process to ensure medications are appropriately administered 5. Team educated on ISL Attendance and Punctuality Standards. PERSON RESPONSIBLE FOR IMPLEMENTING THE ACTION PLAN AND ENSURING COMPLIANCE Executive Director or designated community representative. Plan will being 3/9/22 and completed until 4/30/22.	

on 3/4 and 3/6/22.

- Metoprolol (a heart medication) 75 mg at 8:00 a.m. was not given on 3/5/22.

- Potassium Chloride 10 milliequivalents (meq) at 8:00 a.m. was not given on 3/5/22.

The Level of Care assessment, dated 11/10/21, indicated the resident required assistance with her medication up to 2 times daily.

Interview with the Resident Care Director from a sister facility on 3/9/22 at 1:00 p.m., indicated the resident should have received her medications as ordered.

2. The record for Resident L was reviewed on 3/9/22 at 9:21 a.m. Diagnoses included, but were not limited to, hypertension, rheumatoid arthritis, cardioverter-defibrillator, hyperlipidemia, congestive heart failure, stage 3 chronic kidney disease, anxiety, and bacteriuria.

The March 2022 Medication Administration Record (MAR), indicated the resident did not receive her medications on the following dates:

- Aspirin 81 milligrams (mg) was not given on 3/5/22 at 8:00 a.m.

	- Coreg (a heart medication) 25 mg at 8:00 a.m. was not given on 3/5 and her 5:00 p.m. dose was not given on 3/4 and 3/6/22. - Keflex (an antibiotic) 500 mg was not given at 8:00 a.m. on 3/5/22. - Lexapro (an antidepressant) 10 mg was not given at 8:00 a.m. on 3/5/22. - Furosemide (a diuretic) 40 mg was not given at 7:00 a.m. on 3/5/22. - Losartan Potassium (a blood pressure medication) 25 mg was not given at 8:00 a.m. on 3/5/22. - Metformin (a diabetic medication) 500 mg was not given at 8:00 a.m. on 3/5/22. - Metoprolol (a heart medication) 25 mg at 8:00 a.m. was not given on 3/5 and her 5:00 p.m. dose was not given on 3/4 and 3/6/22. - Potassium Chloride 20 milliequivalents (meq) at 8:00 a.m. was not given on 3/5/22. - Sotalol (a blood pressure medication) 120 mg at 8:00 a.m. was not given on 3/5 and her 5:00 p.m. dose was not given on 3/4 and 3/6/22. - Spironolact (a blood pressure			

	medication) 25 mg at 7:00 a.m. was not given on 3/5/22. The Level of Care assessment, dated 2/22/22, indicated the resident required assistance with medications up to 2 times daily and she had memory impairment. Interview with the Resident Care Director from a sister facility on 3/9/22 at 1:00 p.m., indicated the resident should have received her medications as ordered. Confidential interview with Employee 3 indicated there have been many recent occasions where the residents were not receiving their medications as ordered due to no staff scheduled or staff not showing up. Confidential interview with Employee 4 indicated they had been approached by many residents indicating they were not receiving their medications for days at a time. The time cards for 3/4/22 indicated RN 1 worked from 2:30 p.m. until 11:30 p.m. QMA 1 clocked in at 6:00 p.m. on 3/3 and clocked out at 9:12 a.m. on 3/4/22. LPN 1 clocked in at 5:49 p.m. on 3/4 and clocked out at 6:30 a.m. on 3/5/22. The time cards for 3/7/22 indicated RN 2 clocked in at			

	10:47 p.m. LPN 1 clocked in at 5:54 p.m. on 3/6 and clocked out at 6:39 a.m. on 3/7/22. RN 1 clocked in at 2:00 p.m. on 3/6 and clocked out at 3:20 a.m. on 3/7/22. QMA 2, who worked the Generations Unit, clocked in at 6:00 a.m. and clocked out at 6:36 p.m. 3. The record for Resident K was reviewed on 3/8/22 at 10:20 a.m. Diagnoses included, but were not limited to, stroke, diabetes, depression, high blood pressure, anxiety, seizure disorder, dementia, and psychosis. Nurses' Notes, dated 2/22/22 at 5:39 a.m., indicated "Upon checking resident's blood sugar at 8:00 p.m., glucometer showed resident was hypoglycemic with a reading of 32. Resident was given a cup of orange juice, a chocolate chip cookie, a small serving of chocolate pudding, and an ice cream sandwich. Resident's blood sugar tested again at 9:40 p.m., and her reading was 98. At 1:20 a.m., resident's blood sugar was taken again with a reading of 235. Resident's insulin was given 15 units of Levemir and 14 units of Novolog. The nurse was made aware of situation and doctor faxed." The entry was documented by a QMA. Nurses' Notes, dated 2/23/22 at			

	7:42 a.m., "Notified by QMA via phone call that resident [name] sent to hospital, blood sugar was 330 when EMS arrived." There was no documentation or an assessment of the resident after she had received the insulins. Physician's Orders, dated 2/10/21, indicated Novolog insulin flexpen 10 units three times a day. Physician's Orders, dated 10/1/21 indicated 10/1/21 Levemir insulin 35 units every 7 a.m. and Levemir 30 units every 7 p.m. The order was discontinued on 2/22/22. Physician's Orders, dated 12/16/21, indicated Insulin Lispro per sliding scale before meals and at bed time. Physician's Orders, dated 2/20/22 indicated Levemir insulin 15 units twice a day at 8:00 a.m., and 5:00 p.m. The Medication Administration Record (MAR) for 2/2022, indicated the administration times for the Novolog insulin flexpen were 8:00 a.m., 12:00 p.m. and 5:00 p.m. The administration times for the Lispro insulin was at 8:00 a.m., 11:00 a.m., 4:00 p.m., and 7:00 p.m. The administration times for the Levemir 15 units was at 8:00 a.m. and 5:00 p.m. There			

were no blood sugars documented for the 7:00 p.m., dose of the sliding scale Lispro insulin. The Levemir 15 units was signed out as being administered on 2/22/22 at 12:00 a.m.

Physician's Orders, dated 3/2/22, indicated Novolog insulin flexpen 13 units at 7:30 a.m., 11:30 a.m., and 4:30 p.m.

Physician's Orders dated 3/3/22, indicated Aspart insulin per sliding scale 0-150=0, 151-200=1 unit, 201-250=2 units, 251-300=3 units, 301-350=4 units, 351-400=5 units, and 401 and above=6 units.

The MAR for 3/2022 indicated the resident did not receive the Novolog flexpen insulin on 3/4/22 at 7:30 a.m., 11:30 a.m., and 4:30 a.m., and 3/5/22 at 7:30 a.m., and 11:30 a.m. The Levemir insulin was not administered on 3/4 at 4:30 p.m., and 3/5/22 at 7:30 a.m. and 3/6/22 at 4:30 p.m. The Aspart insulin per sliding scale was not administered on 3/4 at 11:30 a.m., and 4:30 p.m., 3/5 at 7:30 a.m., and 11:30 a.m., and on 3/6/22 at 4:30 p.m.

On 3/5/22 the resident's 4:30 p.m. blood sugar was 416 a high reading.

The MAR for 3/2022 indicated the resident did not receive her

	evening medication on 3/4/22 of Xanax, Levetiracetam, and Systane eye drops. On 3/5/22, the resident did not receive her morning medications of Namenda, Metformin, Levetiracetam, Losartan, Xanax, Risperidone, and Zoloft Interview with the Resident Care Director from the sister facility on 3/9/22 at 11:30 a.m., indicated the medications were not signed out as being administered. 4. The record for Resident G was reviewed on 3/8/22 at 10:00 a.m. Diagnoses included, but were not limited to, dementia, COPD, diabetes, high blood pressure, osteoarthritis, and glaucoma. The Medication Administration Record (MAR) for 2/2022, indicated the resident's Humulin Regular insulin was held on 2/2, 2/5, 2/14, and 2/16/22 at 7:00 a.m. There was no documentation of blood sugar readings or why the insulin was held. The MAR for 3/2022, indicated the resident did not receive any of his 7:30 a.m., or 8 a.m., medications of Allopurinol, Aspirin, Gabapentin, Loratadine, Metformin, and Rivastimine on 3/4/22. The resident did not receive Risperidone at 12:00 p.m. on 3/4/22. On 3/6/22 the			

resident did not receive the Humulin Regular insulin at 7:30 a.m. The evening medications of Latanoprost, Risperidone, Rivastimine, Melatonin Gabapentin, and Metformin were not administered on 3/7/22.

A confidential interview with Employee 3 indicated there was no evening nurse working the "Assisted Living" side of the facility on 3/7/22.

5. The record for Resident J was reviewed on 3/9/22 at 10:35 a.m. Diagnoses included, but were not limited to, major depressive disorder, high blood pressure, glaucoma, diabetes, and congestive heart failure.

Physician's Orders, dated 10/1/21, indicated Lantus 46 units twice a day (never hold Lantus) at 7:30 a.m., and 8 p.m.

Physician's Orders, dated 12/18/21, indicated Humalog insulin inject per sliding scale: blood sugar 201-250=6 units, 251-300=8 units, 301-350=10 units, 351-400=12 units greater than 400 call doctor.

The Medication Administration Record (MAR) for 2/2022 indicated the Humalog insulin was held and not administered on 2/2 and 2/6 at 7:30 a.m. There were no blood sugars documented on the MAR.

	The 3/2022 MAR indicated the resident's Humalog and Lantus insulins were not signed as being administered on 3/3 and 3/6/22 at 7:30 a.m. Interview with the Resident Care Director from the sister facility on 3/9/22 at 11:30 a.m., indicated the insulins were not signed out as being administered and there was no documentation of the blood sugars. 6. During an interview on 3/8/22 at 7:25 a.m., Resident M indicated her and her husband had been up all night due to her husband not receiving his medications for the last 3 days. "He has Alzheimer's and dementia and he gets really bad when he does not get his medications." The resident was worried about the facility closing. She stated, "We are paying 6000.00 a month and are getting nothing for it." The record for Resident H was reviewed on 3/8/22 at 9:00 a.m. Diagnoses included, but were not limited to, dementia without behaviors. The 3/2022 Medication Administration Record (MAR) indicated the 8:00 a.m., and 12:00 p.m. medications of Tramadol, Naproxen, Namenda, Losartan, Gabapentin, Atenolol, and Cetirizine were not signed			

	out as being administered on 3/4/22. The resident's evening medications of Gabapentin, Aricept, Melatonin, Naproxen, and Tramadol were not signed out as being administered on 3/7/22. Interview with the Resident Care Director from the sister facility on 3/9/22 at 11:30 a.m., indicated the medications were not signed out as being administered. This State Residential finding relates to Complaints IN00374578, IN00374674, IN00374823, IN00374827, and IN00374830. Based on record review and interview, the facility failed to ensure medications were given as ordered and blood sugars were obtained as ordered for 6 of 7 residents reviewed for medication administration. The lack of medication administration and blood sugar monitoring resulted in elevated blood sugars and a resident being sent to the hospital for evaluation. (Residents B, L, K, G, J, and H) Findings include:			

	1. Interview with Resident B on 3/8/22 at 7:45 a.m., indicated she did not receive her medications several times last week and over the weekend due to no staff. The record for Resident B was reviewed on 3/8/22 at 7:14 a.m. Diagnoses included, but were not limited to, stage 3 chronic kidney disease, hypertension, hypothyroidism, high cholesterol, atrial fibrillation (an irregular heartbeat), type 2 diabetes, and adjustment disorder with mixed anxiety. The March 2022 Medication Administration Record (MAR), indicated the resident did not receive her medications on the following dates: - Atorvastatin (a medication for high cholesterol) 10 milligrams (mg) at 5:00 p.m. was not administered on 3/4 and 3/6/22. - Furosemide (a diuretic) 20 mg at 8:00 a.m. was not administered on 3/5/22. - Glimepiride (a diabetic medication) 2 mg at 8:00 a.m. was not given on 3/5 and her 5:00 p.m. dose was not given on 3/4 and 3/6/22. - Levothyroxin (a thyroid medication) 50 micrograms (mcg) was not given at 8:00 a.m. on 3/5/22.			

	- Magnesium Oxide 400 mg at 8:00 a.m. was not given on 3/5 and her 5:00 p.m. dose was not given on 3/4 and 3/6/22. - Meloxicam (an anti-inflammatory) 15 mg was not given on 3/5/22 at 8:00 a.m. - Metformin (a diabetic medication) 850 mg at 8:00 a.m. was not given on 3/5 and her 5:00 p.m. dose was not given on 3/4 and 3/6/22. - Metoprolol (a heart medication) 75 mg at 8:00 a.m. was not given on 3/5/22. - Potassium Chloride 10 milliequivalents (meq) at 8:00 a.m. was not given on 3/5/22. The Level of Care assessment, dated 11/10/21, indicated the resident required assistance with her medication up to 2 times daily. Interview with the Resident Care Director from a sister facility on 3/9/22 at 1:00 p.m., indicated the resident should have received her medications as ordered. 2. The record for Resident L was reviewed on 3/9/22 at 9:21 a.m. Diagnoses included, but were not limited to, hypertension, rheumatoid arthritis, cardioverter-defibrillator, hyperlipidemia, congestive heart			

failure, stage 3 chronic kidney disease, anxiety, and bacteriuria.

The March 2022 Medication Administration Record (MAR), indicated the resident did not receive her medications on the following dates:

- Aspirin 81 milligrams (mg) was not given on 3/5/22 at 8:00 a.m.

- Coreg (a heart medication) 25 mg at 8:00 a.m. was not given on 3/5 and her 5:00 p.m. dose was not given on 3/4 and 3/6/22.

- Keflex (an antibiotic) 500 mg was not given at 8:00 a.m. on 3/5/22.

- Lexapro (an antidepressant) 10 mg was not given at 8:00 a.m. on 3/5/22.

- Furosemide (a diuretic) 40 mg was not given at 7:00 a.m. on 3/5/22.

- Losartan Potassium (a blood pressure medication) 25 mg was not given at 8:00 a.m. on 3/5/22.

- Metformin (a diabetic medication) 500 mg was not given at 8:00 a.m. on 3/5/22.

- Metoprolol (a heart medication) 25 mg at 8:00 a.m. was not given on 3/5 and her 5:00 p.m. dose was not given

on 3/4 and 3/6/22.

- Potassium Chloride 20 milliequivalents (meq) at 8:00 a.m. was not given on 3/5/22.

- Sotalol (a blood pressure medication) 120 mg at 8:00 a.m. was not given on 3/5 and her 5:00 p.m. dose was not given on 3/4 and 3/6/22.

- Spironolact (a blood pressure medication) 25 mg at 7:00 a.m. was not given on 3/5/22.

The Level of Care assessment, dated 2/22/22, indicated the resident required assistance with medications up to 2 times daily and she had memory impairment.

Interview with the Resident Care Director from a sister facility on 3/9/22 at 1:00 p.m., indicated the resident should have received her medications as ordered.

Confidential interview with Employee 3 indicated there have been many recent occasions where the residents were not receiving their medications as ordered due to no staff scheduled or staff not showing up.

Confidential interview with Employee 4 indicated they had been approached by many residents indicating they were not receiving their medications

for days at a time.

The time cards for 3/4/22 indicated RN 1 worked from 2:30 p.m. until 11:30 p.m. QMA 1 clocked in at 6:00 p.m. on 3/3 and clocked out at 9:12 a.m. on 3/4/22. LPN 1 clocked in at 5:49 p.m. on 3/4 and clocked out at 6:30 a.m. on 3/5/22.

The time cards for 3/7/22 indicated RN 2 clocked in at 10:47 p.m. LPN 1 clocked in at 5:54 p.m. on 3/6 and clocked out at 6:39 a.m. on 3/7/22. RN 1 clocked in at 2:00 p.m. on 3/6 and clocked out at 3:20 a.m. on 3/7/22. QMA 2, who worked the Generations Unit, clocked in at 6:00 a.m. and clocked out at 6:36 p.m.

3. The record for Resident K was reviewed on 3/8/22 at 10:20 a.m. Diagnoses included, but were not limited to, stroke, diabetes, depression, high blood pressure, anxiety, seizure disorder, dementia, and psychosis.

Nurses' Notes, dated 2/22/22 at 5:39 a.m., indicated "Upon checking resident's blood sugar at 8:00 p.m., glucometer showed resident was hypoglycemic with a reading of 32. Resident was given a cup of orange juice, a chocolate chip cookie, a small serving of chocolate pudding, and an ice cream sandwich. Resident's

	blood sugar tested again at 9:40 p.m., and her reading was 98. At 1:20 a.m., resident's blood sugar was taken again with a reading of 235. Resident's insulin was given 15 units of Levemir and 14 units of Novolog. The nurse was made aware of situation and doctor faxed." The entry was documented by a QMA. Nurses' Notes, dated 2/23/22 at 7:42 a.m., "Notified by QMA via phone call that resident [name] sent to hospital, blood sugar was 330 when EMS arrived." There was no documentation or an assessment of the resident after she had received the insulins. Physician's Orders, dated 2/10/21, indicated Novolog insulin flexpen 10 units three times a day. Physician's Orders, dated 10/1/21 indicated 10/1/21 Levemir insulin 35 units every 7 a.m. and Levemir 30 units every 7 p.m. The order was discontinued on 2/22/22. Physician's Orders, dated 12/16/21, indicated Insulin Lispro per sliding scale before meals and at bed time.			

	Physician's Orders, dated 2/20/22 indicated Levemir insulin 15 units twice a day at 8:00 a.m., and 5:00 p.m. The Medication Administration Record (MAR) for 2/2022, indicated the administration times for the Novolog insulin flexpen were 8:00 a.m., 12:00 p.m. and 5:00 p.m. The administration times for the Lispro insulin was at 8:00 a.m., 11:00 a.m., 4:00 p.m., and 7:00 p.m. The administration times for the Levemir 15 units was at 8:00 a.m. and 5:00 p.m. There were no blood sugars documented for the 7:00 p.m., dose of the sliding scale Lispro insulin. The Levemir 15 units was signed out as being administered on 2/22/22 at 12:00 a.m. Physician's Orders, dated 3/2/22, indicated Novolog insulin flexpen 13 units at 7:30 a.m., 11:30 a.m., and 4:30 p.m. Physician's Orders dated 3/3/22, indicated Aspart insulin per sliding scale 0-150=0, 151-200=1 unit, 201-250=2 units, 251-300=3 units, 301-350=4 units, 351-400=5 units, and 401 and above=6 units. The MAR for 3/2022 indicated the resident did not receive the Novolog flexpen insulin on 3/4/22 at 7:30 a.m., 11:30 a.m.,			

and 4:30 a.m., and 3/5/22 at 7:30 a.m., and 11:30 a.m. The Levemir insulin was not administered on 3/4 at 4:30 p.m., and 3/5/22 at 7:30 a.m. and 3/6/22 at 4:30 p.m. The Aspart insulin per sliding scale was not administered on 3/4 at 11:30 a.m., and 4:30 p.m., 3/5 at 7:30 a.m., and 11:30 a.m., and on 3/6/22 at 4:30 p.m.

On 3/5/22 the resident's 4:30 p.m. blood sugar was 416 a high reading.

The MAR for 3/2022 indicated the resident did not receive her evening medication on 3/4/22 of Xanax, Levetiracetam, and Systane eye drops. On 3/5/22, the resident did not receive her morning medications of Namenda, Metformin, Levetiracetam, Losartan, Xanax, Risperidone, and Zoloft

Interview with the Resident Care Director from the sister facility on 3/9/22 at 11:30 a.m., indicated the medications were not signed out as being administered.

4. The record for Resident G was reviewed on 3/8/22 at 10:00 a.m. Diagnoses included, but were not limited to, dementia, COPD, diabetes, high blood pressure, osteoarthritis, and glaucoma.

The Medication Administration Record (MAR) for 2/2022,

	indicated the resident's Humulin Regular insulin was held on 2/2, 2/5, 2/14, and 2/16/22 at 7:00 a.m. There was no documentation of blood sugar readings or why the insulin was held. The MAR for 3/2022, indicated the resident did not receive any of his 7:30 a.m., or 8 a.m., medications of Allopurinol, Aspirin, Gabapentin, Loratadine, Metformin, and Rivastimine on 3/4/22. The resident did not receive Risperidone at 12:00 p.m. on 3/4/22. On 3/6/22 the resident did not receive the Humulin Regular insulin at 7:30 a.m. The evening medications of Latanoprost, Risperidone, Rivastimine, Melatonin Gabapentin, and Metformin were not administered on 3/7/22. A confidential interview with Employee 3 indicated there was no evening nurse working the "Assisted Living" side of the facility on 3/7/22. 5. The record for Resident J was reviewed on 3/9/22 at 10:35 a.m. Diagnoses included, but were not limited to, major depressive disorder, high blood pressure, glaucoma, diabetes, and congestive heart failure. Physician's Orders, dated 10/1/21, indicated Lantus 46 units twice a day (never hold			

Lantus) at 7:30 a.m., and 8 p.m.

Physician's Orders, dated 12/18/21, indicated Humalog insulin inject per sliding scale: blood sugar 201-250=6 units, 251-300=8 units, 301-350=10 units, 351-400=12 units greater than 400 call doctor.

The Medication Administration Record (MAR) for 2/2022 indicated the Humalog insulin was held and not administered on 2/2 and 2/6 at 7:30 a.m. There were no blood sugars documented on the MAR.

The 3/2022 MAR indicated the resident's Humalog and Lantus insulins were not signed as being administered on 3/3 and 3/6/22 at 7:30 a.m.

Interview with the Resident Care Director from the sister facility on 3/9/22 at 11:30 a.m., indicated the insulins were not signed out as being administered and there was no documentation of the blood sugars.

6. During an interview on 3/8/22 at 7:25 a.m., Resident M indicated her and her husband had been up all night due to her husband not receiving his medications for the last 3 days. "He has Alzheimer's and dementia and he gets really bad when he does not get his medications." The resident was worried about the facility

closing. She stated, "We are paying 6000.00 a month and are getting nothing for it."

The record for Resident H was reviewed on 3/8/22 at 9:00 a.m. Diagnoses included, but were not limited to, dementia without behaviors.

The 3/2022 Medication Administration Record (MAR) indicated the 8:00 a.m., and 12:00 p.m. medications of Tramadol, Naproxen, Namenda, Losartan, Gabapentin, Atenolol, and Cetirizine were not signed out as being administered on 3/4/22. The resident's evening medications of Gabapentin, Aricept, Melatonin, Naproxen, and Tramadol were not signed out as being administered on 3/7/22.

Interview with the Resident Care Director from the sister facility on 3/9/22 at 11:30 a.m., indicated the medications were not signed out as being administered.

This State Residential finding relates to Complaints IN00374578, IN00374674, IN00374823, IN00374827, and IN00374830.

Based on record review and interview, the facility failed to ensure medications were given as ordered and blood sugars were obtained as ordered for 6 of 7 residents reviewed for

	medication administration. The lack of medication administration and blood sugar monitoring resulted in elevated blood sugars and a resident being sent to the hospital for evaluation. (Residents B, L, K, G, J, and H) Findings include: 1. Interview with Resident B on 3/8/22 at 7:45 a.m., indicated she did not receive her medications several times last week and over the weekend due to no staff. The record for Resident B was reviewed on 3/8/22 at 7:14 a.m. Diagnoses included, but were not limited to, stage 3 chronic kidney disease, hypertension, hypothyroidism, high cholesterol, atrial fibrillation (an irregular heartbeat), type 2 diabetes, and adjustment disorder with mixed anxiety. The March 2022 Medication Administration Record (MAR), indicated the resident did not receive her medications on the following dates: - Atorvastatin (a medication for high cholesterol) 10 milligrams (mg) at 5:00 p.m. was not administered on 3/4 and 3/6/22. - Furosemide (a diuretic) 20 mg at 8:00 a.m. was not administered on 3/5/22.			

	- Glimepiride (a diabetic medication) 2 mg at 8:00 a.m. was not given on 3/5 and her 5:00 p.m. dose was not given on 3/4 and 3/6/22. - Levothyroxin (a thyroid medication) 50 micrograms (mcg) was not given at 8:00 a.m. on 3/5/22. - Magnesium Oxide 400 mg at 8:00 a.m. was not given on 3/5 and her 5:00 p.m. dose was not given on 3/4 and 3/6/22. - Meloxicam (an anti-inflammatory) 15 mg was not given on 3/5/22 at 8:00 a.m. - Metformin (a diabetic medication) 850 mg at 8:00 a.m. was not given on 3/5 and her 5:00 p.m. dose was not given on 3/4 and 3/6/22. - Metoprolol (a heart medication) 75 mg at 8:00 a.m. was not given on 3/5/22. - Potassium Chloride 10 milliequivalents (meq) at 8:00 a.m. was not given on 3/5/22. The Level of Care assessment, dated 11/10/21, indicated the resident required assistance with her medication up to 2 times daily. Interview with the Resident Care Director from a sister facility on 3/9/22 at 1:00 p.m., indicated the resident should have			

	received her medications as ordered. 2. The record for Resident L was reviewed on 3/9/22 at 9:21 a.m. Diagnoses included, but were not limited to, hypertension, rheumatoid arthritis, cardioverter-defibrillator, hyperlipidemia, congestive heart failure, stage 3 chronic kidney disease, anxiety, and bacteriuria. The March 2022 Medication Administration Record (MAR), indicated the resident did not receive her medications on the following dates: - Aspirin 81 milligrams (mg) was not given on 3/5/22 at 8:00 a.m. - Coreg (a heart medication) 25 mg at 8:00 a.m. was not given on 3/5 and her 5:00 p.m. dose was not given on 3/4 and 3/6/22. - Keflex (an antibiotic) 500 mg was not given at 8:00 a.m. on 3/5/22. - Lexapro (an antidepressant) 10 mg was not given at 8:00 a.m. on 3/5/22. - Furosemide (a diuretic) 40 mg was not given at 7:00 a.m. on 3/5/22. - Losartan Potassium (a blood pressure medication) 25 mg			

was not given at 8:00 a.m. on 3/5/22.

- Metformin (a diabetic medication) 500 mg was not given at 8:00 a.m. on 3/5/22.

- Metoprolol (a heart medication) 25 mg at 8:00 a.m. was not given on 3/5 and her 5:00 p.m. dose was not given on 3/4 and 3/6/22.

- Potassium Chloride 20 milliequivalents (meq) at 8:00 a.m. was not given on 3/5/22.

- Sotalol (a blood pressure medication) 120 mg at 8:00 a.m. was not given on 3/5 and her 5:00 p.m. dose was not given on 3/4 and 3/6/22.

- Spironolact (a blood pressure medication) 25 mg at 7:00 a.m. was not given on 3/5/22.

The Level of Care assessment, dated 2/22/22, indicated the resident required assistance with medications up to 2 times daily and she had memory impairment.

Interview with the Resident Care Director from a sister facility on 3/9/22 at 1:00 p.m., indicated the resident should have received her medications as ordered.

Confidential interview with Employee 3 indicated there have been many recent

occasions where the residents were not receiving their medications as ordered due to no staff scheduled or staff not showing up.

Confidential interview with Employee 4 indicated they had been approached by many residents indicating they were not receiving their medications for days at a time.

The time cards for 3/4/22 indicated RN 1 worked from 2:30 p.m. until 11:30 p.m. QMA 1 clocked in at 6:00 p.m. on 3/3 and clocked out at 9:12 a.m. on 3/4/22. LPN 1 clocked in at 5:49 p.m. on 3/4 and clocked out at 6:30 a.m. on 3/5/22.

The time cards for 3/7/22 indicated RN 2 clocked in at 10:47 p.m. LPN 1 clocked in at 5:54 p.m. on 3/6 and clocked out at 6:39 a.m. on 3/7/22. RN 1 clocked in at 2:00 p.m. on 3/6 and clocked out at 3:20 a.m. on 3/7/22. QMA 2, who worked the Generations Unit, clocked in at 6:00 a.m. and clocked out at 6:36 p.m.

3. The record for Resident K was reviewed on 3/8/22 at 10:20 a.m. Diagnoses included, but were not limited to, stroke, diabetes, depression, high blood pressure, anxiety, seizure disorder, dementia, and psychosis.

Nurses' Notes, dated 2/22/22 at

	5:39 a.m., indicated "Upon checking resident's blood sugar at 8:00 p.m., glucometer showed resident was hypoglycemic with a reading of 32. Resident was given a cup of orange juice, a chocolate chip cookie, a small serving of chocolate pudding, and an ice cream sandwich. Resident's blood sugar tested again at 9:40 p.m., and her reading was 98. At 1:20 a.m., resident's blood sugar was taken again with a reading of 235. Resident's insulin was given 15 units of Levemir and 14 units of Novolog. The nurse was made aware of situation and doctor faxed." The entry was documented by a QMA. Nurses' Notes, dated 2/23/22 at 7:42 a.m., "Notified by QMA via phone call that resident [name] sent to hospital, blood sugar was 330 when EMS arrived." There was no documentation or an assessment of the resident after she had received the insulins. Physician's Orders, dated 2/10/21, indicated Novolog insulin flexpen 10 units three times a day. Physician's Orders, dated 10/1/21 indicated 10/1/21 Levemir insulin 35 units every 7 a.m. and Levemir 30 units every 7 p.m. The order was			

discontinued on 2/22/22.

Physician's Orders, dated 12/16/21, indicated Insulin Lispro per sliding scale before meals and at bed time.

Physician's Orders, dated 2/20/22 indicated Levemir insulin 15 units twice a day at 8:00 a.m., and 5:00 p.m.

The Medication Administration Record (MAR) for 2/2022, indicated the administration times for the Novolog insulin flexpen were 8:00 a.m., 12:00 p.m. and 5:00 p.m. The administration times for the Lispro insulin was at 8:00 a.m., 11:00 a.m., 4:00 p.m., and 7:00 p.m. The administration times for the Levemir 15 units was at 8:00 a.m. and 5:00 p.m. There were no blood sugars documented for the 7:00 p.m., dose of the sliding scale Lispro insulin. The Levemir 15 units was signed out as being administered on 2/22/22 at 12:00 a.m.

Physician's Orders, dated 3/2/22, indicated Novolog insulin flexpen 13 units at 7:30 a.m., 11:30 a.m., and 4:30 p.m.

Physician's Orders dated 3/3/22, indicated Aspart insulin per sliding scale 0-150=0, 151-200=1 unit, 201-250=2 units, 251-300=3 units, 301-350=4 units, 351-400=5 units, and 401 and above=6

units.

The MAR for 3/2022 indicated the resident did not receive the Novolog flexpen insulin on 3/4/22 at 7:30 a.m., 11:30 a.m., and 4:30 a.m., and 3/5/22 at 7:30 a.m., and 11:30 a.m. The Levemir insulin was not administered on 3/4 at 4:30 p.m., and 3/5/22 at 7:30 a.m. and 3/6/22 at 4:30 p.m. The Aspart insulin per sliding scale was not administered on 3/4 at 11:30 a.m., and 4:30 p.m., 3/5 at 7:30 a.m., and 11:30 a.m., and on 3/6/22 at 4:30 p.m.

On 3/5/22 the resident's 4:30 p.m. blood sugar was 416 a high reading.

The MAR for 3/2022 indicated the resident did not receive her evening medication on 3/4/22 of Xanax, Levetiracetam, and Systane eye drops. On 3/5/22, the resident did not receive her morning medications of Namenda, Metformin, Levetiracetam, Losartan, Xanax, Risperidone, and Zoloft

Interview with the Resident Care Director from the sister facility on 3/9/22 at 11:30 a.m., indicated the medications were not signed out as being administered.

4. The record for Resident G was reviewed on 3/8/22 at 10:00 a.m. Diagnoses included, but were not limited to,

	dementia, COPD, diabetes, high blood pressure, osteoarthritis, and glaucoma. The Medication Administration Record (MAR) for 2/2022, indicated the resident's Humulin Regular insulin was held on 2/2, 2/5, 2/14, and 2/16/22 at 7:00 a.m. There was no documentation of blood sugar readings or why the insulin was held. The MAR for 3/2022, indicated the resident did not receive any of his 7:30 a.m., or 8 a.m., medications of Allopurinol, Aspirin, Gabapentin, Loratadine, Metformin, and Rivastimine on 3/4/22. The resident did not receive Risperidone at 12:00 p.m. on 3/4/22. On 3/6/22 the resident did not receive the Humulin Regular insulin at 7:30 a.m. The evening medications of Latanoprost, Risperidone, Rivastimine, Melatonin Gabapentin, and Metformin were not administered on 3/7/22. A confidential interview with Employee 3 indicated there was no evening nurse working the "Assisted Living" side of the facility on 3/7/22. 5. The record for Resident J was reviewed on 3/9/22 at 10:35 a.m. Diagnoses included, but were not limited to, major depressive disorder, high blood			

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Physician's Orders, dated 10/1/21, indicated Lantus 46 units twice a day (never hold Lantus) at 7:30 a.m., and 8 p.m.

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The Medication Administration Record (MAR) for 2/2022 indicated the Humalog insulin was held and not administered on 2/2 and 2/6 at 7:30 a.m. There were no blood sugars documented on the MAR.

The 3/2022 MAR indicated the resident's Humalog and Lantus insulins were not signed as being administered on 3/3 and 3/6/22 at 7:30 a.m.

Interview with the Resident Care Director from the sister facility on 3/9/22 at 11:30 a.m., indicated the insulins were not signed out as being administered and there was no documentation of the blood sugars.

6. During an interview on 3/8/22 at 7:25 a.m., Resident M indicated her and her husband had been up all night due to her husband not receiving his

	medications for the last 3 days. "He has Alzheimer's and dementia and he gets really bad when he does not get his medications." The resident was worried about the facility closing. She stated, "We are paying 6000.00 a month and are getting nothing for it." The record for Resident H was reviewed on 3/8/22 at 9:00 a.m. Diagnoses included, but were not limited to, dementia without behaviors. The 3/2022 Medication Administration Record (MAR) indicated the 8:00 a.m., and 12:00 p.m. medications of Tramadol, Naproxen, Namenda, Losartan, Gabapentin, Atenolol, and Cetirizine were not signed out as being administered on 3/4/22. The resident's evening medications of Gabapentin, Aricept, Melatonin, Naproxen, and Tramadol were not signed out as being administered on 3/7/22. Interview with the Resident Care Director from the sister facility on 3/9/22 at 11:30 a.m., indicated the medications were not signed out as being administered. This State Residential finding relates to Complaints IN00374578, IN00374674, IN00374823, IN00374827, and IN00374830.			

Based on record review and interview, the facility failed to ensure medications were given as ordered and blood sugars were obtained as ordered for 6 of 7 residents reviewed for medication administration. The lack of medication administration and blood sugar monitoring resulted in elevated blood sugars and a resident being sent to the hospital for evaluation. (Residents B, L, K, G, J, and H)

Findings include:

1. Interview with Resident B on 3/8/22 at 7:45 a.m., indicated she did not receive her medications several times last week and over the weekend due to no staff.

The record for Resident B was reviewed on 3/8/22 at 7:14 a.m. Diagnoses included, but were not limited to, stage 3 chronic kidney disease, hypertension, hypothyroidism, high cholesterol, atrial fibrillation (an irregular heartbeat), type 2 diabetes, and adjustment disorder with mixed anxiety.

The March 2022 Medication Administration Record (MAR), indicated the resident did not receive her medications on the following dates:

- Atorvastatin (a medication for high cholesterol) 10 milligrams (mg) at 5:00 p.m. was not

	administered on 3/4 and 3/6/22. - Furosemide (a diuretic) 20 mg at 8:00 a.m. was not administered on 3/5/22. - Glimepiride (a diabetic medication) 2 mg at 8:00 a.m. was not given on 3/5 and her 5:00 p.m. dose was not given on 3/4 and 3/6/22. - Levothyroxin (a thyroid medication) 50 micrograms (mcg) was not given at 8:00 a.m. on 3/5/22. - Magnesium Oxide 400 mg at 8:00 a.m. was not given on 3/5 and her 5:00 p.m. dose was not given on 3/4 and 3/6/22. - Meloxicam (an anti-inflammatory) 15 mg was not given on 3/5/22 at 8:00 a.m. - Metformin (a diabetic medication) 850 mg at 8:00 a.m. was not given on 3/5 and her 5:00 p.m. dose was not given on 3/4 and 3/6/22. - Metoprolol (a heart medication) 75 mg at 8:00 a.m. was not given on 3/5/22. - Potassium Chloride 10 milliequivalents (meq) at 8:00 a.m. was not given on 3/5/22. The Level of Care assessment, dated 11/10/21, indicated the resident required assistance with her medication up to 2			

times daily.

Interview with the Resident Care Director from a sister facility on 3/9/22 at 1:00 p.m., indicated the resident should have received her medications as ordered.

2. The record for Resident L was reviewed on 3/9/22 at 9:21 a.m. Diagnoses included, but were not limited to, hypertension, rheumatoid arthritis, cardioverter-defibrillator, hyperlipidemia, congestive heart failure, stage 3 chronic kidney disease, anxiety, and bacteriuria.

The March 2022 Medication Administration Record (MAR), indicated the resident did not receive her medications on the following dates:

- Aspirin 81 milligrams (mg) was not given on 3/5/22 at 8:00 a.m.

- Coreg (a heart medication) 25 mg at 8:00 a.m. was not given on 3/5 and her 5:00 p.m. dose was not given on 3/4 and 3/6/22.

- Keflex (an antibiotic) 500 mg was not given at 8:00 a.m. on 3/5/22.

- Lexapro (an antidepressant) 10 mg was not given at 8:00 a.m. on 3/5/22.

	- Furosemide (a diuretic) 40 mg was not given at 7:00 a.m. on 3/5/22. - Losartan Potassium (a blood pressure medication) 25 mg was not given at 8:00 a.m. on 3/5/22. - Metformin (a diabetic medication) 500 mg was not given at 8:00 a.m. on 3/5/22. - Metoprolol (a heart medication) 25 mg at 8:00 a.m. was not given on 3/5 and her 5:00 p.m. dose was not given on 3/4 and 3/6/22. - Potassium Chloride 20 milliequivalents (meq) at 8:00 a.m. was not given on 3/5/22. - Sotalol (a blood pressure medication) 120 mg at 8:00 a.m. was not given on 3/5 and her 5:00 p.m. dose was not given on 3/4 and 3/6/22. - Spironolact (a blood pressure medication) 25 mg at 7:00 a.m. was not given on 3/5/22. The Level of Care assessment, dated 2/22/22, indicated the resident required assistance with medications up to 2 times daily and she had memory impairment. Interview with the Resident Care Director from a sister facility on 3/9/22 at 1:00 p.m., indicated the resident should have			

	received her medications as ordered. Confidential interview with Employee 3 indicated there have been many recent occasions where the residents were not receiving their medications as ordered due to no staff scheduled or staff not showing up. Confidential interview with Employee 4 indicated they had been approached by many residents indicating they were not receiving their medications for days at a time. The time cards for 3/4/22 indicated RN 1 worked from 2:30 p.m. until 11:30 p.m. QMA 1 clocked in at 6:00 p.m. on 3/3 and clocked out at 9:12 a.m. on 3/4/22. LPN 1 clocked in at 5:49 p.m. on 3/4 and clocked out at 6:30 a.m. on 3/5/22. The time cards for 3/7/22 indicated RN 2 clocked in at 10:47 p.m. LPN 1 clocked in at 5:54 p.m. on 3/6 and clocked out at 6:39 a.m. on 3/7/22. RN 1 clocked in at 2:00 p.m. on 3/6 and clocked out at 3:20 a.m. on 3/7/22. QMA 2, who worked the Generations Unit, clocked in at 6:00 a.m. and clocked out at 6:36 p.m. 3. The record for Resident K was reviewed on 3/8/22 at 10:20 a.m. Diagnoses included, but were not limited to, stroke,			

diabetes, depression, high blood pressure, anxiety, seizure disorder, dementia, and psychosis.

Nurses' Notes, dated 2/22/22 at 5:39 a.m., indicated "Upon checking resident's blood sugar at 8:00 p.m., glucometer showed resident was hypoglycemic with a reading of 32. Resident was given a cup of orange juice, a chocolate chip cookie, a small serving of chocolate pudding, and an ice cream sandwich. Resident's blood sugar tested again at 9:40 p.m., and her reading was 98. At 1:20 a.m., resident's blood sugar was taken again with a reading of 235. Resident's insulin was given 15 units of Levemir and 14 units of Novolog. The nurse was made aware of situation and doctor faxed." The entry was documented by a QMA.

Nurses' Notes, dated 2/23/22 at 7:42 a.m., "Notified by QMA via phone call that resident [name] sent to hospital, blood sugar was 330 when EMS arrived."

There was no documentation or an assessment of the resident after she had received the insulins.

Physician's Orders, dated 2/10/21, indicated Novolog insulin flexpen 10 units three times a day.

	Physician's Orders, dated 10/1/21 indicated 10/1/21 Levemir insulin 35 units every 7 a.m. and Levemir 30 units every 7 p.m. The order was discontinued on 2/22/22. Physician's Orders, dated 12/16/21, indicated Insulin Lispro per sliding scale before meals and at bed time. Physician's Orders, dated 2/20/22 indicated Levemir insulin 15 units twice a day at 8:00 a.m., and 5:00 p.m. The Medication Administration Record (MAR) for 2/2022, indicated the administration times for the Novolog insulin flexpen were 8:00 a.m., 12:00 p.m. and 5:00 p.m. The administration times for the Lispro insulin was at 8:00 a.m., 11:00 a.m., 4:00 p.m., and 7:00 p.m. The administration times for the Levemir 15 units was at 8:00 a.m. and 5:00 p.m. There were no blood sugars documented for the 7:00 p.m., dose of the sliding scale Lispro insulin. The Levemir 15 units was signed out as being administered on 2/22/22 at 12:00 a.m. Physician's Orders, dated 3/2/22, indicated Novolog insulin flexpen 13 units at 7:30 a.m., 11:30 a.m., and 4:30 p.m. Physician's Orders dated 3/3/22, indicated Aspart insulin			

	per sliding scale 0-150=0, 151-200=1 unit, 201-250=2 units, 251-300=3 units, 301-350=4 units, 351-400=5 units, and 401 and above=6 units. The MAR for 3/2022 indicated the resident did not receive the Novolog flexpen insulin on 3/4/22 at 7:30 a.m., 11:30 a.m., and 4:30 a.m., and 3/5/22 at 7:30 a.m., and 11:30 a.m. The Levemir insulin was not administered on 3/4 at 4:30 p.m., and 3/5/22 at 7:30 a.m. and 3/6/22 at 4:30 p.m. The Aspart insulin per sliding scale was not administered on 3/4 at 11:30 a.m., and 4:30 p.m., 3/5 at 7:30 a.m., and 11:30 a.m., and on 3/6/22 at 4:30 p.m. On 3/5/22 the resident's 4:30 p.m. blood sugar was 416 a high reading. The MAR for 3/2022 indicated the resident did not receive her evening medication on 3/4/22 of Xanax, Levetiracetam, and Systane eye drops. On 3/5/22, the resident did not receive her morning medications of Namenda, Metformin, Levetiracetam, Losartan, Xanax, Risperidone, and Zoloft Interview with the Resident Care Director from the sister facility on 3/9/22 at 11:30 a.m., indicated the medications were not signed out as being			

administered.

4. The record for Resident G was reviewed on 3/8/22 at 10:00 a.m. Diagnoses included, but were not limited to, dementia, COPD, diabetes, high blood pressure, osteoarthritis, and glaucoma.

The Medication Administration Record (MAR) for 2/2022, indicated the resident's Humulin Regular insulin was held on 2/2, 2/5, 2/14, and 2/16/22 at 7:00 a.m. There was no documentation of blood sugar readings or why the insulin was held.

The MAR for 3/2022, indicated the resident did not receive any of his 7:30 a.m., or 8 a.m., medications of Allopurinol, Aspirin, Gabapentin, Loratadine, Metformin, and Rivastimine on 3/4/22. The resident did not receive Risperidone at 12:00 p.m. on 3/4/22. On 3/6/22 the resident did not receive the Humulin Regular insulin at 7:30 a.m. The evening medications of Latanoprost, Risperidone, Rivastimine, Melatonin Gabapentin, and Metformin were not administered on 3/7/22.

A confidential interview with Employee 3 indicated there was no evening nurse working the "Assisted Living" side of the facility on 3/7/22.

	5. The record for Resident J was reviewed on 3/9/22 at 10:35 a.m. Diagnoses included, but were not limited to, major depressive disorder, high blood pressure, glaucoma, diabetes, and congestive heart failure. Physician's Orders, dated 10/1/21, indicated Lantus 46 units twice a day (never hold Lantus) at 7:30 a.m., and 8 p.m. Physician's Orders, dated 12/18/21, indicated Humalog insulin inject per sliding scale: blood sugar 201-250=6 units, 251-300=8 units, 301-350=10 units, 351-400=12 units greater than 400 call doctor. The Medication Administration Record (MAR) for 2/2022 indicated the Humalog insulin was held and not administered on 2/2 and 2/6 at 7:30 a.m. There were no blood sugars documented on the MAR. The 3/2022 MAR indicated the resident's Humalog and Lantus insulins were not signed as being administered on 3/3 and 3/6/22 at 7:30 a.m. Interview with the Resident Care Director from the sister facility on 3/9/22 at 11:30 a.m., indicated the insulins were not signed out as being administered and there was no documentation of the blood sugars.			

	6. During an interview on 3/8/22 at 7:25 a.m., Resident M indicated her and her husband had been up all night due to her husband not receiving his medications for the last 3 days. "He has Alzheimer's and dementia and he gets really bad when he does not get his medications." The resident was worried about the facility closing. She stated, "We are paying 6000.00 a month and are getting nothing for it." The record for Resident H was reviewed on 3/8/22 at 9:00 a.m. Diagnoses included, but were not limited to, dementia without behaviors. The 3/2022 Medication Administration Record (MAR) indicated the 8:00 a.m., and 12:00 p.m. medications of Tramadol, Naproxen, Namenda, Losartan, Gabapentin, Atenolol, and Cetirizine were not signed out as being administered on 3/4/22. The resident's evening medications of Gabapentin, Aricept, Melatonin, Naproxen, and Tramadol were not signed out as being administered on 3/7/22. Interview with the Resident Care Director from the sister facility on 3/9/22 at 11:30 a.m., indicated the medications were not signed out as being administered.			

	This State Residential finding relates to Complaints IN00374578, IN00374674, IN00374823, IN00374827, and IN00374830.			
R 0268	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(a) (a) The facility shall provide, arrange, or make available three (3) well-planned meals a day, seven (7) days a week that provide a balanced distribution of the daily nutritional requirements. Based on interview and record review, the facility failed to ensure all residents received an adequate meal including modified diets. This had the potential to affect 88 residents residing in the facility. Finding includes: A confidential interview with Employees 1 and 2 indicated a couple of weeks ago, the evening cook did not show up for work and the residents were served Jimmy Johns sandwiches and potato chips. Both staff members indicated the residents who received soft and pureed diets did not eat that evening. Interview with Dietary Server 1 on 3/8/22 at 6:15 a.m., indicated last month the cook for an	R 0268	Care team members will be educated on GP16 Narrative Charting and GP17 Alert Charting policies including elopement, falls and death. 2. Narrative charting will be maintained to promote clear communication regarding resident care. It is Integral Senior Living's policy to chart to the exception. Narrative charting will be completed in Resident Care Notes within Eldermark. 3. Alert charting will be implemented for residents who have had a recent change in their expected or customary function or other reason that initiates a need for closer monitoring. HOW WILL YOU ENSURE ONGOING COMPLIANCE, INCLUDE TIMEFRAMES, DEADLINES 1. Dietary Communication forms will be required for all new admissions, will be	04/25/2022

	evening shift did not show up and the staff bought the residents Jimmy Johns sandwiches. The server indicated there were other dietary staff at the facility that night, just no cook. Interview with the Culinary Manager on 3/8/22 at 9:10 a.m., indicated his first day was supposed to be on 2/22/22, however, he came into the facility on Monday 2/21/22 around 7 p.m., the day the residents were served Jimmy Johns. He came in and they had already been served. He did not know if everyone ate that evening, however, he indicated soft diets could have had tuna or chicken salad and pureed diets could have had yogurt which was available. Interview with the Resident Care Director from a sister facility on 3/9/22 at 2:00 p.m., indicated there were 3 residents who received a pureed diet and 1 resident who received a soft ground meat diet. Review of the monthly menus for February & March 2022 indicated every Monday had soup, sandwich, a vegetable and dessert listed for dinner. This State Residential finding relates to Complaints IN00374578, IN00374674, IN00374823, and IN00374830.		changed based on the resident change of condition per based on the physician order signed off by the resident's physician. 2. Will be reviewed by Culinary Service Director or representative and any dietary concerns will be reported to the resident's primary care physician. 3. Dietary communication forms will be made readily available for all culinary staff and dietary concerns will be reported daily clinical meeting. This will be monitored for the next 30-days and ongoing based on each resident's personal care needs. Alternative emergency culinary menu to implement in the absence of a cook to ensure appropriate meals are provided for all residents. PERSON RESPONSIBLE FOR IMPLEMENTING THE ACTION PLAN AND ENSURING COMPLIANCE Culinary Service Director or representative. DATE OF IMPLEMENTATION AND FOLLOW UP 03/09/2022 and completion by	

	Based on interview and record review, the facility failed to ensure all residents received an adequate meal including modified diets. This had the potential to affect 88 residents residing in the facility. Finding includes: A confidential interview with Employees 1 and 2 indicated a couple of weeks ago, the evening cook did not show up for work and the residents were served Jimmy Johns sandwiches and potato chips. Both staff members indicated the residents who received soft and pureed diets did not eat that evening. Interview with Dietary Server 1 on 3/8/22 at 6:15 a.m., indicated last month the cook for an evening shift did not show up and the staff bought the residents Jimmy Johns sandwiches. The server indicated there were other dietary staff at the facility that night, just no cook. Interview with the Culinary Manager on 3/8/22 at 9:10 a.m., indicated his first day was supposed to be on 2/22/22, however, he came into the facility on Monday 2/21/22 around 7 p.m., the day the residents were served Jimmy Johns. He came in and they had already been served. He did not		4/30/202	

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R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible.	R 0349	1. Care team members will be educated on GP16 Narrative Charting and GP17 Alert Charting policies. 2. Narrative charting will be maintained to promote clear communication regarding resident care. It is Integral Senior Living's policy to chart to the exception. Narrative charting will be completed in Resident Care Notes within Eldermark.	04/25/2022

(4) Systematically organized.

Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to an elopement for 1 of 3 residents reviewed for accidents (Resident D) and a death for 1 of 1 residents reviewed for death. (Resident E)

Findings include:

1. The record for Resident D was reviewed on 3/8/22 at 9:55 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, hallucinations, anxiety, major depression, and restlessness and agitation.

Nurses' Notes, dated 12/11/21 at 7:31 a.m., indicated on 12/10/21 at approximately 6:45 p.m., the facility had received a phone call from the long term care (LTC) facility next door indicating the resident was at their facility stating she had been kicked out of the building and she was waiting for her son and husband to pick her up. Staff were sent to the LTC facility to assist the resident back to the building, the resident refused to leave stating she was waiting for her son and husband to pick her up. The Executive Director and the resident's son were notified.

3. Alert charting will be implemented for residents who have had a recent change in their expected or customary function or other reason that initiates a need for closer monitoring.

HOW WILL YOU ENSURE ONGOING COMPLIANCE, INCLUDE TIMEFRAMES, DEADLINES

1. Care team members will be educated on GP16 Narrative Charting and GP17 Alert Charting policies

2. Narrative charting will be maintained to promote clear communication regarding resident care. It is Integral Senior Living’s policy to chart to the exception.
Narrative charting will be completed in Resident Care Notes within Eldermark.

3. Alert charting will be implemented for residents who have had a recent change in their expected or customary function or other reason that initiates a need for closer monitoring.

4. Nurse to Medtech Binder, End of Shift Binder for care staff will be reviewed and monitored at the daily clinical meeting for 30-days and monitored

	Shortly afterwards, the resident and staff returned to the facility. No injuries were noted and the resident was provided with one to one care until her son arrived. The resident was placed on 30 minute checks and her son stayed with her until 9:30 p.m. There was no documentation of the elopement on 12/10/21. There was also no further documentation in the Nurses' Notes after 7:31 a.m. on 12/11/21. Nurses' Notes, dated 12/12/21 at 12:54 a.m., indicated the resident was out with her family until approximately 8:00 p.m. The resident's son was given a pendant to put on her ankle, he preferred to have it in her purse. The resident remained in her apartment with checks, watching television, and doing crafts. The next documented entry in the nursing progress notes was on 12/15/21 at 4:49 a.m. The note indicated toward mid shift, the resident was becoming belligerent and demanding staff open the doors for her so she could leave. The resident was told that she could not leave the facility at that time of night. The resident began shaking the doors and demanding they be opened. The resident was not able to be redirected and the		ongoing. PERSON RESPONSIBLE FOR IMPLEMENTING THE ACTION PLAN AND ENSURING COMPLIANCE Executive Director or representative. DATE OF IMPLEMENTATION AND FOLLOW UP 03/09/2022 and completion by 4/30/202	

behavior continued for approximately 30 minutes. The resident's son was notified around 3:10 a.m. and he arrived to the facility at 3:45 a.m. and escorted the resident back to her apartment.

Interview with the Resident Care Director from a sister facility on 3/9/22 at 12:08 p.m., indicated documentation should have been completed on 12/10/21 when the resident eloped and follow up documentation should have been completed after the incident.

2. The record for Resident E was reviewed on 3/8/22 at 9:39 a.m. Diagnoses included, but were not limited to, dementia, Alzheimer's disease, diabetes, high cholesterol, hypertension, and depression.

An "Exception Charting" form, dated 10/3/21 (no time), indicated the resident slid out of her wheelchair onto her back side. Her husband was present and indicated she didn't hit her head. The resident was assessed and no injuries were noted and she had no signs or symptoms of pain.

There was no documentation of the fall in the nursing progress notes.

The State Provisional Notification of Death-Burial Transit Permit, dated 10/4/21,

indicated the resident had passed away at the facility at 7:30 a.m.

There was no documentation in the nursing progress notes related to the resident's death.

Interview with the Resident Care Director from a sister facility on 3/9/22 at 1:00 p.m., indicated documentation should have been completed related to both the resident's fall and death.

This State Residential finding relates to Complaint IN00374674.

Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to an elopement for 1 of 3 residents reviewed for accidents (Resident D) and a death for 1 of 1 residents reviewed for death. (Resident E)

Findings include:

1. The record for Resident D was reviewed on 3/8/22 at 9:55 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, hallucinations, anxiety, major depression, and restlessness and agitation.

Nurses' Notes, dated 12/11/21 at 7:31 a.m., indicated on 12/10/21 at approximately 6:45

p.m., the facility had received a phone call from the long term care (LTC) facility next door indicating the resident was at their facility stating she had been kicked out of the building and she was waiting for her son and husband to pick her up. Staff were sent to the LTC facility to assist the resident back to the building, the resident refused to leave stating she was waiting for her son and husband to pick her up. The Executive Director and the resident's son were notified. Shortly afterwards, the resident and staff returned to the facility. No injuries were noted and the resident was provided with one to one care until her son arrived. The resident was placed on 30 minute checks and her son stayed with her until 9:30 p.m.

There was no documentation of the elopement on 12/10/21.

There was also no further documentation in the Nurses' Notes after 7:31 a.m. on 12/11/21.

Nurses' Notes, dated 12/12/21 at 12:54 a.m., indicated the resident was out with her family until approximately 8:00 p.m. The resident's son was given a pendant to put on her ankle, he preferred to have it in her purse. The resident remained in her apartment with checks, watching television, and doing

crafts.

The next documented entry in the nursing progress notes was on 12/15/21 at 4:49 a.m. The note indicated toward mid shift, the resident was becoming belligerent and demanding staff open the doors for her so she could leave. The resident was told that she could not leave the facility at that time of night. The resident began shaking the doors and demanding they be opened. The resident was not able to be redirected and the behavior continued for approximately 30 minutes. The resident's son was notified around 3:10 a.m. and he arrived to the facility at 3:45 a.m. and escorted the resident back to her apartment.

Interview with the Resident Care Director from a sister facility on 3/9/22 at 12:08 p.m., indicated documentation should have been completed on 12/10/21 when the resident eloped and follow up documentation should have been completed after the incident.

2. The record for Resident E was reviewed on 3/8/22 at 9:39 a.m. Diagnoses included, but were not limited to, dementia, Alzheimer's disease, diabetes, high cholesterol, hypertension, and depression.

An "Exception Charting" form,

dated 10/3/21 (no time), indicated the resident slid out of her wheelchair onto her back side. Her husband was present and indicated she didn't hit her head. The resident was assessed and no injuries were noted and she had no signs or symptoms of pain.

There was no documentation of the fall in the nursing progress notes.

The State Provisional Notification of Death-Burial Transit Permit, dated 10/4/21, indicated the resident had passed away at the facility at 7:30 a.m.

There was no documentation in the nursing progress notes related to the resident's death.

Interview with the Resident Care Director from a sister facility on 3/9/22 at 1:00 p.m., indicated documentation should have been completed related to both the resident's fall and death.

This State Residential finding relates to Complaint IN00374674.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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