STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BIRCH OF EVANSVILLE	475 S GOVERNOR STREET, EVANSVILLE, , 47713

(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 IN00361643 and IN00362438. Complaint IN00361643 - Substantiated. State deficiencies related to the allegations are cited at R0052, R0217, R0246, R0306, R357, R090. Complaint IN00362438 - Substantiated. State deficiencies related to the allegations are cited at R0052, R0217, R0246, R0306, R0357, R090. Survey date: September 15 and 16, 2021. Facility number: 014238 Residential Census: 103 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of compliance effective November 19, 2021. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the POC.	

	Quality review completed on September 24, 2021.			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review, and interview, the facility failed to ensure residents were free from neglect for 1 of 2 residents reviewed for death. A resident who had expired was not observed or assessed by staff for 16 hours prior to being found deceased. (Resident D) Findings include: During a confidential interview on 9/15/21 at 9:18 a.m., the Interviewee indicated a resident had "died over the Labor Day weekend and hadn't been found for several days." During review of the State reportable incidents, provided by the Administrator on 9/15/21	R 0052	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** **Resident D is deceased.** **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;** **LSW or designee will interview Alert and oriented residents to ensure that they are observed daily by a clinical staff member.** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** **Inservice clinical licensed staff to re-educate to observe residents at least 1x daily. A CPR certified employee will be on the premises**	11/19/2021

	at 9:30 a.m., the reportables indicated Resident D had expired on 8/30/21 at 11:10 a.m. The Administrator indicated the resident had been a full code and should have had CPR (cardiopulmonary resuscitation) started when the resident was found unresponsive. The clinical record for Resident D was reviewed on 9/15/21 at 3:15 p.m. Diagnosis included, but was not limited to, cognitive communication deficit. A signed service plan, dated 6/25/21, indicated the resident had mild to moderate disorientation or difficulty recalling/retaining information, required frequent hygiene checks, required reminders for activities and required reminders for meals. A signed "Level of Service Assessment/Evaluation," dated 6/30/21, indicated Resident D did not communicate her needs but understood information and was oriented to person, place and time. The physician's orders lacked documentation of a code status for the resident. A Medication Administration Record, dated 8/1/21-8/31/21, indicated the resident had received her medication at 7:00 p.m. on 8/29/21. The Medication Administration Record indicated		**at all times.** **<u>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</u>** **DON or designee to review code status monthly to ensure documentation of wishes for 4 months.** **<u>What date the systemic changes will be completed:</u> 11/19/21**	

	the resident had not received her 7:00 a.m. medications on 8/30/21. A Social Worker's note, dated 8/4/21 at 6:08 p.m., included, but was not limited to, "Met with resident on this date. Reviewed resident code status wishes, community ancillary and guardian. LSW (Licensed Social Worked) to contact Guardian regarding resident consents needing signed. A Social Worker's note, dated 8/16/21 at 4:36 p.m., included, but was not limited to, "Resident services consents, code status, IHCC (Integrated Health Care Coordination) forms emailed to guardian on this date." A nurse's note, dated 8/30/21 at 11:10 a.m., included, but was not limited to, "QMA on the 3rd floor found resident expired while passing morning medication and notified the nurse on duty. The nurse on duty checked for pulse and heart beat and stated resident expired. The nurse notified the DONW (Director of Nursing and Wellness) that the resident expired. The DONW went to the resident's room confirmed and notified the ED (Executive Director). The DONW notified 911 and 911 notified the coroner. The Fire Department and [Initials of the Local Police Department] detectives came			

	and did an investigation and report. The coroner came and stated the resident had a GI (gastrointestinal) bleed. The DONW notified [Name of resident's court appointed guardian]. The guardian picked [Name of Funeral Home] and stated that [Name of Cemetery] had resident's arrangements. The DONW notified [Name of physician] office, resident's MD. unable to leave message due to lunch, will call back to notify of resident's death." The nurse's note was signed by the DONW. A nurse's note, dated 8/30/21 at 3:09 p.m., indicated "This nurse spoke with the [Name of NP] (Nurse Practitioner) about signing the resident's death certificate and was waiting a response." The clinical record lacked documentation the resident had been observed or assessed from 7:00 p.m. on 8/29/21 until 11:10 a.m. on 8/30/21. During an interview on 8/16/21 at 11:30 a.m., QMA 1 indicated he had work the previous evening and had given the resident her medication at 7:00 p.m. He indicated the resident normally came to the dining room for breakfast but he had not seen the resident at breakfast the morning of 8/30/21. QMA 1 indicated the staff was supposed to check on			

	the residents at least twice a day. He always checked on the residents when he arrived, usually at 7:00 a.m., and again before he would leave the facility, usually around 7:00 p.m. QMA 1 indicated the resident had medication ordered for 7:00 a.m., but he had not given the resident her 7:00 a.m. medications as he had until 11:00 a.m. to administer them. QMA 1 indicated when he went to the resident's room around 11:00 a.m. to give the resident her medications, the resident had not answered her door which was different for the resident. He indicated he opened the door and found the resident with emesis on her bed linen, in her hair, and on her gown. QMA 1 indicated he had to go to the second floor to obtain the nurse to check the resident. No CPR was administered to the resident. QMA 1 indicated he was certified in CPR but did not know if the resident was a full code or not. He indicated he was unsure if CPR should be administered on a resident if the code status was unknown, but probably should have started CPR on the resident when she was found unresponsive. During an interview on 9/16/21 at 12:23 p.m. the DON indicated residents were only checked once every 24 hours. The DON			

	indicated CPR should have been started on the resident when the resident was found unresponsive. She indicated if a resident did not have a signed CPR declaration or a physician's order for a DNR (Do Not Resuscitate), the resident would be considered a full code. She indicated the resident did not have an assessment and the resident not been checked on for 16 hours prior to finding the resident deceased. The current facility policy, "Medical Emergency," dated 5/1/18, provided by the DON on 9/16/21 at 10:35 a.m., included, but was not limited to, "The Community Executive Director is responsible for assuring that the staff is trained and knowledgeable about how to respond appropriately to resident and employee medical emergencies. At least one person per shift is trained and could be available to perform CPR and first aid. CPR masks and first aid supplies are accessible to staff. For residents, the following information should be available for emergency medical services upon their arrival: CPR designation." The facility lacked documentation of a policy for assessing or frequency of checking the status of residents.			

This State Residential finding relates to Complaint IN00361643 and Complaint IN00362438.

Based on record review, and interview, the facility failed to ensure residents were free from neglect for 1 of 2 residents reviewed for death. A resident who had expired was not observed or assessed by staff for 16 hours prior to being found deceased. (Resident D)

Findings include:

During a confidential interview on 9/15/21 at 9:18 a.m., the Interviewee indicated a resident had "died over the Labor Day weekend and hadn't been found for several days."

During review of the State reportable incidents, provided by the Administrator on 9/15/21 at 9:30 a.m., the reportables indicated Resident D had expired on 8/30/21 at 11:10 a.m. The Administrator indicated the resident had been a full code and should have had CPR (cardiopulmonary resuscitation) started when the resident was found unresponsive.

The clinical record for Resident D was reviewed on 9/15/21 at 3:15 p.m. Diagnosis included, but was not limited to, cognitive communication deficit.

A signed service plan, dated

6/25/21, indicated the resident had mild to moderate disorientation or difficulty recalling/retaining information, required frequent hygiene checks, required reminders for activities and required reminders for meals.

A signed "Level of Service Assessment/Evaluation," dated 6/30/21, indicated Resident D did not communicate her needs but understood information and was oriented to person, place and time.

The physician's orders lacked documentation of a code status for the resident.

A Medication Administration Record, dated 8/1/21-8/31/21, indicated the resident had received her medication at 7:00 p.m. on 8/29/21. The Medication Administration Record indicated the resident had not received her 7:00 a.m. medications on 8/30/21.

A Social Worker's note, dated 8/4/21 at 6:08 p.m., included, but was not limited to, "Met with resident on this date. Reviewed resident code status wishes, community ancillary and guardian. LSW (Licensed Social Worked) to contact Guardian regarding resident consents needing signed.

A Social Worker's note, dated 8/16/21 at 4:36 p.m., included,

	but was not limited to, "Resident services consents, code status, IHCC (Integrated Health Care Coordination) forms emailed to guardian on this date." A nurse's note, dated 8/30/21 at 11:10 a.m., included, but was not limited to, "QMA on the 3rd floor found resident expired while passing morning medication and notified the nurse on duty. The nurse on duty checked for pulse and heart beat and stated resident expired. The nurse notified the DONW (Director of Nursing and Wellness) that the resident expired. The DONW went to the resident's room confirmed and notified the ED (Executive Director). The DONW notified 911 and 911 notified the coroner. The Fire Department and [Initials of the Local Police Department] detectives came and did an investigation and report. The coroner came and stated the resident had a GI (gastrointestinal) bleed. The DONW notified [Name of resident's court appointed guardian]. The guardian picked [Name of Funeral Home] and stated that [Name of Cemetery] had resident's arrangements. The DONW notified [Name of physician] office, resident's MD. unable to leave message due to lunch, will call back to notify of resident's death." The nurse's note was signed by the DONW.			

	A nurse's note, dated 8/30/21 at 3:09 p.m., indicated "This nurse spoke with the [Name of NP] (Nurse Practitioner) about signing the resident's death certificate and was waiting a response." The clinical record lacked documentation the resident had been observed or assessed from 7:00 p.m. on 8/29/21 until 11:10 a.m. on 8/30/21. During an interview on 8/16/21 at 11:30 a.m., QMA 1 indicated he had work the previous evening and had given the resident her medication at 7:00 p.m. He indicated the resident normally came to the dining room for breakfast but he had not seen the resident at breakfast the morning of 8/30/21. QMA 1 indicated the staff was supposed to check on the residents at least twice a day. He always checked on the residents when he arrived, usually at 7:00 a.m., and again before he would leave the facility, usually around 7:00 p.m. QMA 1 indicated the resident had medication ordered for 7:00 a.m., but he had not given the resident her 7:00 a.m. medications as he had until 11:00 a.m. to administer them. QMA 1 indicated when he went to the resident's room around 11:00 a.m. to give the resident her medications, the resident had not answered her door			

	which was different for the resident. He indicated he opened the door and found the resident with emesis on her bed linen, in her hair, and on her gown. QMA 1 indicated he had to go to the second floor to obtain the nurse to check the resident. No CPR was administered to the resident. QMA 1 indicated he was certified in CPR but did not know if the resident was a full code or not. He indicated he was unsure if CPR should be administered on a resident if the code status was unknown, but probably should have started CPR on the resident when she was found unresponsive. During an interview on 9/16/21 at 12:23 p.m. the DON indicated residents were only checked once every 24 hours. The DON indicated CPR should have been started on the resident when the resident was found unresponsive. She indicated if a resident did not have a signed CPR declaration or a physician's order for a DNR (Do Not Resuscitate), the resident would be considered a full code. She indicated the resident did not have an assessment and the resident not been checked on for 16 hours prior to finding the resident deceased. The current facility policy, "Medical Emergency," dated			

	5/1/18, provided by the DON on 9/16/21 at 10:35 a.m., included, but was not limited to, "The Community Executive Director is responsible for assuring that the staff is trained and knowledgeable about how to respond appropriately to resident and employee medical emergencies. At least one person per shift is trained and could be available to perform CPR and first aid. CPR masks and first aid supplies are accessible to staff. For residents, the following information should be available for emergency medical services upon their arrival: CPR designation." The facility lacked documentation of a policy for assessing or frequency of checking the status of residents. This State Residential finding relates to Complaint IN00361643 and Complaint IN00362438.			
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	R 0090	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** **Resident G was assessed for psychosocial issues.** **How the facility will**	11/19/2021

	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; (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.		**identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** **LSW or designee will interview alert and oriented residents to determine residents feel safe and know who to inform if an incident occurs.** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** **Inservice staff on resident rights and abuse to re-educate types of abuse and recognition of abuse.** **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** **LSW or designee to meet with 3 residents weekly for 4 weeks and ask them questions regarding their feelings of safety and wellbeing.** **Concerns will be addressed immediately by the Executive**	

	(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 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 observation, interview, and record review, the facility failed to ensure an allegation of abuse was thoroughly investigated and reported for 1 of 2 residents reviewed for abuse. (Resident G) Findings include: During review of the State reportable incidents, provided by the Administrator on 9/15/21 at 9:30 a.m., the reportables indicated on 8/5/21 at 8:30 a.m., Resident G had informed another staff member that QMA 6 had told her to "shut up" while providing care. The clinical record for Resident G was reviewed on 9/15/21 at 3:15 p.m. Diagnosis included, but was not limited to, COPD (chronic obstructive pulmonary		**Director or designee.** **<u>What date the systemic changes will be completed:</u> 11/19/21**	

disease), and heart failure.

A signed service plan, "Oxygen Use," initiated 8/16/21, included but was not limited to, the following:

Monitor for increasing difficulty breathing and report to nurse/MD, initiated 8/16/21.

Requires assistance with ordering oxygen, initiated 8/16/21.

The nurse's notes lacked documentation of the incident which occurred on 8/4/21.

During an interview on 9/15/21 at 3:30 p.m., the Director of Nursing (DON) indicated on 8/5/21 at 8:30 a.m., Resident G have been told by QMA 6 to "shut up." She indicated QMA 6 had told her she was in a hurry to assist with getting another resident off of the floor when she stopped by Resident G's room to help her with her oxygen. The DON indicated QMA 6 was suspended but had since returned to work at the facility. The DON indicated she was unable provide an investigation into the allegation as she had been unable to locate any.

On 9/16/21 at 10:04 a.m., Resident G was observed sitting in her room with her oxygen on. The resident indicated she and QMA 6 had a disagreement a

	"little while back." She indicated her oxygen concentrator had not been working correctly. QMA 6 came into her room to help her and the resident indicated she requested QMA 6 to obtain her emergency oxygen but the QMA continued to look at the concentrator. Resident G indicated QMA 6 told her if she "could talk, she was not short of breath" and to "shut up." Resident G indicated QMA 6 eventually obtained the emergency oxygen tank for her and she hooked the machine up herself. QMA 6 exited the resident's room. Resident G indicated she and QMA 6 later apologized to each other and there have been no further issues. The facility lacked documentation of a policy regarding investigating any allegation of abuse. This State Residential tag relates to Complaint IN00361643 and IN00362438. Based on observation, interview, and record review, the facility failed to ensure an allegation of abuse was thoroughly investigated and reported for 1 of 2 residents reviewed for abuse. (Resident G) Findings include: During review of the State			

reportable incidents, provided by the Administrator on 9/15/21 at 9:30 a.m., the reportables indicated on 8/5/21 at 8:30 a.m., Resident G had informed another staff member that QMA 6 had told her to "shut up" while providing care.

The clinical record for Resident G was reviewed on 9/15/21 at 3:15 p.m. Diagnosis included, but was not limited to, COPD (chronic obstructive pulmonary disease), and heart failure.

A signed service plan, "Oxygen Use," initiated 8/16/21, included but was not limited to, the following:

Monitor for increasing difficulty breathing and report to nurse/MD, initiated 8/16/21.

Requires assistance with ordering oxygen, initiated 8/16/21.

The nurse's notes lacked documentation of the incident which occurred on 8/4/21.

During an interview on 9/15/21 at 3:30 p.m., the Director of Nursing (DON) indicated on 8/5/21 at 8:30 a.m., Resident G have been told by QMA 6 to "shut up." She indicated QMA 6 had told her she was in a hurry to assist with getting another resident off of the floor when she stopped by Resident G's room to help her with her

	oxygen. The DON indicated QMA 6 was suspended but had since returned to work at the facility. The DON indicated she was unable provide an investigation into the allegation as she had been unable to locate any. On 9/16/21 at 10:04 a.m., Resident G was observed sitting in her room with her oxygen on. The resident indicated she and QMA 6 had a disagreement a "little while back." She indicated her oxygen concentrator had not been working correctly. QMA 6 came into her room to help her and the resident indicated she requested QMA 6 to obtain her emergency oxygen but the QMA continued to look at the concentrator. Resident G indicated QMA 6 told her if she "could talk, she was not short of breath" and to "shut up." Resident G indicated QMA 6 eventually obtained the emergency oxygen tank for her and she hooked the machine up herself. QMA 6 exited the resident's room. Resident G indicated she and QMA 6 later apologized to each other and there have been no further issues. The facility lacked documentation of a policy regarding investigating any allegation of abuse. This State Residential tag			

	relates to Complaint IN00361643 and IN00362438.			
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; (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	R 0217	**<u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice;</u>** **Resident H is deceased.** **<u>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;</u>** **DON or designee will complete audit of community residents and ensure service plan is up to date and Hospice order is present.**	11/19/2021

	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 on record review and interview, the facility failed to ensure a service plan identified the services provided to 1 of 1 resident reviewed who received hospice services. The facility lacked a physician's order for the hospice service and the service plan had not been updated. (Resident H) Findings include: The closed clinical record of Resident H was reviewed on 9/16/21 at 12:47 p.m., Diagnoses included, but was not limited to, acute kidney failure, diabetes mellitus type 2, and essential hypertension. A signed service plan included, but was not limited to, the following: Transferring, intiated 11/17/20, revised 6/1/21. Bathing, initiated 11/17/20, revised 6/1/21.		**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** **Inservice clinical licensed staff to re-educate that a Hospice order is required once resident elects Hospice benefit and placed into Service Plan.** **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** **DON or designee to review 3 charts weekly for 4 weeks to ensure compliance.** **What date the systemic changes will be completed: 11/19/21**	

	Dressing/Undressing, initiated and revised 6/1/21. Grooming/Oral Hygiene, initiated and revised 6/1/21. Toileting, initiated and revised 6/1/21. Bowel, initiated and revised 6/1/21. A nurse's note, dated 8/19/21 at 3:50 p.m., included, but was not limited to, "Communication with hospice services and nursing regarding order that [Name of Nurse Practitioner] gave for hospice referral. Documentation requested from nursing for referral to be sent." A nurse's note, dated 8/20/21 at 11:55 a.m., included, but was not limited to, "Res (resident) referral, face sheet, and signed orders faxed to [Name of Hospice], NP notified of need for last office note to be faxed to hospice case manager. A nurse's note, dated 8/25/21 at 3:36 p.m., included, but was not limited to, "Res labs reviewed, hospice admitted res onto service, coordinated care with hospice, res feeling well no c/o (complaints) voiced." A nurse's note, dated 9/7/21 at 8:28 p.m., included but was not limited to, "This nurse notified POA (Power of Attorney) that resident had passed and that			

the resident had no set arrangements per the social worker. This nurse directed POA to notify hospice to guide him. POA thankful for this direction."

The facility lacked documentation of a hospice admission order and the service plan had not been updated to include hospice services or the resident's decline.

During an interview on 9/16/21 at 2:25 p.m., the Director of Nursing (DON) indicated the facility did not have an order for hospice services nor had the service plan been revised.

The facility lacked documentation of a policy for obtaining physician's orders.

The current facility policy, "Service Plans," dated 8/1/18, included, but was not limited to, "The DOHW (Director of Health and Wellness) or designee will review the Service Plan every quarter and upon significant change in condition. Service plan shall include coordination and inclusion of services being delivered to a resident by an outside entity."

This State Residential finding relates to Complaint IN00361643 and Complaint IN00362438.

Based on record review and

	interview, the facility failed to ensure a service plan identified the services provided to 1 of 1 resident reviewed who received hospice services. The facility lacked a physician's order for the hospice service and the service plan had not been updated. (Resident H) Findings include: The closed clinical record of Resident H was reviewed on 9/16/21 at 12:47 p.m., Diagnoses included, but was not limited to, acute kidney failure, diabetes mellitus type 2, and essential hypertension. A signed service plan included, but was not limited to, the following: Transferring, intiated 11/17/20, revised 6/1/21. Bathing, initiated 11/17/20, revised 6/1/21. Dressing/Undressing, initiated and revised 6/1/21. Grooming/Oral Hygiene, initiated and revised 6/1/21. Toileting, initiated and revised 6/1/21. Bowel, initiated and revised 6/1/21. A nurse's note, dated 8/19/21 at 3:50 p.m., included, but was not			

	limited to, "Communication with hospice services and nursing regarding order that [Name of Nurse Practitioner] gave for hospice referral. Documentation requested from nursing for referral to be sent." A nurse's note, dated 8/20/21 at 11:55 a.m., included, but was not limited to, "Res (resident) referral, face sheet, and signed orders faxed to [Name of Hospice], NP notified of need for last office note to be faxed to hospice case manager. A nurse's note, dated 8/25/21 at 3:36 p.m., included, but was not limited to, "Res labs reviewed, hospice admitted res onto service, coordinated care with hospice, res feeling well no c/o (complaints) voiced." A nurse's note, dated 9/7/21 at 8:28 p.m., included but was not limited to, "This nurse notified POA (Power of Attorney) that resident had passed and that the resident had no set arrangements per the social worker. This nurse directed POA to notify hospice to guide him. POA thankful for this direction." The facility lacked documentation of a hospice admission order and the service plan had not been updated to include hospice services or the resident's decline.			

	During an interview on 9/16/21 at 2:25 p.m., the Director of Nursing (DON) indicated the facility did not have an order for hospice services nor had the service plan been revised. The facility lacked documentation of a policy for obtaining physician's orders. The current facility policy, "Service Plans," dated 8/1/18, included, but was not limited to, "The DOHW (Director of Health and Wellness) or designee will review the Service Plan every quarter and upon significant change in condition. Service plan shall include coordination and inclusion of services being delivered to a resident by an outside entity." This State Residential finding relates to Complaint IN00361643 and Complaint IN00362438.			
R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to	R 0246	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** **Resident F was in the hospital during the time of this incident.**	11/19/2021

	administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure prn (as needed) medications administered by the QMA (qualified medication aide) were given only upon authorization by a licensed nurse for 1 of 5 residents reviewed. (Resident F) Findings include: During review of the State reportable incidents, provided by the Administrator on 9/15/21 at 9:30 a.m., the reportables indicated during a narcotic medication count at the change of shifts on 7/29/21, Resident F had an Percocet (an opioid medication) 7.5/325 mg (milligrams) missing. The resident had been in the hospital and the staff noted that a potassium pill had been taped into the thirteen pill slot of the bubble medication packet. The clinical record of Resident F was reviewed on 9/16/21 at 9:01 a.m. Diagnoses included, but were not limited to, arteriosclerotic heard disease, chronic obstructive pulmonary disorder (COPD), age-related osteoporosis, and major depressive disorder.		**<u>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;</u>** **DON or designee will complete resident interviews for those who have a PRN order for a Narcotic to verify that those meds are given upon request and proper dosage.** **<u>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;</u>** **Inservice clinical licensed staff to acknowledge that resident is present at time of removing Narc from med card. Re-educate Clinical licensed staff to properly/electronically change status of meds when resident is in the hospital. Inservice clinical staff and re-educate that 2**	

	A service plan, "Medications," initiated 9/14/20, revised 5/25/21, included, but was not limited to, the following: "Has a history of pain. May use PRN (as needed) pain medication as per MAR (Medication Administration Record). Unable to self-inject or self-administer pre-poured medications." Resident F had a physician's order, dated 7/16/21, for Percocet 7.5-325 mg, give 1 tablet by mouth every 8 hours as needed for moderate pain. A Medication Administration Record, dated 7/1/21 through 7/31/21, indicated Percocet 7.5-325 mg 1 tablet by mouth had been administered by QMA 1 on 7/2/21 at 11:10 a.m., QMA 2 on 7/1/21 at 8:23 p.m., 7/11/21 at 4:57 p.m., 7/14/21 at 5:33 p.m., and 7/15/21 at 4:06 p.m., QMA 3 on 7/6/21 at 10:34 a.m., 7/7/21 at 10:12 a.m., 7/8/21 at 4:40 p.m., 7/10/21 at 10:38 a.m., and QMA 4 on 7/13/21 at 5:28 a.m. The clinical record lacked documentation of a nurse authorization prior to administering the medication. During an interview on 9/16/21 at 9:45 a.m., the DON indicated a nurse was either working or		**clinical signatures are obtained at time of disposal of Narc and count is accurate.** **<u>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</u>** **DON or designee to review the MAR when resident is out at hospital for compliance of medications on hold.** **DON or designee will review Narc sheets weekly for 4 weeks for compliance.** **<u>What date the systemic changes will be completed:</u>** **11/19/21**	

on-call 24 hours a day 7 days a week. The QMAs were supposed to notify the nurse prior to administering any prn medication.

During an interview on 9/16/21 at 11:09 a.m., QMA 3 indicated prior to administering a prn medication the QMA should either text or call the nurse and offer non-pharmaceutical interventions. The nurse should document the authorization in the resident's nurse's notes.

During an interview on 9/16/21 at 11:30 a.m., QMA 1 indicated a nurse should be notified to obtain authorization prior to administering prn medications.

The current facility policy, Medication Administration Program Policy," dated 8/1/18, provided by the DON on 9/16/21 at 1:00 p.m., included, but was not limited to, "The resident will be assessed by the licensed nurse to determine the extent of assistance required to safely receive medications."

This State Residential finding relates to Complaint IN00361643 and Complaint IN00362438.

Based on record review and interview, the facility failed to ensure prn (as needed) medications administered by the QMA (qualified medication aide) were given only upon

authorization by a licensed nurse for 1 of 5 residents reviewed. (Resident F)

Findings include:

During review of the State reportable incidents, provided by the Administrator on 9/15/21 at 9:30 a.m., the reportables indicated during a narcotic medication count at the change of shifts on 7/29/21, Resident F had an Percocet (an opioid medication) 7.5/325 mg (milligrams) missing. The resident had been in the hospital and the staff noted that a potassium pill had been taped into the thirteen pill slot of the bubble medication packet.

The clinical record of Resident F was reviewed on 9/16/21 at 9:01 a.m. Diagnoses included, but were not limited to, arteriosclerotic heard disease, chronic obstructive pulmonary disorder (COPD), age-related osteoporosis, and major depressive disorder.

A service plan, "Medications," initiated 9/14/20, revised 5/25/21, included, but was not limited to, the following:

"Has a history of pain. May use PRN (as needed) pain medication as per MAR (Medication Administration Record).

Unable to self-inject or

self-administer pre-poured medications."

Resident F had a physician's order, dated 7/16/21, for Percocet 7.5-325 mg, give 1 tablet by mouth every 8 hours as needed for moderate pain.

A Medication Administration Record, dated 7/1/21 through 7/31/21, indicated Percocet 7.5-325 mg 1 tablet by mouth had been administered by QMA 1 on 7/2/21 at 11:10 a.m., QMA 2 on 7/1/21 at 8:23 p.m., 7/11/21 at 4:57 p.m., 7/14/21 at 5:33 p.m., and 7/15/21 at 4:06 p.m., QMA 3 on 7/6/21 at 10:34 a.m., 7/7/21 at 10:12 a.m., 7/8/21 at 4:40 p.m., 7/10/21 at 10:38 a.m., and QMA 4 on 7/13/21 at 5:28 a.m.

The clinical record lacked documentation of a nurse authorization prior to administering the medication.

During an interview on 9/16/21 at 9:45 a.m., the DON indicated a nurse was either working or on-call 24 hours a day 7 days a week. The QMAs were supposed to notify the nurse prior to administering any prn medication.

During an interview on 9/16/21 at 11:09 a.m., QMA 3 indicated prior to administering a prn medication the QMA should either text or call the nurse and offer non-pharmaceutical

	interventions. The nurse should document the authorization in the resident's nurse's notes. During an interview on 9/16/21 at 11:30 a.m., QMA 1 indicated a nurse should be notified to obtain authorization prior to administering prn medications. The current facility policy, Medication Administration Program Policy," dated 8/1/18, provided by the DON on 9/16/21 at 1:00 p.m., included, but was not limited to, "The resident will be assessed by the licensed nurse to determine the extent of assistance required to safely receive medications." This State Residential finding relates to Complaint IN00361643 and Complaint IN00362438.			
R 0306	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(g)(1-9) (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the	R 0306	**<u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice;</u>** **Resident F was in the hospital during the time of this incident.** **<u>How the facility will identify other residents having the potential to be</u>**	11/19/2021

	drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on record review and interview, the facility failed to provide medication disposition in accordance with federal, state, and local laws for 1 of 5 resident reviewed for medication disposal. A narcotic medication was disposed of without the observation or signature of 2 staff persons. (Resident F) Findings include: During an interview on 9/15/21 at 12:07 p.m., the Director of Nursing indicated Resident F was found to have a Percocet (an opioid medication) missing on July 29, 2021, from her narcotic medication card. She indicated the medication had not been discovered for several weeks as another medication had been taped into the empty bubble on the medication card.		**affected by the same deficient practice and what corrective action will be taken;** **DON or designee will complete resident interviews for those who have a PRN order for a Narcotic to verify that those meds are given upon request and proper dosage.** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** **Inservice clinical licensed staff to acknowledge that resident is present at time of removing Narc from med card. Re-educate Clinical licensed staff to properly/electronically change status of meds when resident is in the hospital. Inservice clinical staff and re-educate that 2 clinical signatures are obtained at time of disposal of Narc and count is**	

	During review of the State reportable incidents, provided by the Administrator on 9/15/21 at 9:30 a.m., the reportables indicated during a narcotic medication count at the change of shifts on 7/29/21, Resident F had an Percocet 7.5/325 mg (milligrams) missing. The staff found the thirteen pill slot of the bubble pack had a potassium tablet taped into the slot and not a Percocet tablet. The reportable indicated a police report had been filed for the missing medication. The clinical record of Resident F was reviewed on 9/16/21 at 9:01 a.m. Diagnoses included, but were not limited to, arteriosclerotic heard disease, chronic obstructive pulmonary disorder (COPD), age-related osteoporosis, and major depressive disorder. Resident F had a physician's order, dated 7/16/21, for Percocet (an opioid medication) 7.5-215 mg (milligrams) give 1 tablet by mouth every 8 hours as needed for moderate pain. A service plan, "Medications," initiated 9/14/20, revised 5/25/21, included, but was not limited to, the following: "Has a history of pain. May use PRN (as needed) pain medication as per MAR (Medication Administration		**accurate.** **<u>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</u>** **DON or designee to review the MAR when resident is out at hospital for compliance of medications on hold.** **DON or designee will review Narc sheets weekly for 4 weeks for compliance.** **<u>What date the systemic changes will be completed:</u> 11/19/21**	

	Record). Unable to self-inject or self-administer pre-poured medications." During a review of the pharmacy "Controlled Drug Use Record," dated 7/8/21-7/18/21, it indicated Resident F had 30 tablets of Percocet 7.5-325 mg on 7/20/21. On 7/18/21 at 6:00 p.m., the form indicated the resident had 13 tablets of the Percocet left in the bubble medication card. During an interview on 9/16/21 at 9:45 a.m., the DON indicated on 6/23/21, QMA 1 had worked the night shift. He had removed a Percocet 7.5-325 mg from Resident F's medication card and taped the resident's potassium pill back into the bubble medication package in the number 13 pill slot when he discovered the resident was not at the facility, but was in the hospital. The DON indicated QMA 1 then disposed of the remainder of Resident F's medications, including the Percocet tablet in the 'Drug Buster" (a drug disposal container) without another staff member observing or signing the disposition. The DON indicated the incorrect medication was not discovered until 7/29/21 by QMA 3 during a shift change narcotic count.			

	During an interview on 9/16/21 at 11:09 a.m., QMA 3 indicated she was the staff member who found the bubble medication card with the incorrect medication taped into it when she was counting narcotics with QMA 5. QMA 3 indicated she did not remember what date it was discovered on. QMA 1 indicated there should be 2 staff members to count the narcotic medications at the end of each shift. She indicated the person on the cart usually looks at the narcotic book while the staff member who is coming to work looks at the medications. She indicated the staff member who looks at the medication usually did not look at the entire card by just at the resident's name and number of medications they have left in the packet. She indicated when counting narcotic medications, the card should be pulled out and looked at by the staff member who is on the medication cart. During an interview with QMA 1 on 9/16/21 at 11:30 a.m., QMA 1 indicated on 6/23/21 he pulled Resident F's medication for her. He indicated he entered the resident's room and discovered the resident was not there. He indicated the resident had been back and forth to the hospital several times and he did not know she was in the hospital at that time. He indicated he returned to the medication cart			

	and taped the potassium pill into the Percocet medication bubble pack slot by mistake. QMA 1 indicated the potassium tablet and the Percocet tablet looked a lot alike. At the end of the medication pass, QMA 1 disposed of all the other medication, which included the Percocet, in the "Drug Buster" in the medication room. QMA 1 indicated he did not receive prior authorization from a nurse before obtaining the medication as the resident always wanted her pain medication and he would just give it to her. QMA 1 indicated he did not have another staff member watch or sign for the disposal of the resident's medications. The current facility policy, "Medication Disposal Policy," dated 4/11/19, provided by the DON on 9/16/21 at 2:10 p.m., included, but was not limited to, "Controlled medications require additional documentation when disposal takes place. A Narcotic Count Sheet (in addition to the Drug Disposal record) is also signed by two witness, verifying the number of medication being disposed, dated and why medication is discontinued. Disposal of non-controlled medication may be performed by two Qualified Medication Aides." This State Residential finding relates to Complaint			

IN00361643 and Complaint IN00362438.

Based on record review and interview, the facility failed to provide medication disposition in accordance with federal, state, and local laws for 1 of 5 resident reviewed for medication disposal. A narcotic medication was disposed of without the observation or signature of 2 staff persons. (Resident F)

Findings include:

During an interview on 9/15/21 at 12:07 p.m., the Director of Nursing indicated Resident F was found to have a Percocet (an opioid medication) missing on July 29, 2021, from her narcotic medication card. She indicated the medication had not been discovered for several weeks as another medication had been taped into the empty bubble on the medication card.

During review of the State reportable incidents, provided by the Administrator on 9/15/21 at 9:30 a.m., the reportables indicated during a narcotic medication count at the change of shifts on 7/29/21, Resident F had an Percocet 7.5/325 mg (milligrams) missing. The staff found the thirteen pill slot of the bubble pack had a potassium tablet taped into the slot and not a Percocet tablet. The reportable indicated a police

report had been filed for the missing medication.

The clinical record of Resident F was reviewed on 9/16/21 at 9:01 a.m. Diagnoses included, but were not limited to, arteriosclerotic heard disease, chronic obstructive pulmonary disorder (COPD), age-related osteoporosis, and major depressive disorder.

Resident F had a physician's order, dated 7/16/21, for Percocet (an opioid medication) 7.5-215 mg (milligrams) give 1 tablet by mouth every 8 hours as needed for moderate pain.

A service plan, "Medications," initiated 9/14/20, revised 5/25/21, included, but was not limited to, the following:

"Has a history of pain. May use PRN (as needed) pain medication as per MAR (Medication Administration Record).

Unable to self-inject or self-administer pre-poured medications."

During a review of the pharmacy "Controlled Drug Use Record," dated 7/8/21-7/18/21, it indicated Resident F had 30 tablets of Percocet 7.5-325 mg on 7/20/21. On 7/18/21 at 6:00 p.m., the form indicated the resident had 13 tablets of the Percocet left in the bubble

	medication card. During an interview on 9/16/21 at 9:45 a.m., the DON indicated on 6/23/21, QMA 1 had worked the night shift. He had removed a Percocet 7.5-325 mg from Resident F's medication card and taped the resident's potassium pill back into the bubble medication package in the number 13 pill slot when he discovered the resident was not at the facility, but was in the hospital. The DON indicated QMA 1 then disposed of the remainder of Resident F's medications, including the Percocet tablet in the 'Drug Buster" (a drug disposal container) without another staff member observing or signing the disposition. The DON indicated the incorrect medication was not discovered until 7/29/21 by QMA 3 during a shift change narcotic count. During an interview on 9/16/21 at 11:09 a.m., QMA 3 indicated she was the staff member who found the bubble medication card with the incorrect medication taped into it when she was counting narcotics with QMA 5. QMA 3 indicated she did not remember what date it was discovered on. QMA 1 indicated there should be 2 staff members to count the narcotic medications at the end of each shift. She indicated the person on the cart usually looks at the			

	narcotic book while the staff member who is coming to work looks at the medications. She indicated the staff member who looks at the medication usually did not look at the entire card by just at the resident's name and number of medications they have left in the packet. She indicated when counting narcotic medications, the card should be pulled out and looked at by the staff member who is on the medication cart. During an interview with QMA 1 on 9/16/21 at 11:30 a.m., QMA 1 indicated on 6/23/21 he pulled Resident F's medication for her. He indicated he entered the resident's room and discovered the resident was not there. He indicated the resident had been back and forth to the hospital several times and he did not know she was in the hospital at that time. He indicated he returned to the medication cart and taped the potassium pill into the Percocet medication bubble pack slot by mistake. QMA 1 indicated the potassium tablet and the Percocet tablet looked a lot alike. At the end of the medication pass, QMA 1 disposed of all the other medication, which included the Percocet, in the "Drug Buster" in the medication room. QMA 1 indicated he did not receive prior authorization from a nurse before obtaining the medication as the resident always wanted			

	her pain medication and he would just give it to her. QMA 1 indicated he did not have another staff member watch or sign for the disposal of the resident's medications. The current facility policy, "Medication Disposal Policy," dated 4/11/19, provided by the DON on 9/16/21 at 2:10 p.m., included, but was not limited to, "Controlled medications require additional documentation when disposal takes place. A Narcotic Count Sheet (in addition to the Drug Disposal record) is also signed by two witness, verifying the number of medication being disposed, dated and why medication is discontinued. Disposal of non-controlled medication may be performed by two Qualified Medication Aides." This State Residential finding relates to Complaint IN00361643 and Complaint IN00362438.			
R 0357	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(j)(1-3) (j) If a death occurs, information concerning the resident ' s death shall include the following: (1) Notification of the physician, family, responsible person, and legal representative.	R 0357	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** **Resident D and H are deceased.**	11/19/2021

	(2) The disposition of the body, personal possessions, and medications. (3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death. Based on record review and interview, the facility failed to document the resident most recent vital signs and condition preceding the resident's death for 2 of 2 resident's reviewed. (Resident D, Resident H) Findings include: 1. During a confidential interview on 9/15/21 at 9:18 a.m., the Interviewee indicated a resident had "died over the Labor Day weekend and hadn't been found for several days." During review of the State reportable incidents, provided by the Administrator on 9/15/21 at 9:30 a.m., the reportables indicated Resident D had expired on 8/30/21 at 11:10 a.m. The Administrator indicated the resident had been a full code and should have had CPR (cardiopulmonary resuscitation) started when the resident was found unresponsive.		**<u>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;</u>** **Facility clinical staff cannot report/take/document resident death vitals prior to death in this citation.** **<u>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;</u>** **Inservice clinical licensed staff to re-educate procedure of a death to ensure death vital signs, disposition of resident medication, personal possessions and disposition of resident’s body are documented.** **<u>How the corrective action</u>**	

The clinical record for Resident D was reviewed on 9/15/21 at 3:15 p.m. Diagnosis included, but was not limited to, cognitive communication deficit.

A signed service plan, dated 6/25/21, indicated the resident had mild to moderate disorientation or difficulty recalling/retaining information, required frequent hygiene checks, required reminders for activities, and required reminders for meals.

A signed "Level of Service Assessment/Evaluation," dated 6/30/21, indicated Resident D did not communicate her needs but understood information and was oriented to person, place, and time.

The physician's orders lacked documentation of a code status for the resident or a signed Advanced Directive for the resident.

A Medication Administration Record, dated 8/1/21-8/31/21, indicated the resident had last received her medications at 7:00 p.m. on 8/29/21. The Medication Administration Record indicated the resident had not received her 7:00 a.m. medications on 8/30/21.

A Social Worker's note, dated 8/4/21 at 6:08 p.m., included, but was not limited to, "Met with resident on this date. Reviewed

<u>will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</u>

DON or designee to review deaths monthly for accurate documentation for 4 months.

<u>What date the systemic changes will be completed:</u>
11/19/21

resident code status wishes, community ancillary and guardian. LSW (Licensed Social Worked) to contact Guardian regarding resident consents needing signed."

A Social Worker's note, dated 8/16/21 at 4:36 p.m., included, but was not limited to, "Resident services consents, code status, IHCC (Integrated Health Care Coordination) forms emailed to guardian on this date."

A nurse's note, dated 8/30/21 at 11:10 a.m., included, but was not limited to, "QMA on the 3rd floor found resident expired while passing morning medication and notified the nurse on duty. The nurse on duty checked for pulse and heart beat and stated resident expired. The nurse notified the DONW (Director of Nursing and Wellness) that the resident expired. The DONW went to the resident's room confirmed and notified the ED (Executive Director). The DONW notified 911 and 911 notified the coroner. The Fire Department and [Initials of the Local Police Department] detectives came and did an investigation and report. The coroner came and stated the resident had a GI (gastrointestinal) bleed. The DONW notified [Name of resident's court appointed guardian]. The guardian picked [Name of Funeral Home] and

stated that [Name of Cemetery] had resident's arrangements. The DONW notified [Name of physician] office, resident's MD. unable to leave message due to lunch, will call back to notifies of resident's death." The nurse's note was signed by the DONW.

A nurse's note, dated 8/30/21 at 3:09 p.m., indicated "This nurse spoke with the [Name of Nurse Practitioner] about signing the resident's death certificate and was waiting a response."

The clinical record lacked documentation the resident had been observed or assessed from 7:00 p.m. on 8/29/21 until 11:10 a.m. 8/30/21.

During an interview on 9/16/21 at 9:06 a.m., the Director of Nursing (DON) indicated she had not attempted to obtain a blood pressure on the resident when she first saw her. The resident had vomited all over herself also, but she had not documented it.

During an interview on 8/16/21 at 11:30 a.m., QMA 1 indicated he had worked the previous evening and had given the resident her medication at 7:00 p.m. He indicated the resident normally came to the dining room for breakfast but he had not seen the resident at breakfast the morning of 8/30/21. QMA 1 indicated the

staff was supposed to check on the residents at least twice a day. He always checked on the residents when he arrived, usually at 7:00 a.m., and again before he would leave the facility, usually around 7:00 p.m. QMA 1 indicated the resident had medication ordered for 7:00 a.m., but he had not given the resident her 7:00 a.m. medications as he had until 11:00 a.m. to administer them. QMA 1 indicated when he went to the resident's room around 11:00 a.m. to give the resident her medications, the resident had not answered her door which was different for the resident. He indicated he opened the door and found the resident with emesis on her bed linen, in her hair, and on her gown. QMA 1 indicated he obtained the nurse who came to assess the resident, No CPR was administered to the resident. QMA 1 indicated he was certified in CPR but did not know if the resident was a full code or not. He indicated CPR should be administered if a person's code status is unknown and CPR should have been started on the resident when she was found unresponsive.

During an interview on 9/16/21 at 12:23 p.m. the DON indicated residents were only checked once every 24 hours. The DON indicated CPR should have

been started on the resident when the resident was found unresponsive. She indicated if a resident did not have a signed CPR declaration, the resident would be considered a full code. She indicated the resident did not have an assessment and the resident not been checked on for 16 hours prior to finding the resident deceased.

The clinical record lacked documentation of the resident's condition, vital signs prior to the resident's death, or the disposition of the resident's medications.

2. The closed clinical record of Resident H was reviewed on 9/16/21 at 12:47 p.m., Diagnoses included, but was not limited to, acute kidney failure, diabetes mellitus type 2, and essential hypertension.

A nurse's note, dated 8/19/21 at 3:50 p.m., included but was not limited to, "Communication with hospice services and nursing regarding order that [Name of Nurse Practitioner] gave for hospice referral. Documentation requested from nursing for referral to be sent."

A nurse's note, dated 8/20/21 at 11:55 a.m., included, but was not limited to, "Res (resident) referral, face sheet, and signed orders faxed to [Name of Hospice], NP (Nurse

Practitioner) notified of need for last office note to be faxed to hospice case manager.

A nurse's note, dated 8/25/21 at 3:36 p.m., included, but was not limited to, "Res labs reviewed, hospice admitted res onto service, coordinated cares with hospice, res feeling well no c/o (complaints) voiced."

A nurse's note, dated 9/7/21 at 8:28 p.m., included, but was not limited to, "This nurse notified POA (Power of Attorney) that resident had passed and that the resident had no set arrangements per the social worker. This nurse directed POA to notify hospice to guide him. POA thankful for this direction."

A nurse's note, dated 9/7/21 at 10:27 p.m., included, but was not limited to, "Received call from DONW stating resident has passed and asked if this writer (Social Worker) knows resident end of life wishes. LSW stated resident has POA and was on hospice service. Stated end of life planning is part of Hospice benefit. LSW also informed DONW, POA may have ex-wife phone number who may have soma information on resident end of life planning."

A nurse's note, dated 9/8/21 at 2:33 p.m., included, but was not limited to, "Communication with

(Name of POA) regarding resident room, next steps and timeline for moving items out of room."

The facility lacked documentation of any vital signs prior to the resident's death, the disposition of the resident's medications, personal possessions, or the disposition of the resident's body.

The facility lacked documentation of a policy for documenting information concerning the resident's death such as, the disposition of the body, personal possessions, and medications or a complete and accurate notation of the resident's condition and most recent vital signs and symptoms preceding a resident's death.

This State Residential finding relates to Complaint IN00361643 and Complaint IN00362438.

Based on record review and interview, the facility failed to document the resident most recent vital signs and condition preceding the resident's death for 2 of 2 resident's reviewed. (Resident D, Resident H)

Findings include:

1. During a confidential interview on 9/15/21 at 9:18 a.m., the Interviewee indicated a resident had "died over the

Labor Day weekend and hadn't been found for several days."

During review of the State reportable incidents, provided by the Administrator on 9/15/21 at 9:30 a.m., the reportables indicated Resident D had expired on 8/30/21 at 11:10 a.m. The Administrator indicated the resident had been a full code and should have had CPR (cardiopulmonary resuscitation) started when the resident was found unresponsive.

The clinical record for Resident D was reviewed on 9/15/21 at 3:15 p.m. Diagnosis included, but was not limited to, cognitive communication deficit.

A signed service plan, dated 6/25/21, indicated the resident had mild to moderate disorientation or difficulty recalling/retaining information, required frequent hygiene checks, required reminders for activities, and required reminders for meals.

A signed "Level of Service Assessment/Evaluation," dated 6/30/21, indicated Resident D did not communicate her needs but understood information and was oriented to person, place, and time.

The physician's orders lacked documentation of a code status for the resident or a signed Advanced Directive for the

resident.

A Medication Administration Record, dated 8/1/21-8/31/21, indicated the resident had last received her medications at 7:00 p.m. on 8/29/21. The Medication Administration Record indicated the resident had not received her 7:00 a.m. medications on 8/30/21.

A Social Worker's note, dated 8/4/21 at 6:08 p.m., included, but was not limited to, "Met with resident on this date. Reviewed resident code status wishes, community ancillary and guardian. LSW (Licensed Social Worked) to contact Guardian regarding resident consents needing signed."

A Social Worker's note, dated 8/16/21 at 4:36 p.m., included, but was not limited to, "Resident services consents, code status, IHCC (Integrated Health Care Coordination) forms emailed to guardian on this date."

A nurse's note, dated 8/30/21 at 11:10 a.m., included, but was not limited to, "QMA on the 3rd floor found resident expired while passing morning medication and notified the nurse on duty. The nurse on duty checked for pulse and heart beat and stated resident expired. The nurse notified the DONW (Director of Nursing and Wellness) that the resident

expired. The DONW went to the resident's room confirmed and notified the ED (Executive Director). The DONW notified 911 and 911 notified the coroner. The Fire Department and [Initials of the Local Police Department] detectives came and did an investigation and report. The coroner came and stated the resident had a GI (gastrointestinal) bleed. The DONW notified [Name of resident's court appointed guardian]. The guardian picked [Name of Funeral Home] and stated that [Name of Cemetery] had resident's arrangements. The DONW notified [Name of physician] office, resident's MD. unable to leave message due to lunch, will call back to notifies of resident's death." The nurse's note was signed by the DONW.

A nurse's note, dated 8/30/21 at 3:09 p.m., indicated "This nurse spoke with the [Name of Nurse Practitioner] about signing the resident's death certificate and was waiting a response."

The clinical record lacked documentation the resident had been observed or assessed from 7:00 p.m. on 8/29/21 until 11:10 a.m. 8/30/21.

During an interview on 9/16/21 at 9:06 a.m., the Director of Nursing (DON) indicated she had not attempted to obtain a blood pressure on the resident

when she first saw her. The resident had vomited all over herself also, but she had not documented it.

During an interview on 8/16/21 at 11:30 a.m., QMA 1 indicated he had worked the previous evening and had given the resident her medication at 7:00 p.m. He indicated the resident normally came to the dining room for breakfast but he had not seen the resident at breakfast the morning of 8/30/21. QMA 1 indicated the staff was supposed to check on the residents at least twice a day. He always checked on the residents when he arrived, usually at 7:00 a.m., and again before he would leave the facility, usually around 7:00 p.m. QMA 1 indicated the resident had medication ordered for 7:00 a.m., but he had not given the resident her 7:00 a.m. medications as he had until 11:00 a.m. to administer them. QMA 1 indicated when he went to the resident's room around 11:00 a.m. to give the resident her medications, the resident had not answered her door which was different for the resident. He indicated he opened the door and found the resident with emesis on her bed linen, in her hair, and on her gown. QMA 1 indicated he obtained the nurse who came to assess the resident, No CPR was administered to the

resident. QMA 1 indicated he was certified in CPR but did not know if the resident was a full code or not. He indicated CPR should be administered if a person's code status is unknown and CPR should have been started on the resident when she was found unresponsive.

During an interview on 9/16/21 at 12:23 p.m. the DON indicated residents were only checked once every 24 hours. The DON indicated CPR should have been started on the resident when the resident was found unresponsive. She indicated if a resident did not have a signed CPR declaration, the resident would be considered a full code. She indicated the resident did not have an assessment and the resident not been checked on for 16 hours prior to finding the resident deceased.

The clinical record lacked documentation of the resident's condition, vital signs prior to the resident's death, or the disposition of the resident's medications.

2. The closed clinical record of Resident H was reviewed on 9/16/21 at 12:47 p.m., Diagnoses included, but was not limited to, acute kidney failure, diabetes mellitus type 2, and essential hypertension.

A nurse's note, dated 8/19/21 at 3:50 p.m., included but was not limited to, "Communication with hospice services and nursing regarding order that [Name of Nurse Practitioner] gave for hospice referral. Documentation requested from nursing for referral to be sent."

A nurse's note, dated 8/20/21 at 11:55 a.m., included, but was not limited to, "Res (resident) referral, face sheet, and signed orders faxed to [Name of Hospice], NP (Nurse Practitioner) notified of need for last office note to be faxed to hospice case manager.

A nurse's note, dated 8/25/21 at 3:36 p.m., included, but was not limited to, "Res labs reviewed, hospice admitted res onto service, coordinated cares with hospice, res feeling well no c/o (complaints) voiced."

A nurse's note, dated 9/7/21 at 8:28 p.m., included, but was not limited to, "This nurse notified POA (Power of Attorney) that resident had passed and that the resident had no set arrangements per the social worker. This nurse directed POA to notify hospice to guide him. POA thankful for this direction."

A nurse's note, dated 9/7/21 at 10:27 p.m., included, but was not limited to, "Received call

from DONW stating resident has passed and asked if this writer (Social Worker) knows resident end of life wishes. LSW stated resident has POA and was on hospice service. Stated end of life planning is part of Hospice benefit. LSW also informed DONW, POA may have ex-wife phone number who may have soma information on resident end of life planning."

A nurse's note, dated 9/8/21 at 2:33 p.m., included, but was not limited to, "Communication with (Name of POA) regarding resident room, next steps and timeline for moving items out of room."

The facility lacked documentation of any vital signs prior to the resident's death, the disposition of the resident's medications, personal possessions, or the disposition of the resident's body.

The facility lacked documentation of a policy for documenting information concerning the resident's death such as, the disposition of the body, personal possessions, and medications or a complete and accurate notation of the resident's condition and most recent vital signs and symptoms preceding a resident's death.

This State Residential finding relates to Complaint

	IN00361643 and Complaint IN00362438.			

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