STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/02/2022

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

(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 IN00382184, IN00383132, and IN00383783. Complaint IN00382184 - Substantiated. State deficiencies related to the allegations are cited at R029, R216, and R240. Complaint IN00383132 - Substantiated. State deficiencies related to the allegations are cited at R052. Complaint IN00383783 - Substantiated. No deficiencies related to the allegations are cited. Survey date: July 2, 2022 Facility number: 011799 Residential Census: 94 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000		

	Quality review completed on July 7, 2022			
R 0029	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(d) (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on interview and record reviewed, the facility failed to promote a dignified existence during verbal interaction and care for 4 of 4 residents reviewed for resident's rights. (Residents C, D, K, and one anonymous resident) Findings include: 1. The clinical record for Resident C was reviewed on 7/2/2022 at 4:03 p.m. The medical diagnoses included, but were not limited to, heart disease and arthritis. A cognitive examination completed on 4/23/2020, indicated Resident C was cognitively intact. An interview with Resident C on 7/2/2022 at 12:20 p.m., indicated she felt that staff were rude, dismissive, and "verbally abusive". She stated QMA 6 was the preparator that would be "verbally abusive" to her. When asked to elaborate on the	R 0029	**This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of Greenbriar Village as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or**	08/05/2022

	verbal abuse, Resident C indicated that QMA 6 would ignore her and instruct other staff members to not give Resident C care. When Resident C would ask QMA 6 for assistance, QMA 6 would not assist her. When QMA 6 answered her call light, she would slam her door. Resident C denied QMA 6 ever yelling at her or calling her derogatory names, but stated she was "terrified of [QMA 6] escalating or getting even more hostile". 2. The clinical record for Resident D was reviewed on 7/2/2022 at 4:34 p.m. The medical diagnoses included, but were not limited to, anxiety and pain. An interview with Resident D on 7/2/2022 at 1:33 p.m. indicated there were two staff that she had issues with their attitudes. She indicated QMA 6 and QMA 8 were rude with their interactions. She recalled one event "a month or two ago" where QMA 6 was administering her medications. When Resident D asked a question regarding her medicine, QMA 6 stated, "I am over you asking me questions" and left the medications on the table in the apartment. QMA 6 then "huffed out of the room and slammed the door". On another occasion		**criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.** · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; . What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; . How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program	

	about two months ago, Resident D went to ask QMA 6 a question. In response QMA 6 stated that she "didn't have to deal with this and was leaving", before going outside. Resident D indicated that QMA 8 was just always short and rude to her but did not have specific details or events. 3. The clinical record for Resident K was reviewed on 7/2/2022 at 5:52 p.m. The medical diagnoses included, but were not limited to, dysphagia and insomnia. An interview with Resident K on 7/2/2022 at 4:53 p.m. indicated that QMA 8 would enter her room and not speak to her. When Resident K asked QMA 8 a question, QMA 8 "huffs and puffs" in disregard.		will be put into place?; and . By the date, the systemic changes will be completed. R 029 1. Residents C, D, and K are being treated with dignity during verbal interactions and care. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. On July 5, 2022, all staff were in-serviced on treating residents with dignity during verbal interactions and care. In addition, residents were educated on Resident Rights	

	4. An anonymous interview was completed on 7/2/2022 at 1:15 p.m. The interviewee stated that QMA 6 is often rude to her, moaning about how her back hurts, and that she does not have time to help. The interviewee stated that QMA 6's demeanor is very rude and dismissive, that when she passes medications, she will bring them in without saying a word and shove them at the interviewee or just leave them sitting on the counter. The interviewee indicated this is an ongoing issue. A policy entitled, "Health Related Services Ops Manual", was provided by the Executive Director on 7/2/2022 at 5:00 p.m. This policy indicated, " ...at all times, the principles of choice, dignity, privacy, independence, individuality and a home-like setting, which should be supported by all Community Team Members ..." This Residential tag relates to Complaint IN00382184. Based on interview and record reviewed, the facility failed to promote a dignified existence during verbal interaction and care for 4 of 4 residents reviewed for resident's rights. (Residents C, D, K, and one anonymous resident) Findings include:		and Greivance Policy at meeting with Ombudsman on Julu 28, 2022, and Resident Council Meeting on August 1, 2022. 4. The Executive Director or designee will review all grievances in morning meetings Monday – Friday. In addition, Resident Council Meeting document any issues monthly. 5. Systemic changes will be completed: August 5, 2022	

	1. The clinical record for Resident C was reviewed on 7/2/2022 at 4:03 p.m. The medical diagnoses included, but were not limited to, heart disease and arthritis. A cognitive examination completed on 4/23/2020, indicated Resident C was cognitively intact. An interview with Resident C on 7/2/2022 at 12:20 p.m., indicated she felt that staff were rude, dismissive, and "verbally abusive". She stated QMA 6 was the preparator that would be "verbally abusive" to her. When asked to elaborate on the verbal abuse, Resident C indicated that QMA 6 would ignore her and instruct other staff members to not give Resident C care. When Resident C would ask QMA 6 for assistance, QMA 6 would not assist her. When QMA 6 answered her call light, she would slam her door. Resident C denied QMA 6 ever yelling at her or calling her derogatory names, but stated she was "terrified of [QMA 6] escalating or getting even more hostile". 2. The clinical record for Resident D was reviewed on 7/2/2022 at 4:34 p.m. The medical diagnoses included, but were not limited to, anxiety and			

	pain. An interview with Resident D on 7/2/2022 at 1:33 p.m. indicated there were two staff that she had issues with their attitudes. She indicated QMA 6 and QMA 8 were rude with their interactions. She recalled one event "a month or two ago" where QMA 6 was administering her medications. When Resident D asked a question regarding her medicine, QMA 6 stated, "I am over you asking me questions" and left the medications on the table in the apartment. QMA 6 then "huffed out of the room and slammed the door". On another occasion about two months ago, Resident D went to ask QMA 6 a question. In response QMA 6 stated that she "didn't have to deal with this and was leaving", before going outside. Resident D indicated that QMA 8 was just always short and rude to her but did not have specific details or events. 3. The clinical record for Resident K was reviewed on 7/2/2022 at 5:52 p.m. The medical diagnoses included, but were not limited to, dysphagia and insomnia. An interview with Resident K on 7/2/2022 at 4:53 p.m. indicated that QMA 8 would enter her room and not speak to her. When Resident K asked QMA 8			

	a question, QMA 8 "huffs and puffs" in disregard. 4. An anonymous interview was completed on 7/2/2022 at 1:15 p.m. The interviewee stated that QMA 6 is often rude to her, moaning about how her back hurts, and that she does not have time to help. The interviewee stated that QMA 6's demeanor is very rude and dismissive, that when she passes medications, she will bring them in without saying a word and shove them at the interviewee or just leave them sitting on the counter. The interviewee indicated this is an ongoing issue. A policy entitled, "Health Related Services Ops Manual", was provided by the Executive Director on 7/2/2022 at 5:00 p.m. This policy indicated, " ...at all times, the principles of choice, dignity, privacy, independence, individuality and a home-like setting, which should be supported by all Community Team Members ..." This Residential tag relates to Complaint IN00382184.			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from:	R 0052	R 052 1. Resident B is not left in a room that is locked. Residents G, H, and J	08/05/2022

	(1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview, and record review, the facility failed to ensure a resident was not left in a room that was locked (Resident B) and failed to ensure a child lock device was not in place to the door handles of 2 apartments for the potential to affect 3 residents (Residents G, H and J). Findings include: 1. The clinical record for Resident B was reviewed on 7/2/22 at 4:00 p.m. The diagnosis included, but was not limited to, dementia. A SLUMS (Saint Louis University Mental Status) Examination, dated 1/10/22, listed a score indicative of dementia. A service plan, dated 4/13/22, indicated Resident B had moderate cognitive impairment, was to reside on a secured unit, was independent with ambulation, and needed		child locks were removed from their doors. In addition, CNA 2 is no longer employed by the Community and Caregiver 3 received disciplinary action and was in-serviced on residents rights. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. The Community inspected all resident's room for restraints. In addition the Executive Director and/or Wellness Director initated an all staff in-service regarding abuse. 4. The Magnolia Trails Director or designee will audit the memory care for child locks weekly x for 4 weeks, then monthly thereafter x 5 months. 5. Systemic changes will be completed: August 5, 2022	

	minimal assistance with bathing, personal hygiene, dressing, and toileting.			

	An incident reported to the Indiana State Department of Health survey report system, dated 6/16/22, indicated the following, "...[name of Resident B]...Staff Involved...[name of Certified Nursing Assistant 2]...[name of Caregiver 3]...Brief Description of Incident...Memory Care Director came in at approximately 8am [sic] to find an item of [name of Resident B's] door preventing her from leaving her room with [name of Caregiver 3] sitting outside her door guarding. [Name of Certified Nursing Assistant 2] had placed a childproof device on the door to prevent the resident from leaving her room as she has COVID and was continuing to come out...Follow up...Surveillance confirmed resident came out of her room 4 times while nursing was attempting to pass meal trays. Resident was redirected momentarily, but due to resident's cognition, resident would not remain in her room. Staff [name of Certified Nursing Assistant 2] admits to putting the device on the door and telling the Activity Worker [name of Caregiver 3] to watch even though she knew it was against the abuse policy...[Name of Certified Nursing Assistant 2] was terminated...." The investigative file was reviewed for the incident involving Resident B on 7/2/22			

at 12:04 p.m.

A written statement by Caregiver 3, dated 6/16/22, indicated the following, "...I came in this morning and was told there was COVID in Memory Care. I texted [name of Memory Care Director] on what the breakfast situation and so on was going to look like [sic]. She told me room trays and they were to eat in their rooms. I helped make plates and as we were moving down the hallway the other CNA [name of Certified Nursing Assistant 2] put a type of baby lock on a resident's door [name of Resident B] while she fed two other residents in a COVID quaratine [sic] room. She told me to sit in the hallway and she would take the baby lock off after she was done eating. It felt off but I wasn't sure and was told shortly after that it is not acceptable and is not apart of COVID protocals [sic]." The statement was signed by Caregiver 3.

A written statement by the Memory Care Director (MCD), dated 6/16/22, indicated the following, "...This writer witnessed at approx. [approximately] 8am that there was an item on [name of Resident B] door. When writer asked CNA [CNA 2] and shift employee [Caregiver 3] why the item was on the resident's door

knob [sic], the CNA stated she put the item on the resident's door because the resident is COVID positive and would not stay in her room. This writer contacted the Executive Director [symbol for and] the Director of Nursing immediately, and removed the item off of the door within minutes of noticing." The statement was signed by the MCD.

A written statement by CNA 2, dated 6/16/22, indicated the following, "...Removed a child proof lock off another door placed it on another door [name of Resident B door] ask the activit [sic] worker to could she sit there while I went to get the rooms [sic] trays. The lock fell off as soon as the door was open. Came back a few minutes later and the lock was off the door as well. The activities work [sic] said it fell off and put the lock in the shelve [sic] and remain feeding [sic]." The statement was signed by CNA 2.

A "Corrective Action Form", dated 6/20/22, indicated CNA 2 was terminated for violation of the company's abuse policy for placing a child lock on the door of a resident in attempt to keep her in her room.

The video recording of the incident occurring on 6/16/22, outside of the common area

	outside of Resident B's room was reviewed on 7/2/22 at 2:40 p.m. The ED indicated the time on the camera footage was 37 minutes ahead of the standard time. The following was noted: - 7:47 a.m.- Resident B came out of her room, - 7:56 a.m.- Resident B came out of her room again, - 7:59 a.m.- CNA 2 went in Resident B's room, - 8:04 a.m.- Resident B came out of her room again, - 8:10 a.m.- Resident B came out of her room again, - 8:20 a.m.- Resident B came out of her room again, - 8:22 a.m.- Resident B came out of her room again, - 8:24 a.m.- CNA 2 was observed standing by Resident B's door for a period of time. ED indicated this was when she believes the child lock was placed on Resident B's door. - 8:29 a.m.- CNA 10 was observed standing outside of Resident B's door but didn't open it. - 8:39 a.m.- Caregiver 3 took a chair to sit outside of Resident B's room.			

	- 8:45 a.m.- MCD comes onto the unit. - 8:46 a.m.- Caregiver 3 observed looking through the window of Resident B's room. - 8:56 a.m.- Nurse 11 observed outside of Resident B's room but door didn't open. - 9:05 a.m.- MCD removed the child lock device to Resident B's door, per the ED. An interview conducted with the ED, on 7/2/22 at 2:46 p.m., indicated the child lock device did not just fall off. The MCD had to physically remove it. 2. A tour was conducted of the first floor of the Memory Care Unit on 7/2/22 at 10:05 a.m. An apartment that housed Resident H and Resident J was noted with a lock device to the door handle that wasn't engaged at the time of observation. If the device was engaged, it could potentially prohibit the ability for someone to open the door. A button would need to be pressed to activate an arm to move across and ensure the door handle cannot move up or down. CNA 12 indicated a resident in that room could open the door when the lock was engaged. The lock was to ensure residents do not wander into their room during the night. The tour continued onto the 2nd floor of the Memory Care Unit.			

	An apartment that housed Resident G also had a lock device that wasn't engaged during the time of observation but could potentially prohibit the ability for someone to open the door handle if it was engaged. It was the same lock device that was observed on Resident H and J's apartment door. An interview conducted with the ED, on 7/2/22 at 11:05 a.m., indicated she was not aware there were child locks still present on the door handles to resident apartments. 2a. Resident G's clinical record was reviewed on 7/2/22 at 4:40 p.m. The diagnoses included, but were not limited to, dementia and hypertension. A SLUMS examination, dated 11/23/21, noted a score indicative of dementia. 2b. Resident H's clinical record was reviewed on 7/2/22 at 4:43 p.m. The diagnoses included, but were not limited to, dementia, hypertension, mood disorder, and chronic kidney disease. A SLUMS examination, dated 12/29/21, noted a score indicative of dementia. 2c. Resident J's clinical record was reviewed on 7/2/22 at 4:45 p.m. The diagnoses included, but were not limited to,			

	dementia, hypertension, and respiratory disease. A SLUMS examination, dated 3/30/22, noted a score indicative of dementia. An interview conducted with the ED, on 7/2/22 at 2:46 p.m., indicated she was told by the staff Resident G's lock to her apartment door handle was there before she moved in prior during renovation. Regarding Resident H and J's apartment, Resident H requested such device to be placed on her door handle and now she's upset that we removed it. She indicated she wasn't sure if Resident J could even open the door handle from the inside if the device was engaged. The residents or family cannot request such devices on their doors. They are a restraint. A policy titled "Abuse Prevention Policy", dated 8/10/18, was provided by the ED on 7/2/22 at 5:00 p.m. The policy indicated the following, "...It is the policy of the Facility to protect residents from abusive acts and to adequately train Facility personnel in methods of detection and prevention of abuse. The Facility will comply with state and federal regulations for reporting suspected or actual acts of abuse...Involuntary Seclusion - Separation of the			

	resident from other residents or from the resident's room against the resident's will or the will of the resident's legal representative...." This Residential tag relates to Complaint IN00383132. Based on observation, interview, and record review, the facility failed to ensure a resident was not left in a room that was locked (Resident B) and failed to ensure a child lock device was not in place to the door handles of 2 apartments for the potential to affect 3 residents (Residents G, H and J). Findings include: 1. The clinical record for Resident B was reviewed on 7/2/22 at 4:00 p.m. The diagnosis included, but was not limited to, dementia. A SLUMS (Saint Louis University Mental Status) Examination, dated 1/10/22, listed a score indicative of dementia.			

	A service plan, dated 4/13/22, indicated Resident B had moderate cognitive impairment, was to reside on a secured unit, was independent with ambulation, and needed minimal assistance with bathing, personal hygiene, dressing, and toileting. An incident reported to the Indiana State Department of Health survey report system, dated 6/16/22, indicated the following, "...[name of Resident B]...Staff Involved...[name of Certified Nursing Assistant 2]...[name of Caregiver 3]...Brief Description of Incident...Memory Care Director came in at approximately 8am [sic] to find an item of [name of Resident B's] door preventing her from leaving her room with [name of Caregiver 3] sitting outside her door guarding. [Name of Certified Nursing Assistant 2] had placed a childproof device on the door to prevent the resident from leaving her room as she has COVID and was continuing to come out...Follow up...Surveillance confirmed resident came out of her room 4 times while nursing was attempting to pass meal trays. Resident was redirected momentarily, but due to resident's cognition, resident would not remain in her room. Staff [name of Certified Nursing Assistant 2] admits to putting the device on the door and			

	telling the Activity Worker [name of Caregiver 3] to watch even though she knew it was against the abuse policy...[Name of Certified Nursing Assistant 2] was terminated...." The investigative file was reviewed for the incident involving Resident B on 7/2/22 at 12:04 p.m. A written statement by Caregiver 3, dated 6/16/22, indicated the following, "...I came in this morning and was told there was COVID in Memory Care. I texted [name of Memory Care Director] on what the breakfast situation and so on was going to look like [sic]. She told me room trays and they were to eat in their rooms. I helped make plates and as we were moving down the hallway the other CNA [name of Certified Nursing Assistant 2] put a type of baby lock on a resident's door [name of Resident B] while she fed two other residents in a COVID quaratine [sic] room. She told me to sit in the hallway and she would take the baby lock off after she was done eating. It felt off but I wasn't sure and was told shortly after that it is not acceptable and is not apart of COVID protocals [sic]." The statement was signed by Caregiver 3. A written statement by the			

	Memory Care Director (MCD), dated 6/16/22, indicated the following, "...This writer witnessed at approx. [approximately] 8am that there was an item on [name of Resident B] door. When writer asked CNA [CNA 2] and shift employee [Caregiver 3] why the item was on the resident's door knob [sic], the CNA stated she put the item on the resident's door because the resident is COVID positive and would not stay in her room. This writer contacted the Executive Director [symbol for and] the Director of Nursing immediately, and removed the item off of the door within minutes of noticing." The statement was signed by the MCD. A written statement by CNA 2, dated 6/16/22, indicated the following, "...Removed a child proof lock off another door placed it on another door [name of Resident B door] ask the activit [sic] worker to could she sit there while I went to get the rooms [sic] trays. The lock fell off as soon as the door was open. Came back a few minutes later and the lock was off the door as well. The activities work [sic] said it fell off and put the lock in the shelve [sic] and remain feeding [sic]." The statement was signed by CNA 2. A "Corrective Action Form",			

	dated 6/20/22, indicated CNA 2 was terminated for violation of the company's abuse policy for placing a child lock on the door of a resident in attempt to keep her in her room. The video recording of the incident occurring on 6/16/22, outside of the common area outside of Resident B's room was reviewed on 7/2/22 at 2:40 p.m. The ED indicated the time on the camera footage was 37 minutes ahead of the standard time. The following was noted: - 7:47 a.m.- Resident B came out of her room, - 7:56 a.m.- Resident B came out of her room again, - 7:59 a.m.- CNA 2 went in Resident B's room, - 8:04 a.m.- Resident B came out of her room again, - 8:10 a.m.- Resident B came out of her room again, - 8:20 a.m.- Resident B came out of her room again, - 8:22 a.m.- Resident B came out of her room again,			

	- 8:24 a.m.- CNA 2 was observed standing by Resident B's door for a period of time. ED indicated this was when she believes the child lock was placed on Resident B's door. - 8:29 a.m.- CNA 10 was observed standing outside of Resident B's door but didn't open it. - 8:39 a.m.- Caregiver 3 took a chair to sit outside of Resident B's room. - 8:45 a.m.- MCD comes onto the unit. - 8:46 a.m.- Caregiver 3 observed looking through the window of Resident B's room. - 8:56 a.m.- Nurse 11 observed outside of Resident B's room but door didn't open. - 9:05 a.m.- MCD removed the child lock device to Resident B's door, per the ED. An interview conducted with the ED, on 7/2/22 at 2:46 p.m., indicated the child lock device did not just fall off. The MCD had to physically remove it. 2. A tour was conducted of the first floor of the Memory Care Unit on 7/2/22 at 10:05 a.m. An apartment that housed Resident H and Resident J was noted with a lock device to the door handle that wasn't engaged at			

	the time of observation. If the device was engaged, it could potentially prohibit the ability for someone to open the door. A button would need to be pressed to activate an arm to move across and ensure the door handle cannot move up or down. CNA 12 indicated a resident in that room could open the door when the lock was engaged. The lock was to ensure residents do not wander into their room during the night. The tour continued onto the 2nd floor of the Memory Care Unit. An apartment that housed Resident G also had a lock device that wasn't engaged during the time of observation but could potentially prohibit the ability for someone to open the door handle if it was engaged. It was the same lock device that was observed on Resident H and J's apartment door. An interview conducted with the ED, on 7/2/22 at 11:05 a.m., indicated she was not aware there were child locks still present on the door handles to resident apartments. 2a. Resident G's clinical record was reviewed on 7/2/22 at 4:40 p.m. The diagnoses included, but were not limited to, dementia and hypertension.			

A SLUMS examination, dated 11/23/21, noted a score indicative of dementia.

2b. Resident H's clinical record was reviewed on 7/2/22 at 4:43 p.m. The diagnoses included, but were not limited to, dementia, hypertension, mood disorder, and chronic kidney disease.

A SLUMS examination, dated 12/29/21, noted a score indicative of dementia.

2c. Resident J's clinical record was reviewed on 7/2/22 at 4:45 p.m. The diagnoses included, but were not limited to, dementia, hypertension, and respiratory disease.

A SLUMS examination, dated 3/30/22, noted a score indicative of dementia.

An interview conducted with the ED, on 7/2/22 at 2:46 p.m., indicated she was told by the staff Resident G's lock to her apartment door handle was there before she moved in prior during renovation. Regarding Resident H and J's apartment, Resident H requested such device to be placed on her door handle and now she's upset that we removed it. She indicated she wasn't sure if Resident J could even open the door handle from the inside if the device was engaged. The residents or family cannot

	request such devices on their doors. They are a restraint. A policy titled "Abuse Prevention Policy", dated 8/10/18, was provided by the ED on 7/2/22 at 5:00 p.m. The policy indicated the following, "...It is the policy of the Facility to protect residents from abusive acts and to adequately train Facility personnel in methods of detection and prevention of abuse. The Facility will comply with state and federal regulations for reporting suspected or actual acts of abuse...Involuntary Seclusion - Separation of the resident from other residents or from the resident's room against the resident's will or the will of the resident's legal representative...." This Residential tag relates to Complaint IN00383132.			
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living.	R 0216	R 216 1. Resident’s D prepared medications are not being left inside apartment. Residents D and F’s were assessed for self-admintration of medication by the Wellness Director or designee and an order from the physician for self administration.	08/05/2022

	(3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview, and record review, the facility failed to obtain self-administration physician orders as indicated in self-administration of medication assessments for 2 residents (Resident D and F), failed to ensure prepared medications were not left inside the apartment of 1 resident (Resident D) for 2 of 3 residents reviewed for medication management. Findings include: 1. The clinical record for Resident D was reviewed on 7/2/2022 at 4:34 p.m. The medical diagnoses included, but were not limited to, anxiety and pain.		2. The Community reviewed each resident’s record to determine which residents, if any, could be affected by the alleged deficient practice. 3. The Wellness Director and/or designee will audit all residents to ensure a Self Administration Assessment was conducted and and orders are in the chart. 4. The Wellness Director or designee will monitor all new admissions to ensure that resident’s who are able to self-medicate have the order to do so. 5. The Wellness Director or designee will audit 5 random med passes with staff weekly x 4 weeks, then monthly x 5 months to ensure compliance with medication administration.	

	An observation on 7/2/2022 at 1:33 p.m. indicated Resident D sitting in a recliner in her room. There was a Lovenox shot on the bedside table as well as 4 unidentified pills in a medicine cup. An interview with Resident D on 7/2/2022 at 1:33 p.m. indicated the "medication aide" had brought her medicine in about 30 minutes ago and left them there because she prefers to time her medications spaced out to a previous gastrointestinal surgery. She stated the staff administer her medications because when she was administering her medications herself that she would often forget to take her medications all together or would take double the dose, but she can give herself her blood thinner shots (Lovenox). A Self Admin of Medication Results Assessment, completed on 6/17/2022, indicated a physician order for Resident D to self-administer medications was obtained. A physician order listing for Resident D, signed on 6/30/2022, indicated an order of "Nurse or QMA may administer medications". The July 2022 Medication Administration Record (MAR) for Resident D, indicated staff		6. Systemic changes will be completed: August 5, 2022	

administering Resident D's medications.

An interview with QMA 4 on 7/2/2022 at 5:34 p.m. indicated that staff administer Resident's D medications.

2. The clinical record for Resident F was reviewed on 7/2/2022 at 4:39 p.m. The medical diagnoses included, but were not limited to, hypertension and kidney disease.

A cognitive examination, completed on 3/23/2020, indicated Resident F was cognitively intact.

An observation of Resident F on 7/2/2022 at 4:12 p.m. indicated Resident F sitting in his recliner in his room. Two bottles of Tylenol 500 mg extended release were on a shelf to the left of the chair as well as a box of Salonpas pain patches.

An interview with Resident F on 7/2/2022 at 4:12 p.m. indicated the staff administer his medications, but he uses the "stuff" (Tylenol and Salonpas) in his room as he needed it because he was recovering from oral surgery. He stated he did take over administering his medications for a short amount of time prior to his oral surgery because the staff kept trying to administer his blood thinner that was supposed to be held and he kept his pain medicine in his

	room after his surgery, but the staff are back to administering all his medications now. A Self Admin of Medication Results Assessment, completed on 5/16/2022, indicated a physician order for Resident F to self-administer medications was obtained. No order present on the chart to self-administer medications on the chart at this time. The July 2022 Medication Administration Record (MAR) for Resident F indicated staff administering Resident F's medications. An interview with LPN 5 on 7/2/2022 at 5:45 p.m. indicated that staff administer all of Resident F's medication. Observed LPN 5 administering two pills to Resident F. A policy entitled, "Community Team Members Procedure for Medication Assistance", was provided by the Director of Nursing on 7/2/2022 at 7:00 p.m. The policy indicated, " ...Be sure to observe the Resident talking his/her medications. If you are assigned to administer the medications, do not leave the mediations in the Resident's apartments and/or dining room table ..."			

This Residential tag relates to Complaint IN00382184.

Based on observation, interview, and record review, the facility failed to obtain self-administration physician orders as indicated in self-administration of medication assessments for 2 residents (Resident D and F), failed to ensure prepared medications were not left inside the apartment of 1 resident (Resident D) for 2 of 3 residents reviewed for medication management.

Findings include:

1. The clinical record for Resident D was reviewed on 7/2/2022 at 4:34 p.m. The medical diagnoses included, but were not limited to, anxiety and pain.

An observation on 7/2/2022 at 1:33 p.m. indicated Resident D sitting in a recliner in her room. There was a Lovenox shot on the bedside table as well as 4 unidentified pills in a medicine cup.

An interview with Resident D on 7/2/2022 at 1:33 p.m. indicated the "medication aide" had brought her medicine in about 30 minutes ago and left them there because she prefers to time her medications spaced out to a previous gastrointestinal surgery. She stated the staff

	administer her medications because when she was administering her medications herself that she would often forget to take her medications all together or would take double the dose, but she can give herself her blood thinner shots (Lovenox). A Self Admin of Medication Results Assessment, completed on 6/17/2022, indicated a physician order for Resident D to self-administer medications was obtained. A physician order listing for Resident D, signed on 6/30/2022, indicated an order of "Nurse or QMA may administer medications". The July 2022 Medication Administration Record (MAR) for Resident D, indicated staff administering Resident D's medications. An interview with QMA 4 on 7/2/2022 at 5:34 p.m. indicated that staff administer Resident's D medications. 2. The clinical record for Resident F was reviewed on 7/2/2022 at 4:39 p.m. The medical diagnoses included, but were not limited to, hypertension and kidney disease. A cognitive examination, completed on 3/23/2020, indicated Resident F was			

cognitively intact.

An observation of Resident F on 7/2/2022 at 4:12 p.m. indicated Resident F sitting in his recliner in his room. Two bottles of Tylenol 500 mg extended release were on a shelf to the left of the chair as well as a box of Salonpas pain patches.

An interview with Resident F on 7/2/2022 at 4:12 p.m. indicated the staff administer his medications, but he uses the "stuff" (Tylenol and Salonpas) in his room as he needed it because he was recovering from oral surgery. He stated he did take over administering his medications for a short amount of time prior to his oral surgery because the staff kept trying to administer his blood thinner that was supposed to be held and he kept his pain medicine in his room after his surgery, but the staff are back to administering all his medications now.

A Self Admin of Medication Results Assessment, completed on 5/16/2022, indicated a physician order for Resident F to self-administer medications was obtained.

No order present on the chart to self-administer medications on the chart at this time.

The July 2022 Medication Administration Record (MAR) for Resident F indicated staff

	administering Resident F's medications. An interview with LPN 5 on 7/2/2022 at 5:45 p.m. indicated that staff administer all of Resident F's medication. Observed LPN 5 administering two pills to Resident F. A policy entitled, "Community Team Members Procedure for Medication Assistance", was provided by the Director of Nursing on 7/2/2022 at 7:00 p.m. The policy indicated, " ...Be sure to observe the Resident talking his/her medications. If you are assigned to administer the medications, do not leave the mediations in the Resident's apartments and/or dining room table ..." This Residential tag relates to Complaint IN00382184.			
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 interview and record review the facility failed to provide showers to Resident C per her Individual Service Plan (ISP) and to Resident E per her preferences for a total of 2 of 3	R 0240	R 240 1. Resident C and E's preferences for shower times were added to the assignment sheet. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged	08/05/2022

	resident reviewed for showers. Findings include: 1. The clinical record for Resident C was reviewed on 7/2/2022 at 4:03 p.m. The medical diagnoses included, but were not limited to, heart disease and arthritis. A cognitive examination completed on 4/23/2020, indicated Resident C was cognitively intact. An ISP, revised on 4/26/2022, indicated that Resident C preferred showers on Tuesday, Thursday, and Saturday and needed minimal assistance from a care partner. An interview with Resident C on 7/2/2022 at 12:20 p.m., indicated she did not receive showers on Saturdays. She stated when she asked for help with her showers on Saturday, the facility staff would tell her that she could do her showers herself and they refused to help her. 2. The clinical record for Resident E was reviewed on 7/2/2022 at 5:05 p.m. The medical diagnoses included, but were not limited to, kidney disease and hypertension. An ISP, revised on 2/9/2022, indicated Resident E needed minimal assistance of a shower		deficient practice. 3. The Wellness Director or designee will provide education to staff regarding resident preferences and use of shower sheets. 4. The Wellness Director or designee will audit completed shower sheets weekly x 4 weeks, then monthly x 5 months to ensure compliance. 5. Systemic changes will be completed: August 5, 2022	

aide for bathing/showering tasks. No indication of preferred days or times on this ISP.

An interview with Resident E on 7/2/2022 at 1:12 p.m., indicated she was aware of her name, place, date, and situation. She stated she preferred to have her showers in the evening, but the facility did not have the staff to assist her with them at that time. She reported staff would tell that she would take her showers in the morning, or she would not receive help with them. Resident E indicated she would shower herself without assistance in the evening because of this.

An interview with the Director of Nursing on 7/2/2022 at 6:30 p.m., indicated that staff would supplement showers if give outside of the time of an agency such as a weekend per the resident's preference.

A policy entitled, "Health Related Services Ops Manual", was provided by the Executive Director on 7/2/2022 at 5:00 p.m. This policy indicated, " ...Individual needs and preferences are met ..."

This Residential tag relates to Complaint IN00382184.

Based on interview and record review the facility failed to provide showers to Resident C per her Individual Service Plan

(ISP) and to Resident E per her preferences for a total of 2 of 3 resident reviewed for showers.

Findings include:

1. The clinical record for Resident C was reviewed on 7/2/2022 at 4:03 p.m. The medical diagnoses included, but were not limited to, heart disease and arthritis.

A cognitive examination completed on 4/23/2020, indicated Resident C was cognitively intact.

An ISP, revised on 4/26/2022, indicated that Resident C preferred showers on Tuesday, Thursday, and Saturday and needed minimal assistance from a care partner.

An interview with Resident C on 7/2/2022 at 12:20 p.m., indicated she did not receive showers on Saturdays. She stated when she asked for help with her showers on Saturday, the facility staff would tell her that she could do her showers herself and they refused to help her.

2. The clinical record for Resident E was reviewed on 7/2/2022 at 5:05 p.m. The medical diagnoses included, but were not limited to, kidney disease and hypertension.

An ISP, revised on 2/9/2022,

indicated Resident E needed minimal assistance of a shower aide for bathing/showering tasks. No indication of preferred days or times on this ISP.

An interview with Resident E on 7/2/2022 at 1:12 p.m., indicated she was aware of her name, place, date, and situation. She stated she preferred to have her showers in the evening, but the facility did not have the staff to assist her with them at that time. She reported staff would tell that she would take her showers in the morning, or she would not receive help with them. Resident E indicated she would shower herself without assistance in the evening because of this.

An interview with the Director of Nursing on 7/2/2022 at 6:30 p.m., indicated that staff would supplement showers if give outside of the time of an agency such as a weekend per the resident's preference.

A policy entitled, "Health Related Services Ops Manual", was provided by the Executive Director on 7/2/2022 at 5:00 p.m. This policy indicated, " ...Individual needs and preferences are met ..."

This Residential tag relates to Complaint IN00382184.

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