STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENCE VILLAGE OF FISHERS EAST	12950 TALBLICK STREET, FISHERS, , 46037

(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 Complaint IN00393589. Complaint IN00393589 - Substantiated. State Residential Findings related to the allegations are cited at R0055, R0091, and R0217. Survey dates: November 9 and 10, 2022. Facility number: 013945 Residential Census: 67 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 16, 2022	R 0000		
R 0055	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(y)(1-4) (y) Residents have the right to be treated as individuals with	R 0055	. What corrective action(s) will be accomplished for those residents found to have	12/15/2022

	consideration and respect for their privacy. Privacy shall be afforded for at least the following: (1) Bathing. (2) Personal care. (3) Physical examinations and treatments. (4) Visitations. Based on interview and record review, the facility failed to provide a resident privacy in her personal apartment for 1 of 3 residents reviewed for privacy (Resident B). Findings include: The clinical record for Resident B was reviewed on 11/9/22 at 11:00 a.m. The Resident's diagnosis included, but were not limited to, dementia and hypertension. The clinical record for Resident C was reviewed on 11/9/22 at 1:30 p.m. The Residents diagnosis included, but were not limited to, dementia. The clinical record for Resident D was reviewed on 11/9/22 at 11:38 a.m. The Resident's diagnosis included, but were not limited to, dementia with behavioral disturbance. A progress note, dated 10/11/22 as a late entry for 10/6/22,		been affected by the deficient practice; ***Affected resident has been provided with a key to lock her apartment. Staff is continuing to monitor resident to ensure resident is able to lock and unlock her apartment. An automatic door closer has been installed to ensure the door closes.*** . 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; ***Wellness team will monitor and documenting resident wandering and updating care plans to include wander and any necessary interventions. Wellness team will monitor and document any concerns expressed by residents about privacy issues and take any necessary actions.*** .	

	indicated that Resident B had reported to her family member that another resident had been in her apartment and when she asked him to leave, he had grabbed her hand. A progress note, written by the Physician's Assistant and dated 10/12/22 at 12:09 p.m., read "... Message received... If possible, could you add a visit to see [Resident B] ...on 10/6/22 [Resident B] called ...and told me a resident in her area had pulled on her arm causing pain in the wrist area... Spoke with staff who explained that there is a particular resident who gets confused and continues to go into her room rather than his own. Staff reports that this resident did grab patient's arm while she was lying in bed. Staff has not seen any cause for concern, or heard any complaints from resident of pain or soreness in the last 2-3 days..." During an interview on 11/9/22 at 11:20 a.m., the WD (Wellness Director) indicated that she had been informed that Resident C had been found in Resident B's apartment on 10/6/22. She has an end room which tend to be were residents who wander end up unintentionally going into, because it is the end of the hall. She had been made aware of 2 other incidents where Resident C had gone into Resident B's		What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; ***Care plans will be updated and discussed in regular wellness meetings.*** . How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place ***Will be discussed in weekly wellness meetings to ensure that effective necessary actions are taken.*** . By what date the systemic changes will be completed. **December 15, 2022**	

	apartment prior to her beginning employment with the facility. During an interview on 11/9/22 at 1:20 p.m., the ED (Executive Director) indicated that he was aware of an incident that had happened in June when Resident C was sitting on the Resident B's bed and in July when Resident C had attempted to take a shower in Resident B's bathroom. During an interview on 11/9/22 at 1:38 p.m., CNA (Certified Nursing Assistant) 4 indicated that Resident C had a history of wandering into other's rooms. The staff monitor his movements. Resident C "loves" Resident B's room. A couple weeks ago, Resident B was mad because someone was in her room. During an interview on 11/9/22 at 1:38 p.m., QMA (Qualified Medication Aide) 3 indicated that she was working on 10/6/22 when Resident B found Resident C in her room. She came to get us to get him out. We found him sitting on the bed and it took about 5 minutes for us to get him out of her room. After that there was another incident when Resident D was found in Resident B's room. During an interview on 11/9/22 at 2:45 p.m., FM (Family Member) 1 indicated that he had			

	made staff aware of 4 different incidents of other residents being in Resident B's room uninvited. The first incident was in June of 2022, when Resident C was found in Resident B's bed. The second incident was in July 2022, when Resident B found Resident C naked in her bathroom during the night. The third incident was on 10/6/22 when Resident C was found in Resident B's room and had grabbed her arm when she tried to get him to leave. After the last incident a meeting was held on 10/13/22 and the facility agreed to lock her door and give her a key. The staff were supposed to be assuring the door was locked when she was out of the room. The fourth incident was 10/18/22, when during a visit Family Member 2 took Resident B to her room to visit with her and when Family Member 2 opened her door Resident D was already in the room. The door had obviously not been locked since Resident D had entered after Resident B left the room. Resident B became upset when she found other residents in her room. FM 1 understood that the other residents would wander at times, however, did not feel Resident B should just have to accept that other residents could come into her room as they pleased. During an interview on 11/10/22 at 11:13 a.m., the WD indicated			

	that in her experience when a resident with dementia wanders into other rooms it may not be viewed as a behavior, however, if the resident who's room is being entered has a concern with it, then it becomes an issue. Resident B had expressed she did not want others in her room. She has an expectation of privacy. This state residential finding relates to compliant IN00393589. Based on interview and record review, the facility failed to provide a resident privacy in her personal apartment for 1 of 3 residents reviewed for privacy (Resident B). Findings include: The clinical record for Resident B was reviewed on 11/9/22 at 11:00 a.m. The Resident's diagnosis included, but were not limited to, dementia and hypertension. The clinical record for Resident C was reviewed on 11/9/22 at 1:30 p.m. The Residents diagnosis included, but were not limited to, dementia.			

	The clinical record for Resident D was reviewed on 11/9/22 at 11:38 a.m. The Resident's diagnosis included, but were not limited to, dementia with behavioral disturbance. A progress note, dated 10/11/22 as a late entry for 10/6/22, indicated that Resident B had reported to her family member that another resident had been in her apartment and when she asked him to leave, he had grabbed her hand. A progress note, written by the Physician's Assistant and dated 10/12/22 at 12:09 p.m., read "... Message received... If possible, could you add a visit to see [Resident B] ...on 10/6/22 [Resident B] called ...and told me a resident in her area had pulled on her arm causing pain in the wrist area... Spoke with staff who explained that there is a particular resident who gets confused and continues to go into her room rather than his own. Staff reports that this resident did grab patient's arm while she was lying in bed. Staff has not seen any cause for concern, or heard any complaints from resident of pain or soreness in the last 2-3 days..." During an interview on 11/9/22 at 11:20 a.m., the WD (Wellness Director) indicated that she had been informed that Resident C			

	had been found in Resident B's apartment on 10/6/22. She has an end room which tend to be were residents who wander end up unintentionally going into, because it is the end of the hall. She had been made aware of 2 other incidents where Resident C had gone into Resident B's apartment prior to her beginning employment with the facility. During an interview on 11/9/22 at 1:20 p.m., the ED (Executive Director) indicated that he was aware of an incident that had happened in June when Resident C was sitting on the Resident B's bed and in July when Resident C had attempted to take a shower in Resident B's bathroom. During an interview on 11/9/22 at 1:38 p.m., CNA (Certified Nursing Assistant) 4 indicated that Resident C had a history of wandering into other's rooms. The staff monitor his movements. Resident C "loves" Resident B's room. A couple weeks ago, Resident B was mad because someone was in her room. During an interview on 11/9/22 at 1:38 p.m., QMA (Qualified Medication Aide) 3 indicated that she was working on 10/6/22 when Resident B found Resident C in her room. She came to get us to get him out. We found him sitting on the bed			

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R 0091	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(h)(1-4) (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations.	R 0091	. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ***All Managers will review and be trained on standard operational procedures on reporting allegation of abuse and neglect to the Executive Director.***	12/15/2022

	The policies shall be made available to residents upon request. Based on interview and record review, the facility failed to report an allegation of abuse to the IDOH (Indiana Department of Health) and report it immediately to the ED (Executive Director,) per policy, for 2 of 3 residents reviewed for abuse. (Residents B and C) Findings include: The clinical record for Resident B was reviewed on 11/9/22 at 11:00 a.m. Her diagnoses included, but were not limited to, dementia and hypertension. The clinical record for Resident C was reviewed on 11/9/22 at 1:30 p.m. His diagnoses included, but were not limited to, dementia. Resident B's progress note, dated 10/11/22 as a late entry for 10/6/22, indicated that Resident B had reported to her family member that another resident had been in her apartment and when she asked him to leave he grabbed her hand. Resident B's progress note, written by the Physician's Assistant and dated 10/12/22 at 12:09 p.m., read "... Message received... If possible could you		. 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; ***During daily stand up meetings and weekly wellness meeting at risk residents will be discussed.*** . What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; ***At risk residents discussion will be part of stand up process and weekly wellness process. It will be part of all new managers orientation. All and any potential abuse or neglect identified will be reported by the Executive Director per the community policy.*** . How the corrective action(s) will be	

	add a visit to see [Resident B]...on 10/6/22 [Resident B] called ...and told me a resident in her area had pulled on her arm causing pain in the wrist area... Spoke with staff who explained that there is a particular resident who gets confused and continues to go into her room rather than his own. Staff reports that this resident did grab patient's arm while she was lying in bed. Staff has not seen any cause for concern, or heard any complaints from resident of pain or soreness in the last 2-3 days..." On 11/9/22 at 1:24 p.m., the ED (Executive Director) provided a 10/10/22, 12:14 a.m. email from Family Member 2, Resident B's son, to the ED. It read, "My brother [name of Family Member 1] and I urgently request a meeting with you...This is to discuss a safety issue with our mother [name of Resident B.]...Three abusive incidents occurred that endanger the safety of Memory Care residents. Each of these incidents involved abuse by the same male MC [Memory Care] resident. In each of these cases, the family members learned of the incident only when the abused Memory Care resident called her family. Subsequently, the report was corroborated when the family asked the MC staff about it. In		monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place ***Executive Director will audit Abuse and Neglect reporting training, will oversee and document the stand-up discussions.*** . By what date the systemic changes will be completed. **December 15, 2022**	

	NONE of these cased did the [abbreviated name of facility] staff call the family members to inform them of the incident. 1. Man in [name of Resident B's] bed on 6/23/2022. 2. Same man was naked in [name of Resident B's bathroom on Friday 7/29/2022. 3. Same man physically assaulted [name of Resident B] in her room on Thursday 10/6/2022....Incident #3: Same man physically assaulted [name of Resident B] in her room on Thursday 10/6/2022: Thursday 10/6/2022 morning: - [Name of Resident B] called her son [name of Family Member 2] at 9:24 am, very upset, to explain what she referred to as an 'emergency'. When [Name of Resident B] returned to her room, Offender was on her bed. He pulled her by her wrist causing pain and redness (and later she described pain in her side). She went to get staff for assistance. Staff removed Offender from her room. [Name of Family Member 2] drove to [name of facility] to comfort [name of Resident B] and assess the situation. Memory care staff confirmed from discussion with other staff that were present that they removed Offender from [name of Resident B's] room. On [name of Family Member 2's] way out he spoke with [name of WD-Wellness Director] in her office about the Offender and what has repeated again. She			

	was very sympathetic - she's going to work with the staff again. As [name of Family Member 2] was signing out he was able to meet up with [name of AIT-Administrator in Training] in his office (name of ED was not available). [Name of Family Member 2] briefed him on the situation for about five minutes. [Name of AIT] was sympathetic as well and had one suggestion that we could try on our end that may help along with what they can do on their end - hang a wreath on her door..., like floral, that may cue Offender that this is not his room." An interview was conducted with QMA (Qualified Medication Aide) 3 on 11/9/22 at 1:38 p.m. She indicated Resident C would go into women's rooms and get in their beds, whether the resident was in bed or not. He loved Resident B's room. A couple of weeks ago, Resident B was mad that someone was in her room. Family Member 2 came to QMA 3 and informed her Resident B had a bruise. QMA 3 asked Resident B if Resident C touched her and Resident B told her that Resident C pulled her hand and showed her a bruise on the top of her left wrist that was very small, purplish red, "very fresh to me." QMA 3 informed the DON of the incident. "The shower thing happened on night shift," and QMA 3 was not			

present. Resident B was very upset and called her son. Resident C was normally very nice and gentle with women. "I think the day of the bruise was just a bad day for him."

An interview was conducted with CNA (Certified Nursing Assistant) 4 on 11/9/22 at 1:38 p.m. She indicated she had just assisted Resident C into his recliner in his room, "then all of a sudden," Resident B was like, 'Come, come, [name of Resident C] is in my room." CNA 4 went into Resident B's room and found Resident C sitting on her bed, kicking his feet. It took about 5 minutes to get him out of her room and into the common area. CNA 3 asked Resident B if she was okay. Resident B informed her she was okay, but then 2 hours later Family Member 2 came to the facility and asked her if any of the staff knew anything about someone being in Resident B's room.

An interview was conducted with the WD on 11/10/22 at 11:25 a.m. She indicated QMA 3 never informed her of the bruise she saw on Resident B or that Family Member 2 spoke to her about it. The WD was sitting in her office when Family Member 2 stopped by her office and informed her Resident B called him and told him there was a man in her room. Family

	Member 2 informed her that Resident B informed him that Resident C "grabbed her hand." Family Member 2 checked it out and didn't see anything. The WD informed Family Member 2 she was going to go check and see how Resident B was doing. The WD checked on Resident B a little later, after QMA 3 and CNA 4 were already gone for the day. The WD spoke to the staff who were currently working the unit and was informed they didn't get any report at shift change about an incident between Resident B and Resident C. The WD asked Resident B how she was doing and Resident B informed her she was okay. The WD looked at her hand, but Resident B pulled her hand away, wondering why she was looking at her hand. Resident B did not mention any pain to her. Resident C was in his own room at the time. After dinner, the WD "glanced" at Resident B's hands and asked her if everything was okay, and again Resident B informed her she was okay. The WD did not talk to QMA 3 about the incident afterwards. If QMA 3 had informed her right away, she would have reported it to the ED immediately and proceeded to do an investigation. "If we'd seen the bruise at the time, now it's a reportable event." The way Family Member 2 informed her of the incident, "I didn't really			

	consider it an allegation. Had he reacted differently, I would have taken it differently." The WD confirmed that Family Member 2 informed her that Resident B told him that Resident C grabbed her hand. An interview was conducted with the ED on 11/10/22 at 10:27 a.m. He indicated he found out about the 10/6/22 incident between Resident B and Resident C on 10/10/22 when Family Member 2 informed him of it via email and with a follow up phone call. He considered the email an allegation of abuse. When they investigated it, there was nothing substantiated. The facility reported any substantiated allegations of abuse to IDOH, but not the actual allegation at the time it was made. Generally, it would be reported. With this specific incident, it was investigated right away on 10/10/22. Family Member 2 informed the WD of the incident on 10/6/22. The DON assessed Resident B's hand and found no bruising. Per their policy, he should have been notified of the allegation on 10/6/22. The reportable incident reports from September, 2022 through present were provided by the ED on 11/9/22 at 11:45 a.m. There was no report for the 10/6/22 incident between			

	Resident B and Resident C. The Abuse, Mistreatment, Neglect or Misappropriation of Resident Property policy was provided by the ED on 11/9/22 at 1:24 p.m. It read, "It is the policy to investigate all allegations, suspicions and incidents of Abuse, Neglect, or Misappropriation of resident property, and injuries sustained by its residents....Abuse is defined as 'knowingly causing physical harm or recklessly causing serious physical harm to a resident by physical contact with the resident or by use of a physical or chemical restraint, medication, or isolation as punishment, for staff convenience, excessively, as a substitute for treatment or in amounts that preclude habilitation and treatment....' Prevention and Identification: In addition to the above procedures, additional prevention and identification will include: ...Monitoring residents with needs and behaviors that may lead to conflict and neglect. Developing and implementing care plans to address behavioral issues....All allegations of Abuse, Neglect, and Misappropriation of Resident Property must be reported immediately to both the Wellness Director and Executive Director. For the purposes of this policy, 'immediately' means as soon as possible, but ought			

not to exceed twenty-four (24) hours after the incident or discovery of the injury....An investigation of the allegation or suspicion will be conducted....Results of the investigation will be reported to the appropriate licensing agencies, other officials and registries in accordance with the law."

This state residential finding relates to compliant IN00393589.

Based on interview and record review, the facility failed to report an allegation of abuse to the IDOH (Indiana Department of Health) and report it immediately to the ED (Executive Director,) per policy, for 2 of 3 residents reviewed for abuse. (Residents B and C)

Findings include:

The clinical record for Resident B was reviewed on 11/9/22 at 11:00 a.m. Her diagnoses included, but were not limited to, dementia and hypertension.

The clinical record for Resident C was reviewed on 11/9/22 at 1:30 p.m. His diagnoses included, but were not limited to, dementia.

Resident B's progress note, dated 10/11/22 as a late entry for 10/6/22, indicated that Resident B had reported to her

	family member that another resident had been in her apartment and when she asked him to leave he grabbed her hand. Resident B's progress note, written by the Physician's Assistant and dated 10/12/22 at 12:09 p.m., read "... Message received... If possible could you add a visit to see [Resident B]...on 10/6/22 [Resident B] called ...and told me a resident in her area had pulled on her arm causing pain in the wrist area... Spoke with staff who explained that there is a particular resident who gets confused and continues to go into her room rather than his own. Staff reports that this resident did grab patient's arm while she was lying in bed. Staff has not seen any cause for concern, or heard any complaints from resident of pain or soreness in the last 2-3 days..." On 11/9/22 at 1:24 p.m., the ED (Executive Director) provided a 10/10/22, 12:14 a.m. email from Family Member 2, Resident B's son, to the ED. It read, "My brother [name of Family Member 1] and I urgently request a meeting with you...This is to discuss a safety issue with our mother [name of Resident B.]...Three abusive incidents occurred that endanger the safety of Memory			

	Care residents. Each of these incidents involved abuse by the same male MC [Memory Care] resident. In each of these cases, the family members learned of the incident only when the abused Memory Care resident called her family. Subsequently, the report was corroborated when the family asked the MC staff about it. In NONE of these cased did the [abbreviated name of facility] staff call the family members to inform them of the incident. 1. Man in [name of Resident B's] bed on 6/23/2022. 2. Same man was naked in [name of Resident B's bathroom on Friday 7/29/2022. 3. Same man physically assaulted [name of Resident B] in her room on Thursday 10/6/2022....Incident #3: Same man physically assaulted [name of Resident B] in her room on Thursday 10/6/2022: Thursday 10/6/2022 morning: - [Name of Resident B] called her son [name of Family Member 2] at 9:24 am, very upset, to explain what she referred to as an 'emergency'. When [Name of Resident B] returned to her room, Offender was on her bed. He pulled her by her wrist causing pain and redness (and later she described pain in her side). She went to get staff for assistance. Staff removed Offender from her room. [Name of Family Member 2] drove to [name of facility] to comfort [name of Resident B]			

	and assess the situation. Memory care staff confirmed from discussion with other staff that were present that they removed Offender from [name of Resident B's] room. On [name of Family Member 2's] way out he spoke with [name of WD-Wellness Director] in her office about the Offender and what has repeated again. She was very sympathetic - she's going to work with the staff again. As [name of Family Member 2] was signing out he was able to meet up with [name of AIT-Administrator in Training] in his office (name of ED was not available). [Name of Family Member 2] briefed him on the situation for about five minutes. [Name of AIT] was sympathetic as well and had one suggestion that we could try on our end that may help along with what they can do on their end - hang a wreath on her door..., like floral, that may cue Offender that this is not his room." An interview was conducted with QMA (Qualified Medication Aide) 3 on 11/9/22 at 1:38 p.m. She indicated Resident C would go into women's rooms and get in their beds, whether the resident was in bed or not. He loved Resident B's room. A couple of weeks ago, Resident B was mad that someone was in her room. Family Member 2 came to QMA 3 and informed her Resident B had a bruise.			

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	WD did not talk to QMA 3 about the incident afterwards. If QMA 3 had informed her right away, she would have reported it to the ED immediately and proceeded to do an investigation. "If we'd seen the bruise at the time, now it's a reportable event." The way Family Member 2 informed her of the incident, "I didn't really consider it an allegation. Had he reacted differently, I would have taken it differently." The WD confirmed that Family Member 2 informed her that Resident B told him that Resident C grabbed her hand. An interview was conducted with the ED on 11/10/22 at 10:27 a.m. He indicated he found out about the 10/6/22 incident between Resident B and Resident C on 10/10/22 when Family Member 2 informed him of it via email and with a follow up phone call. He considered the email an allegation of abuse. When they investigated it, there was nothing substantiated. The facility reported any substantiated allegations of abuse to IDOH, but not the actual allegation at the time it was made. Generally, it would be reported. With this specific incident, it was investigated right away on 10/10/22. Family Member 2 informed the WD of the incident on 10/6/22. The DON assessed Resident B's			

	hand and found no bruising. Per their policy, he should have been notified of the allegation on 10/6/22. The reportable incident reports from September, 2022 through present were provided by the ED on 11/9/22 at 11:45 a.m. There was no report for the 10/6/22 incident between Resident B and Resident C. The Abuse, Mistreatment, Neglect or Misappropriation of Resident Property policy was provided by the ED on 11/9/22 at 1:24 p.m. It read, "It is the policy to investigate all allegations, suspicions and incidents of Abuse, Neglect, or Misappropriation of resident property, and injuries sustained by its residents....Abuse is defined as 'knowingly causing physical harm or recklessly causing serious physical harm to a resident by physical contact with the resident or by use of a physical or chemical restraint, medication, or isolation as punishment, for staff convenience, excessively, as a substitute for treatment or in amounts that preclude habilitation and treatment....' Prevention and Identification: In addition to the above procedures, additional prevention and identification will include: ...Monitoring residents with needs and behaviors that may lead to conflict and neglect.			

	Developing and implementing care plans to address behavioral issues....All allegations of Abuse, Neglect, and Misappropriation of Resident Property must be reported immediately to both the Wellness Director and Executive Director. For the purposes of this policy, 'immediately' means as soon as possible, but ought not to exceed twenty-four (24) hours after the incident or discovery of the injury....An investigation of the allegation or suspicion will be conducted....Results of the investigation will be reported to the appropriate licensing agencies, other officials and registries in accordance with the law." This state residential finding relates to compliant IN00393589.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope;	R 0217	***The facility failed to update a resident's service plan to address a behavior of wandering*** . What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	12/15/2022

	(B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based observation, interview and record review, the facility failed to update a resident's service plan to address a behavior of wandering for 2 of 3 residents reviewed for behaviors (Resident C annd D).		***Residents that are identified to have behaviors will have their Service Care Plan updated with interventions.*** . 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; ***The Wellness Director and Memory Care Director will review residents for behaviors.*** . What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; ***When a resident has been identified as having any type of behavior the Service Plan will be updated with focuses and necessary interventions.*** . How the corrective action(s) will be monitored to ensure the deficient practice	

Findings include:

1. The clinical record for Resident C was reviewed on 11/9/22 at 1:30 p.m. The Residents diagnosis included, but were not limited to, dementia.

The Level of Care Evaluation, dated 3/28/22, indicated he did not engage in wandering outside of his immediate area or demonstrating anxious, disruptive, or obsessive behaviors.

During an interview on 11/9/22 at 11:20 a.m., the WD (Wellness Director) indicated that she had been informed that Resident C had been found in Resident B's apartment on 10/6/22. She had been made of 2 other incidents where Resident C had gone into Resident B's apartment prior to her beginning employment with the facility.

During an interview on 11/9/22 at 1:20 p.m., the ED (Executive Director) indicated that he was aware of an incident that had happened in June when Resident C was sitting on the Resident B's bed and in July when Resident C had attempted to take a shower in Resident B's bathroom.

During an interview on 11/9/22 at 1:38 p.m., QMA (Qualified Medication Aide) 3 indicated that Resident C had a history of

will not recur, i.e., what quality assurance program will be put into place; ***During the Communities Wellness meeting The service plan will be reviewed to ensure that the necessary interventions are in the service plan and updated as needed and Semi-annually.***

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By what date the systemic changes will be completed.

The Over all Audit/ review will be completed along with Update Service plan will be completed by December 15th. 12/15/22.

wandering into other's rooms. The staff monitor his movements. Resident C "loves" women's rooms.

During an interview on 11/9/22 at 1:38 p.m., CNA (Certified Nursing Assistant) 4 indicated that she was working on 10/6/22 when Resident B found Resident C in her room. She came to get us so that we could get him out. We found him sitting on the bed and it took about 5 minutes for us to get him out of her room.

2. The clinical record for Resident D was reviewed on 11/9/22 at 11:53 a.m. The diagnoses included, but were not limited to: dementia with behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.

The 3/28/22 Level of Care Evaluation indicated she resided on the memory care unit and was independent with ambulation.

An observation of Resident D was made on 11/9/22 at 1:32 p.m. upon entrance to the memory care unit of the facility. She was walking down the hallway towards the entrance/exit door to the unit. She stopped just outside of the doorways to the last 2 rooms on the unit and stood there for a while. She did not enter into the

	rooms and eventually made her way back down the hallway into the common area. An interview was conducted with CNA (Certified Nursing Assistant) 4 on 11/9/22 at 1:38 p.m. She indicated Resident D had a history of wandering the unit, but would "just stand there and touch stuff." An interview was conducted with QMA (Qualified Medication Aide) 3 on 11/9/22 at 1:38 p.m. She indicated Resident D had a history of wandering the unit and "will just start touching things or lock herself in the room." In July, 2022 Resident D was found in Resident B's room. Resident B's family member, Family Member 2, was visiting with Resident B in the common area of the unit and went into Resident B's room where they found Resident D already in there.			

An interview was conducted with Family Member 1 on 11/9/22 at 2:46 p.m. He indicated his brother, Family Member 2, was at the facility visiting with Resident B when they found Resident D in Resident B's room. Family Member 2 assisted Resident D out of Resident B's room. Resident B was not happy to see Resident D in her room, as Resident B did not welcome uninvited people into her room.

The Behavior/Mood section of Resident D's current service plan indicated, "Orientation: Wanders aimlessly or in undirected fashion without definable or obtainable purpose, i.e. looking for visitors who are not coming, or relatives who may be deceased. Not a disturbance to others." The service plan did not indicate approaches or interventions to address her wandering behavior.

During an interview on 11/10/22 at 11:13 a.m., the WD indicated that Resident C's service plan should have been updated with his tendency to go into other rooms.

An interview was conducted with the WD (Wellness Director) on 11/10/22 at 11:25 a.m. She indicated she noticed there were no interventions or approaches for staff to implement for

Resident D's wandering, but hadn't yet had a chance to update it. She expected for staff to verbally redirect Resident D to prevent her from going into or if found in other residents' rooms.

The Resident Evaluation and Service Plan policy was provided by the ED (Executive Director) on 11/10/22 at 9:30 a.m. It read, "The Service Plan will address, but is not limited to, the following: ...b. The service plan shall indicate the resident's identified needs and preferences for assistance of ADL's (activities of daily living,) medication management, chronic disease management, behavioral needs and fall risk and prevention."

This state residential finding relates to compliant IN00393589.

Based observation, interview and record review, the facility failed to update a resident's service plan to address a behavior of wandering for 2 of 3 residents reviewed for behaviors (Resident C annd D).

Findings include:

1. The clinical record for Resident C was reviewed on 11/9/22 at 1:30 p.m. The Residents diagnosis included, but were not limited to, dementia.

The Level of Care Evaluation, dated 3/28/22, indicated he did not engage in wandering outside of his immediate area or demonstrating anxious, disruptive, or obsessive behaviors.

During an interview on 11/9/22 at 11:20 a.m., the WD (Wellness Director) indicated that she had been informed that Resident C had been found in Resident B's apartment on 10/6/22. She had been made of 2 other incidents where Resident C had gone into Resident B's apartment prior to her beginning employment with the facility.

During an interview on 11/9/22 at 1:20 p.m., the ED (Executive Director) indicated that he was aware of an incident that had happened in June when Resident C was sitting on the Resident B's bed and in July when Resident C had attempted to take a shower in Resident B's bathroom.

During an interview on 11/9/22 at 1:38 p.m., QMA (Qualified Medication Aide) 3 indicated that Resident C had a history of wandering into other's rooms.

The staff monitor his movements. Resident C "loves" women's rooms.

During an interview on 11/9/22 at 1:38 p.m., CNA (Certified Nursing Assistant) 4 indicated that she was working on 10/6/22 when Resident B found Resident C in her room. She came to get us so that we could get him out. We found him sitting on the bed and it took about 5 minutes for us to get him out of her room.

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An observation of Resident D was made on 11/9/22 at 1:32 p.m. upon entrance to the memory care unit of the facility. She was walking down the hallway towards the entrance/exit door to the unit. She stopped just outside of the doorways to the last 2 rooms on the unit and stood there for a while. She did not enter into the rooms and eventually made her

way back down the hallway into the common area.

An interview was conducted with CNA (Certified Nursing Assistant) 4 on 11/9/22 at 1:38 p.m. She indicated Resident D had a history of wandering the unit, but would "just stand there and touch stuff."

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The Behavior/Mood section of Resident D's current service plan indicated, "Orientation: Wanders aimlessly or in undirected fashion without definable or obtainable purpose, i.e. looking for visitors who are not coming, or relatives who may be deceased. Not a disturbance to others." The service plan did not indicate approaches or interventions to address her wandering behavior.

During an interview on 11/10/22 at 11:13 a.m., the WD indicated that Resident C's service plan should have been updated with his tendency to go into other rooms.

An interview was conducted with the WD (Wellness Director) on 11/10/22 at 11:25 a.m. She indicated she noticed there were no interventions or approaches for staff to implement for Resident D's wandering, but hadn't yet had a chance to update it. She expected for staff to verbally redirect Resident D to prevent her from going into or if found in other residents' rooms.

The Resident Evaluation and Service Plan policy was provided by the ED (Executive Director) on 11/10/22 at 9:30 a.m. It read, "The Service Plan will address, but is not limited to, the following: ...b. The service

plan shall indicate the resident's identified needs and preferences for assistance of ADL's (activities of daily living,) medication management, chronic disease management, behavioral needs and fall risk and prevention."

This state residential finding relates to compliant IN00393589.

Based observation, interview and record review, the facility failed to update a resident's service plan to address a behavior of wandering for 2 of 3 residents reviewed for behaviors (Resident C annd D).

Findings include:

1. The clinical record for Resident C was reviewed on 11/9/22 at 1:30 p.m. The Residents diagnosis included, but were not limited to, dementia.

The Level of Care Evaluation, dated 3/28/22, indicated he did not engage in wandering outside of his immediate area or demonstrating anxious, disruptive, or obsessive behaviors.

During an interview on 11/9/22 at 11:20 a.m., the WD (Wellness Director) indicated that she had been informed that Resident C had been found in Resident B's apartment on 10/6/22. She had

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behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.

The 3/28/22 Level of Care Evaluation indicated she resided on the memory care unit and was independent with ambulation.

An observation of Resident D was made on 11/9/22 at 1:32 p.m. upon entrance to the memory care unit of the facility. She was walking down the hallway towards the entrance/exit door to the unit. She stopped just outside of the doorways to the last 2 rooms on the unit and stood there for a while. She did not enter into the rooms and eventually made her way back down the hallway into the common area.

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Family Member 2, was visiting with Resident B in the common area of the unit and went into Resident B's room where they found Resident D already in there.

An interview was conducted with Family Member 1 on 11/9/22 at 2:46 p.m. He indicated his brother, Family Member 2, was at the facility visiting with Resident B when they found Resident D in Resident B's room. Family Member 2 assisted Resident D out of Resident B's room. Resident B was not happy to see Resident D in her room, as Resident B did not welcome uninvited people into her room.

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The Resident Evaluation and Service Plan policy was provided by the ED (Executive Director) on 11/10/22 at 9:30 a.m. It read, "The Service Plan will address, but is not limited to, the following: ...b. The service plan shall indicate the resident's identified needs and preferences for assistance of ADL's (activities of daily living,) medication management, chronic disease management, behavioral needs and fall risk and prevention."

This state residential finding relates to compliant IN00393589.

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failed to update a resident's service plan to address a behavior of wandering for 2 of 3 residents reviewed for behaviors (Resident C annd D).

Findings include:

1. The clinical record for Resident C was reviewed on 11/9/22 at 1:30 p.m. The Residents diagnosis included, but were not limited to, dementia.

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During an interview on 11/9/22 at 1:20 p.m., the ED (Executive Director) indicated that he was aware of an incident that had happened in June when Resident C was sitting on the Resident B's bed and in July when Resident C had attempted to take a shower in Resident B's

bathroom.

During an interview on 11/9/22 at 1:38 p.m., QMA (Qualified Medication Aide) 3 indicated that Resident C had a history of wandering into other's rooms. The staff monitor his movements. Resident C "loves" women's rooms.

During an interview on 11/9/22 at 1:38 p.m., CNA (Certified Nursing Assistant) 4 indicated that she was working on 10/6/22 when Resident B found Resident C in her room. She came to get us so that we could get him out. We found him sitting on the bed and it took about 5 minutes for us to get him out of her room.

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out of Resident B's room. Resident B was not happy to see Resident D in her room, as Resident B did not welcome uninvited people into her room.

The Behavior/Mood section of Resident D's current service plan indicated, "Orientation: Wanders aimlessly or in undirected fashion without definable or obtainable purpose, i.e. looking for visitors who are not coming, or relatives who may be deceased. Not a disturbance to others." The service plan did not indicate approaches or interventions to address her wandering behavior.

During an interview on 11/10/22 at 11:13 a.m., the WD indicated that Resident C's service plan should have been updated with his tendency to go into other rooms.

An interview was conducted with the WD (Wellness Director) on 11/10/22 at 11:25 a.m. She indicated she noticed there were no interventions or approaches for staff to implement for Resident D's wandering, but hadn't yet had a chance to update it. She expected for staff to verbally redirect Resident D to prevent her from going into or if found in other residents' rooms.

The Resident Evaluation and

	Service Plan policy was provided by the ED (Executive Director) on 11/10/22 at 9:30 a.m. It read, "The Service Plan will address, but is not limited to, the following: ...b. The service plan shall indicate the resident's identified needs and preferences for assistance of ADL's (activities of daily living,) medication management, chronic disease management, behavioral needs and fall risk and prevention." This state residential finding relates to compliant IN00393589.			

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