STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELLENIC SENIOR LIVING OF ELKHART	2528 BYPASS ROAD, ELKHART, , 46514

(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 IN00463336, IN00463090, and IN00462643. Complaint IN00463336 - No deficiencies related to the allegations are cited. Complaint IN00463090 - No deficiencies related to the allegations are cited. Complaint IN00462643 - State deficiencies related to the allegations are cited at R0036, R0052 and R0090. Survey date: July 16, 17, 18, & 21, 2025 Facility number: 014241 Residential Census: 105 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 7/22/2025	R 0000		

R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interviews and record reviews, the facility failed to ensure the physician and resident representative were notified timely of a resident's suicide attempt for 1 of 3 resident reviewed for changes in condition, (Residents E) Finding includes: 1. During an interview with Employee 4 on 7/17/25 at 10:22 A.M., she indicated on 6/8/25, she was not scheduled to work but had gone to the facility to visit residents and to complete some paperwork. She indicated upon arrival, at approximately 10:00 A.M., she was approached by Qualified Medication Aide (QMA) 3, who	R 0036	2.All residents could have been affected, however in this case, no other residents were affected. 3.All nursing staff in-service completed 7/23/25 in regard to community's policies onunusual occurrences, documentation, change of condition.Any staff found non-compliant will be re-educated and disciplined per facility policy. 4. DON/Designee will review PCC daily x5 days/week for six months to ensure procedure completed per policy for any unusual occurrences or changes of condition.Change of Condition form completed and reviewed by DON/Designee. Results of forms will be brought to ExecutiveDirectorweeklyfor final review and/or recommendations	08/08/2025

	asked her to go to the Nurse's Station next to the dining room. Employee 4 indicated while in the nurses station, QMA 3 told to her that she had gone to Resident E's room about an hour earlier to pass medication and found the resident with a plastic bag over his head in an attempt to commit suicide. Employee 4 indicated she asked QMA 3 if she had notified the Director of Nursing and QMA 3 indicated she had not, but that she had removed the plastic bag from the resident's head, administered his medication and left the room. Employee 4 indicated she instructed QMA 3 to notify the Director of Nursing immediately. Employee 4 indicated QMA 3 did notify the DON at that time. On 7/18/25 at 10:40 A.M., during an interview with the Administrator, she indicated on 6/8/25, Resident E was found in his room with a plastic bag over his head by QMA 3. The Administrator indicated Nursing Progress notes were all late entries, had not included the actual time the QMA had found the resident, when she had notified the Director of Nursing or when Emergency Medical Services (EMS) had been called. The Administrator indicated Resident E's physician had not been notified of the incident.			

	During an interview on 7/18/25 at 10:51 A.M., the Assistant Director of Nursing indicated Resident E's medical record lacked information regarding when the resident was found, when the Director of Nursing was notified, and when EMS was notified and when EMS transferred the resident to the Emergency Room (ER). The Assistant Director of Nursing indicated the late entries were made in Resident E's Electronic Medical Record (EMR) regarding the resident's incident, so exact times of the events were unknown. The Assistant Director of Nursing indicated late entries that were entered showed the correct "Created Date," where the "Effective Date," was whatever the writer entered into that area on the computer. She indicated "Created Date" could not be altered and "Effective Dates," could be altered in the Electronic Medical Record. The Assistant Director on Nursing indicated there was no documentation to indicate the resident's physician was notified of the incident, though there should have been notification at the time of the incident. On 7/18/25 at 11:55 A.M., during an interview with QMA 3, she indicated on 6/8/25 Resident E had not gone to the dining room to take his medications, so she went to			

	give his medications in his room. She indicated breakfast was served until 9:00 A.M. so she had gone to the resident's room shortly after 9:00 A.M. She indicated when she entered the resident's room, she found him laying on his couch with a plastic bag over his head. She indicated she asked him what he was doing and he responded that he was ready to "get out of here." QMA 3 indicated she took the bag off of the resident's head and left him to go back to the Nurse's Station to call the Director of Nursing. QMA 3 indicated when she called the Director of Nursing and reported the incident, the Director of Nursing instructed her to take the phone back to the resident's room so she could speak with the resident on the phone. QMA 3 indicated when the Director of Nursing finished talking on the phone with the resident, she spoke with the Director of Nursing who, at that time, gave her the phone number for the local EMS and instructed her to call and remain in the room with the resident until EMS arrived. QMA 3 indicated EMS told her it would be about 25 minutes before they would arrive. QMA 3 indicated there were no nurses in the facility to assess the resident and no nursing staff came in to assess the resident. QMA 3 indicated she had documented the incident in the nurse's note as a late entry and			

	was not certain what time the incident had actually occurred, what time she had enter or left the resident's room, when she had notified the Director of Nursing, when she had notified EMS, when EMS had arrived, or when EMS had transported the resident. On 7/16/25 at 3:54 P.M., Resident E's clinical record was reviewed. Diagnoses included but were not limited to type 2 diabetes, neuropathy, endocarditis, liver disease, hepatitis, squamous cell carcinoma to scalp and neck, and rhabdomylosis (a breakdown of muscle tissue, leading to the release of harmful substances into the bloodstream). Resident E was found to be cognitively intact on 5/15/25 when he was assessed for a Brief Interview for Mental Status (BIMS). In addition, the evaluation indicated on the resident's Service Plan that Resident E required his medications to be administered two times daily, blood sugar checks one time daily by nursing staff and behavior monitoring due to his reluctance to accept care. In addition, staff were to report any behavior changes from his base line behaviors Resident E's Progress Notes			

	included but were not limited to the following; A late entry, created by QMA 3 on 6/8/25 at 11:53 A.M., with an effective date of 6/8/25 at 11:48 A.M., which indicated Resident E had not gone to breakfast, as usual, so she had gone to check on the resident in his room and found him lying on the couch with a winter cap on and a plastic bag over his head and face. When QMA 3 asked him why he had a bag over his face, he ignored the question and told the QMA to bring his pills and check his blood. The entry indicated the resident had been sent to the hospital as directed by the Director of Nursing. There was no documentation the physician and/or the resident's representative was notified of the incident and transfer. A late entry created by the Director of Nursing on 6/25/25 at 1:54 P.M., with an effective date of 6/8/25 at 10:36 A.M., indicated she had received a phone call from QMA 3, who indicated during the morning medication pass, she had gone to the resident's room because he had not gone down for breakfast in the dining room to receive his medication. The Director of Nursing indicated when QMA 3 entered the resident's room, she had observed a clear plastic small			

	trash bag over his head and loosely open at the jaw line. She indicated the QMA was in the residents room at the time of the phone call notifying her and she had informed the Resident that she took all suicidal behavior seriously and EMS would be called to have him checked at the hospital. She also informed the resident he could return to the facility if the hospital deemed him as safe to return. The Director of Nursing indicated she had directed QMA 3 to notify EMS, and that EMS had already been notified, and QMA 3 was instructed to remain in the resident's room until EMS arrived. Review of Resident E's Medication Administration History. dated 6/8/25, indicated QMA 3 had administered Resident E's morning medication and checked his blood sugar at 9:37 A.M. Review of the Emergency Medical Service report indicated they had received a call at 10:47 A.M. from the facility and were on the scene at 11 :12 A.M. The report indicated the facility reported an onset date of 6/8/25 at 9:30 A.M. and the chief complaint was suicidal ideation's with a plan. The report indicated the facility nurse had stated that after the patient had missed breakfast, she had checked on the patient and			

found the patient with a bag over his head at 9:30 A.M.,. in an attempt to commit suicide. The nurse indicated the patient had made several statements about ending his life. While the crew was securing the patient onto the ambulance cot, the patient loosely grabbed onto one of the belts and stated, "here why don't we just do this," while attempting to wrap the belt around his neck. Resident E was transferred to the care of the ER on 6/8/25 at 11:35 A.M.

The ER physician's note, dated 6/8/25 - 9/9/25, indicated the resident had presented to the ER after nursing staff found him with a plastic bag over his head and that the patient was trying to suffocate himself. The ER physician indicated Resident E required inpatient psychiatric evaluation and was admitted to psychiatry.

A facility Nursing Progress Note, dated 6/17/25 at 4:11 P.M., indicated Resident E had returned to the facility from his hospital stay.

A policy titled "Resident Rights," dated 9/30/22, was provided by the Administrator on 7/18/25 at 9:00 A.M., indicating it was the current facility policy. The policy indicated, "...the facility must immediately consult the resident's physician...when the facility had noticed: (1) a

	significant decline in the resident's physical, mental, or psychosocial status..." This citation relates to Complaint IN00462643 Based on interviews and record reviews, the facility failed to ensure the physician and resident representative were notified timely of a resident's suicide attempt for 1 of 3 resident reviewed for changes in condition, (Residents E) Finding includes: 1. During an interview with Employee 4 on 7/17/25 at 10:22 A.M., she indicated on 6/8/25, she was not scheduled to work but had gone to the facility to visit residents and to complete some paperwork. She indicated upon arrival, at approximately 10:00 A.M., she was approached by Qualified Medication Aide (QMA) 3, who asked her to go to the Nurse's Station next to the dining room. Employee 4 indicated while in the nurses station, QMA 3 told to her that she had gone to Resident E's room about an hour earlier to pass medication and found the resident with a plastic bag over his head in an attempt to commit suicide. Employee 4 indicated she asked QMA 3 if she had notified the Director of Nursing and QMA 3 indicated she had not, but that			

	she had removed the plastic bag from the resident's head, administered his medication and left the room. Employee 4 indicated she instructed QMA 3 to notify the Director of Nursing immediately. Employee 4 indicated QMA 3 did notify the DON at that time. On 7/18/25 at 10:40 A.M., during an interview with the Administrator, she indicated on 6/8/25, Resident E was found in his room with a plastic bag over his head by QMA 3. The Administrator indicated Nursing Progress notes were all late entries, had not included the actual time the QMA had found the resident, when she had notified the Director of Nursing or when Emergency Medical Services (EMS) had been called. The Administrator indicated Resident E's physician had not been notified of the incident. During an interview on 7/18/25 at 10:51 A.M., the Assistant Director of Nursing indicated Resident E's medical record lacked information regarding when the resident was found, when the Director of Nursing was notified, and when EMS was notified and when EMS transferred the resident to the Emergency Room (ER). The Assistant Director of Nursing indicated the late entries were made in Resident E's Electronic			

	Medical Record (EMR) regarding the resident's incident, so exact times of the events were unknown. The Assistant Director of Nursing indicated late entries that were entered showed the correct "Created Date," where the "Effective Date," was whatever the writer entered into that area on the computer. She indicated "Created Date" could not be altered and "Effective Dates," could be altered in the Electronic Medical Record. The Assistant Director on Nursing indicated there was no documentation to indicate the resident's physician was notified of the incident, though there should have been notification at the time of the incident. On 7/18/25 at 11:55 A.M., during an interview with QMA 3, she indicated on 6/8/25 Resident E had not gone to the dining room to take his medications, so she went to give his medications in his room. She indicated breakfast was served until 9:00 A.M. so she had gone to the resident's room shortly after 9:00 A.M. She indicated when she entered the resident's room, she found him laying on his couch with a plastic bag over his head. She indicated she asked him what he was doing and he responded that he was ready to "get out of here." QMA 3 indicated she took the bag off of the resident's			

	head and left him to go back to the Nurse's Station to call the Director of Nursing. QMA 3 indicated when she called the Director of Nursing and reported the incident, the Director of Nursing instructed her to take the phone back to the resident's room so she could speak with the resident on the phone. QMA 3 indicated when the Director of Nursing finished talking on the phone with the resident, she spoke with the Director of Nursing who, at that time, gave her the phone number for the local EMS and instructed her to call and remain in the room with the resident until EMS arrived. QMA 3 indicated EMS told her it would be about 25 minutes before they would arrive. QMA 3 indicated there were no nurses in the facility to assess the resident and no nursing staff came in to assess the resident. QMA 3 indicated she had documented the incident in the nurse's note as a late entry and was not certain what time the incident had actually occurred, what time she had enter or left the resident's room, when she had notified the Director of Nursing, when she had notified EMS, when EMS had arrived, or when EMS had transported the resident. On 7/16/25 at 3:54 P.M., Resident E's clinical record was reviewed. Diagnoses included but were not limited to type 2			

	diabetes, neuropathy, endocarditis, liver disease, hepatitis, squamous cell carcinoma to scalp and neck, and rhabdomylosis (a breakdown of muscle tissue, leading to the release of harmful substances into the bloodstream). Resident E was found to be cognitively intact on 5/15/25 when he was assessed for a Brief Interview for Mental Status (BIMS). In addition, the evaluation indicated on the resident's Service Plan that Resident E required his medications to be administered two times daily, blood sugar checks one time daily by nursing staff and behavior monitoring due to his reluctance to accept care. In addition, staff were to report any behavior changes from his base line behaviors Resident E's Progress Notes included but were not limited to the following; A late entry, created by QMA 3 on 6/8/25 at 11:53 A.M., with an effective date of 6/8/25 at 11:48 A.M., which indicated Resident E had not gone to breakfast, as usual, so she had gone to check on the resident in his room and found him lying on the couch with a winter cap on and a plastic bag over his head and face. When QMA 3 asked him			

	why he had a bag over his face, he ignored the question and told the QMA to bring his pills and check his blood. The entry indicated the resident had been sent to the hospital as directed by the Director of Nursing. There was no documentation the physician and/or the resident's representative was notified of the incident and transfer. A late entry created by the Director of Nursing on 6/25/25 at 1:54 P.M., with an effective date of 6/8/25 at 10:36 A.M., indicated she had received a phone call from QMA 3, who indicated during the morning medication pass, she had gone to the resident's room because he had not gone down for breakfast in the dining room to receive his medication. The Director of Nursing indicated when QMA 3 entered the resident's room, she had observed a clear plastic small trash bag over his head and loosely open at the jaw line. She indicated the QMA was in the residents room at the time of the phone call notifying her and she had informed the Resident that she took all suicidal behavior seriously and EMS would be called to have him checked at the hospital. She also informed the resident he could return to the facility if the hospital deemed him as safe to return. The Director of Nursing			

	indicated she had directed QMA 3 to notify EMS, and that EMS had already been notified, and QMA 3 was instructed to remain in the resident's room until EMS arrived. Review of Resident E's Medication Administration History. dated 6/8/25, indicated QMA 3 had administered Resident E's morning medication and checked his blood sugar at 9:37 A.M. Review of the Emergency Medical Service report indicated they had received a call at 10:47 A.M. from the facility and were on the scene at 11 :12 A.M. The report indicated the facility reported an onset date of 6/8/25 at 9:30 A.M. and the chief complaint was suicidal ideation's with a plan. The report indicated the facility nurse had stated that after the patient had missed breakfast, she had checked on the patient and found the patient with a bag over his head at 9:30 A.M.,. in an attempt to commit suicide. The nurse indicated the patient had made several statements about ending his life. While the crew was securing the patient onto the ambulance cot, the patient loosely grabbed onto one of the belts and stated, "here why don't we just do this," while attempting to wrap the belt around his neck. Resident E was transferred to the care of			

	the ER on 6/8/25 at 11:35 A.M. The ER physician's note, dated 6/8/25 - 9/9/25, indicated the resident had presented to the ER after nursing staff found him with a plastic bag over his head and that the patient was trying to suffocate himself. The ER physician indicated Resident E required inpatient psychiatric evaluation and was admitted to psychiatry. A facility Nursing Progress Note, dated 6/17/25 at 4:11 P.M., indicated Resident E had returned to the facility from his hospital stay. A policy titled "Resident Rights," dated 9/30/22, was provided by the Administrator on 7/18/25 at 9:00 A.M., indicating it was the current facility policy. The policy indicated, "...the facility must immediately consult the resident's physician...when the facility had noticed: (1) a significant decline in the resident's physical, mental, or psychosocial status..." This citation relates to Complaint IN00462643			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from:	R 0052	2.All residents could have been affected, however in this case, no other residents were affected. 3.All nursing staff in-service	08/08/2025

	(1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interviews and record reviews, the facility failed to ensure residents were free from neglect related to the lack of assessments, lack of physician notifications, and delays in calling for Emergency Services for 2 of 3 resident reviewed for neglect, (Residents C and E). Findings include: 1. During an interview with Employee 4 on 7/17/25 at 10:22 A.M., she indicated Resident C had been admitted to the facility on 12/27/24 and was very involved in facility activities. Employee 4 indicated she had planned to visit the resident at the facility on 1/10/25 because the resident was new to the facility and she wanted to check on her. Employee 4 indicated she had asked the Activities Assistant to check on the resident earlier in the daybefore she had planned to arrive. Upon arrival, Employee 4 asked the Activities Assistant if she had checked on Resident C, and the Activities Assistant indicated		completed 7/23/25 in regard to community's policy on falls, unusual occurrences, documentation and follow-up.Any staff found non-compliant will be re-educated and disciplined per facility policy. 4.DON/Designee will review PCC daily x5 days/week for six months to ensure procedure completed per policy for any and all falls. Fall Task form completed for all falls and completed by DON/Designee. Results of forms will be brought to Executive Director weeklyfor review and/or recommendations	

	she had knocked on the Resident's room door but there was no answer, so she left without checking the resident. Employee 4 indicated she and the Activities Assistant went to the resident's room and found the resident seated in a wheelchair, in the bedroom, having what looked like a seizure. Employee 4 indicated she had instructed the Activities Assistant to get Licensed Practical Nurse (LPN) 5. When LPN 5 arrived she told the LPN to call an ambulance. Employee 4 indicated LPN 5 told her that an hour earlier, LPN 6 had observed the resident having a seizure and they were still trying to determine if an ambulance should be called. Employee 4 indicated she immediately called the Director of Nursing, who stated she would call and speak with LPN 5. On 7/18/25 at 1:00 P.M., the Administrator indicated Resident C had had a fall on 1/10/25 at in the morning. She indicated she was found on the floor by LPN 6. The Administrator indicated LPN 6 had called Emergency Medical Services (EMS) to have the resident taken to the Emergency Room (ER) for an assessment, but when the ambulance arrived, the resident refused to go and stated she was okay. The Administrator indicated the EMTs had assessed the resident and			

	indicated she was "okay" and had left without taking the resident. The Administrator indicated when LPN 5 had called the Director of Nursing, later that day, regarding how the resident was behaving, they determined the resident was not at her normal baseline and the DON had instructed LPN 5 to send Resident C to the hospital. However, LPN 5 had not sent the resident to the hospital at that time as she had been instructed. The Administrator indicated there were no follow-up assessments charted after the resident's fall except what was in the Nursing Progress Notes and an incident report had not been completed. The Administrator indicated there had been no neurological assessment initiated after Resident C had fallen. The Administrator indicated there had not been an investigation into the reason for the fall and the State had not been notified of the fall. On 7/18/25 at 1:17 P.M., during an interview with the Assistant Director of Nursing, she indicated the charting in the Nursing Progress Notes by nursing staff was confusing because most entries were late entries and the times where not entered correctly because staff had not always use military time and some events appeared to have happened at incorrect			

	times. The Assistant Director of Nursing indicated there was a delay in sending the resident to the hospital after the Director of Nursing had instructed LPN 5 to send the resident to the hospital. She indicated LPN 5 had not called EMS services for over an hour after she had been instructed to send the resident to the hospital. On 7/17/25 at 3:01 P.M., Resident C's clinical record was reviewed. Diagnoses included but were not limited to type 2 diabetes, low back pain, chronic kidney disease, occlusion and stenosis of her carotid arteries. Resident C's assessment for Brief Interview for Mental Status (BIMS), dated 12/30/24, indicated the resident was not cognitively impaired. The resident's Service Plan also dated 12/30/24, indicated Resident C required assistance for her oxygen therapy, pacemaker status, and reminders for medication management. The resident required reminders of safety hazards due to a history of hoarding and was independent for the use of her wheelchair. Resident C's fall risk assessment indicated she was at high risk for falling.			

	Resident C's Nursing Progress Notes, included but were not limited to; On 1/10/25 at 3:53 P.M., LPN 6 indicated on 1/10/25 at 8:00 A.M., a QMA had reported to LPN 6 that Resident C had been found on the floor, laying on her back with her head against the wall. The wheelchair had been positioned next to her. The resident stated her legs had given way and she had fallen. The residnt denied hitting her head. A visual assessment was completed and the resident had normal range of motion to her upper and lower extremities, her vital signs were within normal limits, she had expressed no complaints of pain and the resident remained oriented. LPN had called emergency services for further evaluation and when fire department showed up, the resident stated she was okay. The resident's physician and responsible party were notified of the resident's fall but it was unclear when they had been notified. In a subsequent note, created on 1/11/25 at 2:13 A.M., with an effective date of 1/10/25 at 9:30 A.M., LPN 5 indicated a post fall assessment had been completed and upon entering the room, she noted a pungent odor and found the resident near the window with her wheelchair close. LPN 5			

	indicated the resident answered some questions at the time, with some forgetfulness, and stated she was had been attempting to transfer herself and her legs had "gave out." Upon assessment, the resident had responded appropriatly to questions about her family and self. The resident's movements were at baseline. LPN 5 indicated, at that time, the fire department had arrived and had asked several questions and the resident indicated she did not want to go to the hospital. The fire chief stated she seemed fine and he was leaving. Resident C's vital signs were assessed and the physician, family, and ED were notified of the incident. Again, it is unclear which time the physician, family and Adminstrator had been made aware of the resident's fall as the previous late entry for 8:00 A.M. indicated the physician and resident's family member had been notified of her fall. A late entry created by LPN 5 on 1/11/25 at 11:53 A.M., indicated on 1/10/25 at 3:52 A.M., a post fall note had been created as a follow up to the note on 1/10/25 at 8:00 A.M., and indicated a post fall assessment had been completed with vitals and family and Administrator were notified of the incident. Again, this note seemed to reference a time frame prior to the reisdent's fall			

	around 8:00 A.M. on 1/10/2025 and again referenced notifying the physician and family a third time. There were no physician's orders or mention of the physician and/or family members response to having been notified of the fall. A late entry, created by the Director of Nursing on 1/13/25 at 11:15 A.M., with an effective time of 1/13/25 at 3:17 A.M., indicated the Activities Department had sent her a text with concern for Resident C's status after visiting her in her apartment. The Director of Nursing indicated she immediately called nursing staff, instructed them to go Resident C's room and instructed nursing staff to immediately discharge the resident to the Emergency Room. The Director of Nursing indicated the nursing staff was assisted with the transfer by the Administrator and Activities staff. The times of the "effective" portion of the note did not fit correctly into the time line reported per interview by the Activity Director. A late entry, created by the Director of Nursing on 1/13/25 at 11:12 A.M., with an effective date of 1/10/25 at 2:13 P.M., indicated she had received a phone call from LPN 5 at 2:13 P.M., requesting the DON's opinion regarding what Resident C's baseline behaviors and			

	Activities of Daily living abilities were. It was determined that the resident was not at her baseline and the Director of Nursing had "encouraged" LPN 5 to send the resident to the hospital due to a significant change in her cognition. A Nursing Progress Note, dated 1/10/25 at 3:30 P.M., created by LPN 5, indicated a QMA had gone to Resident C's room prior to end of her shift and had noted the resident slouching in the chair but she was able to respond to verbal stimuli. LPN 5 indicated she had started the procedure to transition the resident to the hospital due to lethargy and confusion and the Director of Nursing was consulted regarding the resident Baseline abilities. Resident C's Emergency Room record indicated the resident arrived at the local hospital on 1/10/25 at 3:50 P.M. The Emergency Room report indicated she was admitted due to an altered mental status and a report that she had fallen in the morning and had refused transport to ER. Later, the resident had been found unresponsive and the Emergency Medical Services was called again. The EMS paramedics had initiated a sternal rub that had aroused the resident. The ER physician indicated the resident had a			

slight urinary tract infections but did not feel that explained her mental status.

Resident C's Discharge Summary from the hospital, dated 1/17/25, indicated the resident's discharge summary included but were not limited to: an acute cerebral accident (stroke), and a urinary tract infection.

2. During an interview with Employee 4 on 7/17/25 at 10:22 A.M., she indicated on 6/8/25, she was not scheduled to work but had gone to the facility to visit residents and to complete some paperwork. She indicated upon arrival, at approximately 10:00 A.M., she was approached by Qualified Medication Aide (QMA) 3, who asked her to go to the Nurse's Station next to the dining room. Employee 4 indicated while in the nurses station, QMA 3 told to her that she had gone to Resident E's room about an hour earlier to pass medication and found the resident with a plastic bag over his head in an attempt to commit suicide. Employee 4 indicated she asked QMA 3 if she had notified the Director of Nursing and QMA 3 indicated she had not, but that she had removed the plastic bag from the resident's head, administered his medication and left the room. Employee 4 indicated she instructed QMA 3

	to notify the Director of Nursing immediately. Employee 4 indicated QMA 3 did notify the DON at that time. On 7/18/25 at 10:40 A.M., during an interview with the Administrator, she indicated on 6/8/25, Resident E was found in his room with a plastic bag over his head by QMA 3. The Administrator indicated Nursing Progress notes were all late entries, had not included the actual time the QMA had found the resident, when she had notified the Director of Nursing or when Emergency Medical Services (EMS) had been called. The Administrator indicated Resident E's physician had not been notified of the incident. During an interview on 7/18/25 at 10:51 A.M., the Assistant Director of Nursing indicated Resident E's medical record lacked information regarding when the resident was found, when the Director of Nursing was notified, and when EMS was notified and when EMS transferred the resident to the Emergency Room (ER). The Assistant Director of Nursing indicated the late entries were made in Resident E's Electronic Medical Record (EMR) regarding the resident's incident, so exact times of the events were unknown. The Assistant Director of Nursing			

	indicated late entries that were entered showed the correct "Created Date," where the "Effective Date," was whatever the writer entered into that area on the computer. She indicated "Created Date" could not be altered and "Effective Dates," could be altered in the Electronic Medical Record. The Assistant Director on Nursing indicated there was no documentation to indicate the resident's physician was notified of the incident, though there should have been notification at the time of the incident. On 7/18/25 at 11:55 A.M., during an interview with QMA 3, she indicated on 6/8/25 Resident E had not gone to the dining room to take his medications, so she went to give his medications in his room. She indicated breakfast was served until 9:00 A.M. so she had gone to the resident's room shortly after 9:00 A.M. She indicated when she entered the resident's room, she found him laying on his couch with a plastic bag over his head. She indicated she asked him what he was doing and he responded that he was ready to "get out of here." QMA 3 indicated she took the bag off of the resident's head and left him to go back to the Nurse's Station to call the Director of Nursing. QMA 3 indicated when she called the Director of Nursing and reported			

	the incident, the Director of Nursing instructed her to take the phone back to the resident's room so she could speak with the resident on the phone. QMA 3 indicated when the Director of Nursing finished talking on the phone with the resident, she spoke with the Director of Nursing who, at that time, gave her the phone number for the local EMS and instructed her to call and remain in the room with the resident until EMS arrived. QMA 3 indicated EMS told her it would be about 25 minutes before they would arrive. QMA 3 indicated there were no nurses in the facility to assess the resident and no nursing staff came in to assess the resident. QMA 3 indicated she had documented the incident in the nurse's note as a late entry and was not certain what time the incident had actually occurred, what time she had enter or left the resident's room, when she had notified the Director of Nursing, when she had notified EMS, when EMS had arrived, or when EMS had transported the resident. On 7/16/25 at 3:54 P.M., Resident E's clinical record was reviewed. Diagnoses included but were not limited to type 2 diabetes, neuropathy, endocarditis, liver disease, hepatitis, squamous cell carcinoma to scalp and neck, and rhabdomylosis (a			

	breakdown of muscle tissue, leading to the release of harmful substances into the bloodstream). Resident E was found to be cognitively intact on 5/15/25 when he was assessed for a Brief Interview for Mental Status (BIMS). In addition, the evaluation indicated on the resident's Service Plan that Resident E required his medications to be administered two times daily, blood sugar checks one time daily by nursing staff and behavior monitoring due to his reluctance to accept care. In addition, staff were to report any behavior changes from his base line behaviors Resident E's Progress Notes included but were not limited to the following; A late entry, created by QMA 3 on 6/8/25 at 11:53 A.M., with an effective date of 6/8/25 at 11:48 A.M., which indicated Resident E had not gone to breakfast, as usual, so she had gone to check on the resident in his room and found him lying on the couch with a winter cap on and a plastic bag over his head and face. When QMA 3 asked him why he had a bag over his face, he ignored the question and told the QMA to bring his pills and check his blood. The entry indicated the resident had been			

	sent to the hospital as directed by the Director of Nursing. There was no documentation the physician and/or the resident's representative was notified of the incident and transfer. A late entry created by the Director of Nursing on 6/25/25 at 1:54 P.M., with an effective date of 6/8/25 at 10:36 A.M., indicated she had received a phone call from QMA 3, who indicated during the morning medication pass, she had gone to the resident's room because he had not gone down for breakfast in the dining room to receive his medication. The Director of Nursing indicated when QMA 3 entered the resident's room, she had observed a clear plastic small trash bag over his head and loosely open at the jaw line. She indicated the QMA was in the residents room at the time of the phone call notifying her and she had informed the Resident that she took all suicidal behavior seriously and EMS would be called to have him checked at the hospital. She also informed the resident he could return to the facility if the hospital deemed him as safe to return. The Director of Nursing indicated she had directed QMA 3 to notify EMS, and that EMS had already been notified, and QMA 3 was instructed to remain in the resident's room until EMS			

	arrived. Review of Resident E's Medication Administration History. dated 6/8/25, indicated QMA 3 had administered Resident E's morning medication and checked his blood sugar at 9:37 A.M. Review of the Emergency Medical Service report indicated they had received a call at 10:47 A.M. from the facility and were on the scene at 11 :12 A.M. The report indicated the facility reported an onset date of 6/8/25 at 9:30 A.M. and the chief complaint was suicidal ideation's with a plan. The report indicated the facility nurse had stated that after the patient had missed breakfast, she had checked on the patient and found the patient with a bag over his head at 9:30 A.M.,. in an attempt to commit suicide. The nurse indicated the patient had made several statements about ending his life. While the crew was securing the patient onto the ambulance cot, the patient loosely grabbed onto one of the belts and stated, "here why don't we just do this," while attempting to wrap the belt around his neck. Resident E was transferred to the care of the ER on 6/8/25 at 11:35 A.M. The ER physician's note, dated 6/8/25 - 9/9/25, indicated the resident had presented to the			

	ER after nursing staff found him with a plastic bag over his head and that the patient was trying to suffocate himself. The ER physician indicated Resident E required inpatient psychiatric evaluation and was admitted to psychiatry. A facility Nursing Progress Note, dated 6/17/25 at 4:11 P.M., indicated Resident E had returned to the facility from his hospital stay. A policy titled Falls, dated 9/30/22, was provided by the Administrator on 7/18/25 at 9:00 A.M. who indicated it was the current facility policy. The policy indicated, "...Each resident fall will be documented in the nursing notes and on the Incident Report by the licensed nurse in charge on the shift during which the fall occurred..." A policy titled "Incident/Accident/Unusual Occurrence Investigation and Reporting," dated 9/30/22, was provided by the Administrator on 7/18/25 at 9:00 A.M., she indicated it was the current facility policy. The policy indicated, "...For the safety and well being of the residents, all incidents, accidents, and unusual occurrences will be handled in a uniform, prompt and efficient manner...completion of an incident report for internal			

use...The charge nurse will be responsible for immediate response to any incident...Documentation of the incident...in the resident's medical record, including i. Time, ii. place iii. assessment findings iv. immediate care rendered v.physician...notification vi. and additional interventions provided relative to the occurrence...the physician notification should take place first in order...

A policy titled "Resident Rights," dated 9/30/22, was provided by the Administrator on 7/18/25 at 9:00 A.M. and she indicated it was the current facility policy. The policy indicated, "...the facility must immediately consult the resident's physician...when the facility had noticed: (1) a significant decline in the resident's physical, mental, or psychosocial status..."

This citation relates to Complaint IN00462643

Based on interviews and record reviews, the facility failed to ensure residents were free from neglect related to the lack of assessments, lack of physician notifications, and delays in calling for Emergency Services for 2 of 3 resident reviewed for neglect, (Residents C and E).

Findings include:

1. During an interview with

	Employee 4 on 7/17/25 at 10:22 A.M., she indicated Resident C had been admitted to the facility on 12/27/24 and was very involved in facility activities. Employee 4 indicated she had planned to visit the resident at the facility on 1/10/25 because the resident was new to the facility and she wanted to check on her. Employee 4 indicated she had asked the Activities Assistant to check on the resident earlier in the daybefore she had planned to arrive. Upon arrival, Employee 4 asked the Activities Assistant if she had checked on Resident C, and the Activities Assistant indicated she had knocked on the Resident's room door but there was no answer, so she left without checking the resident. Employee 4 indicated she and the Activities Assistant went to the resident's room and found the resident seated in a wheelchair, in the bedroom, having what looked like a seizure. Employee 4 indicated she had instructed the Activities Assistant to get Licensed Practical Nurse (LPN) 5. When LPN 5 arrived she told the LPN to call an ambulance. Employee 4 indicated LPN 5 told her that an hour earlier, LPN 6 had observed the resident having a seizure and they were still trying to determine if an ambulance should be called. Employee 4 indicated she immediately called the Director of Nursing, who			

	stated she would call and speak with LPN 5. On 7/18/25 at 1:00 P.M., the Administrator indicated Resident C had had a fall on 1/10/25 at in the morning. She indicated she was found on the floor by LPN 6. The Administrator indicated LPN 6 had called Emergency Medical Services (EMS) to have the resident taken to the Emergency Room (ER) for an assessment, but when the ambulance arrived, the resident refused to go and stated she was okay. The Administrator indicated the EMTs had assessed the resident and indicated she was "okay" and had left without taking the resident. The Administrator indicated when LPN 5 had called the Director of Nursing, later that day, regarding how the resident was behaving, they determined the resident was not at her normal baseline and the DON had instructed LPN 5 to send Resident C to the hospital. However, LPN 5 had not sent the resident to the hospital at that time as she had been instructed. The Administrator indicated there were no follow-up assessments charted after the resident's fall except what was in the Nursing Progress Notes and an incident report had not been completed. The Administrator indicated there had been no neurological assessment initiated after			

	Resident C had fallen. The Administrator indicated there had not been an investigation into the reason for the fall and the State had not been notified of the fall. On 7/18/25 at 1:17 P.M., during an interview with the Assistant Director of Nursing, she indicated the charting in the Nursing Progress Notes by nursing staff was confusing because most entries were late entries and the times where not entered correctly because staff had not always use military time and some events appeared to have happened at incorrect times. The Assistant Director of Nursing indicated there was a delay in sending the resident to the hospital after the Director of Nursing had instructed LPN 5 to send the resident to the hospital. She indicated LPN 5 had not called EMS services for over an hour after she had been instructed to send the resident to the hospital. On 7/17/25 at 3:01 P.M., Resident C's clinical record was reviewed. Diagnoses included but were not limited to type 2 diabetes, low back pain, chronic kidney disease, occlusion and stenosis of her carotid arteries. Resident C's assessment for Brief Interview for Mental Status (BIMS), dated 12/30/24, indicated the resident was not			

	cognitively impaired. The resident's Service Plan also dated 12/30/24, indicated Resident C required assistance for her oxygen therapy, pacemaker status, and reminders for medication management. The resident required reminders of safety hazards due to a history of hoarding and was independent for the use of her wheelchair. Resident C's fall risk assessment indicated she was at high risk for falling. Resident C's Nursing Progress Notes, included but were not limited to; On 1/10/25 at 3:53 P.M., LPN 6 indicated on 1/10/25 at 8:00 A.M., a QMA had reported to LPN 6 that Resident C had been found on the floor, laying on her back with her head against the wall. The wheelchair had been positioned next to her. The resident stated her legs had given way and she had fallen. The residnt denied hitting her head. A visual assessment was completed and the resident had normal range of motion to her upper and lower extremities, her vital signs were within normal limits, she had expressed no complaints of pain and the resident remained oriented. LPN had called emergency services for further evaluation and when fire department showed up, the resident stated she was okay.			

	The resident's physician and responsible party were notified of the resident's fall but it was unclear when they had been notified. In a subsequent note, created on 1/11/25 at 2:13 A.M., with an effective date of 1/10/25 at 9:30 A.M., LPN 5 indicated a post fall assessment had been completed and upon entering the room, she noted a pungent odor and found the resident near the window with her wheelchair close. LPN 5 indicated the resident answered some questions at the time, with some forgetfulness, and stated she was had been attempting to transfer herself and her legs had "gave out." Upon assessment, the resident had responded appropriatly to questions about her family and self. The resident's movements were at baseline. LPN 5 indicated, at that time, the fire department had arrived and had asked several questions and the resident indicated she did not want to go to the hospital. The fire chief stated she seemed fine and he was leaving. Resident C's vital signs were assessed and the physician, family, and ED were notified of the incident. Again, it is unclear which time the physician, family and Adminstrator had been made aware of the resident's fall as the previous late entry for 8:00 A.M. indicated the physician and			

	resident's family member had been notified of her fall. A late entry created by LPN 5 on 1/11/25 at 11:53 A.M., indicated on 1/10/25 at 3:52 A.M., a post fall note had been created as a follow up to the note on 1/10/25 at 8:00 A.M., and indicated a post fall assessment had been completed with vitals and family and Administrator were notified of the incident. Again, this note seemed to reference a time frame prior to the reisdent's fall around 8:00 A.M. on 1/10/2025 and again referenced notifying the physician and family a third time. There were no physician's orders or mention of the physician and/or family members response to having been notified of the fall. A late entry, created by the Director of Nursing on 1/13/25 at 11:15 A.M., with an effective time of 1/13/25 at 3:17 A.M., indicated the Activities Department had sent her a text with concern for Resident C's status after visiting her in her apartment. The Director of Nursing indicated she immediately called nursing staff, instructed them to go Resident C's room and instructed nursing staff to immediately discharge the resident to the Emergency Room. The Director of Nursing indicated the nursing staff was assisted with the transfer by the			

	Administrator and Activities staff. The times of the "effective" portion of the note did not fit correctly into the time line reported per interview by the Activity Director. A late entry, created by the Director of Nursing on 1/13/25 at 11:12 A.M., with an effective date of 1/10/25 at 2:13 P.M., indicated she had received a phone call from LPN 5 at 2:13 P.M., requesting the DON's opinion regarding what Resident C's baseline behaviors and Activities of Daily living abilities were. It was determined that the resident was not at her baseline and the Director of Nursing had "encouraged" LPN 5 to send the resident to the hospital due to a significant change in her cognition. A Nursing Progress Note, dated 1/10/25 at 3:30 P.M., created by LPN 5, indicated a QMA had gone to Resident C's room prior to end of her shift and had noted the resident slouching in the chair but she was able to respond to verbal stimuli. LPN 5 indicated she had started the procedure to transition the resident to the hospital due to lethargy and confusion and the Director of Nursing was consulted regarding the resident Baseline abilities. Resident C's Emergency Room record indicated the resident			

	arrived at the local hospital on 1/10/25 at 3:50 P.M. The Emergency Room report indicated she was admitted due to an altered mental status and a report that she had fallen in the morning and had refused transport to ER. Later, the resident had been found unresponsive and the Emergency Medical Services was called again. The EMS paramedics had initiated a sternal rub that had aroused the resident. The ER physician indicated the resident had a slight urinary tract infections but did not feel that explained her mental status. Resident C's Discharge Summary from the hospital, dated 1/17/25, indicated the resident's discharge summary included but were not limited to: an acute cerebral accident (stroke), and a urinary tract infection. 2. During an interview with Employee 4 on 7/17/25 at 10:22 A.M., she indicated on 6/8/25, she was not scheduled to work but had gone to the facility to visit residents and to complete some paperwork. She indicated upon arrival, at approximately 10:00 A.M., she was approached by Qualified Medication Aide (QMA) 3, who asked her to go to the Nurse's Station next to the dining room. Employee 4 indicated while in			

	the nurses station, QMA 3 told to her that she had gone to Resident E's room about an hour earlier to pass medication and found the resident with a plastic bag over his head in an attempt to commit suicide. Employee 4 indicated she asked QMA 3 if she had notified the Director of Nursing and QMA 3 indicated she had not, but that she had removed the plastic bag from the resident's head, administered his medication and left the room. Employee 4 indicated she instructed QMA 3 to notify the Director of Nursing immediately. Employee 4 indicated QMA 3 did notify the DON at that time. On 7/18/25 at 10:40 A.M., during an interview with the Administrator, she indicated on 6/8/25, Resident E was found in his room with a plastic bag over his head by QMA 3. The Administrator indicated Nursing Progress notes were all late entries, had not included the actual time the QMA had found the resident, when she had notified the Director of Nursing or when Emergency Medical Services (EMS) had been called. The Administrator indicated Resident E's physician had not been notified of the incident. During an interview on 7/18/25 at 10:51 A.M., the Assistant Director of Nursing indicated			

	Resident E's medical record lacked information regarding when the resident was found, when the Director of Nursing was notified, and when EMS was notified and when EMS transferred the resident to the Emergency Room (ER). The Assistant Director of Nursing indicated the late entries were made in Resident E's Electronic Medical Record (EMR) regarding the resident's incident, so exact times of the events were unknown. The Assistant Director of Nursing indicated late entries that were entered showed the correct "Created Date," where the "Effective Date," was whatever the writer entered into that area on the computer. She indicated "Created Date" could not be altered and "Effective Dates," could be altered in the Electronic Medical Record. The Assistant Director on Nursing indicated there was no documentation to indicate the resident's physician was notified of the incident, though there should have been notification at the time of the incident. On 7/18/25 at 11:55 A.M., during an interview with QMA 3, she indicated on 6/8/25 Resident E had not gone to the dining room to take his medications, so she went to give his medications in his room. She indicated breakfast was served until 9:00 A.M. so			

	she had gone to the resident's room shortly after 9:00 A.M. She indicated when she entered the resident's room, she found him laying on his couch with a plastic bag over his head. She indicated she asked him what he was doing and he responded that he was ready to "get out of here." QMA 3 indicated she took the bag off of the resident's head and left him to go back to the Nurse's Station to call the Director of Nursing. QMA 3 indicated when she called the Director of Nursing and reported the incident, the Director of Nursing instructed her to take the phone back to the resident's room so she could speak with the resident on the phone. QMA 3 indicated when the Director of Nursing finished talking on the phone with the resident, she spoke with the Director of Nursing who, at that time, gave her the phone number for the local EMS and instructed her to call and remain in the room with the resident until EMS arrived. QMA 3 indicated EMS told her it would be about 25 minutes before they would arrive. QMA 3 indicated there were no nurses in the facility to assess the resident and no nursing staff came in to assess the resident. QMA 3 indicated she had documented the incident in the nurse's note as a late entry and was not certain what time the incident had actually occurred, what time she had enter or left			

	the resident's room, when she had notified the Director of Nursing, when she had notified EMS, when EMS had arrived, or when EMS had transported the resident. On 7/16/25 at 3:54 P.M., Resident E's clinical record was reviewed. Diagnoses included but were not limited to type 2 diabetes, neuropathy, endocarditis, liver disease, hepatitis, squamous cell carcinoma to scalp and neck, and rhabdomylosis (a breakdown of muscle tissue, leading to the release of harmful substances into the bloodstream). Resident E was found to be cognitively intact on 5/15/25 when he was assessed for a Brief Interview for Mental Status (BIMS). In addition, the evaluation indicated on the resident's Service Plan that Resident E required his medications to be administered two times daily, blood sugar checks one time daily by nursing staff and behavior monitoring due to his reluctance to accept care. In addition, staff were to report any behavior changes from his base line behaviors Resident E's Progress Notes included but were not limited to the following;			

	A late entry, created by QMA 3 on 6/8/25 at 11:53 A.M., with an effective date of 6/8/25 at 11:48 A.M., which indicated Resident E had not gone to breakfast, as usual, so she had gone to check on the resident in his room and found him lying on the couch with a winter cap on and a plastic bag over his head and face. When QMA 3 asked him why he had a bag over his face, he ignored the question and told the QMA to bring his pills and check his blood. The entry indicated the resident had been sent to the hospital as directed by the Director of Nursing. There was no documentation the physician and/or the resident's representative was notified of the incident and transfer. A late entry created by the Director of Nursing on 6/25/25 at 1:54 P.M., with an effective date of 6/8/25 at 10:36 A.M., indicated she had received a phone call from QMA 3, who indicated during the morning medication pass, she had gone to the resident's room because he had not gone down for breakfast in the dining room to receive his medication. The Director of Nursing indicated when QMA 3 entered the resident's room, she had observed a clear plastic small trash bag over his head and loosely open at the jaw line. She indicated the QMA was in the			

	residents room at the time of the phone call notifying her and she had informed the Resident that she took all suicidal behavior seriously and EMS would be called to have him checked at the hospital. She also informed the resident he could return to the facility if the hospital deemed him as safe to return. The Director of Nursing indicated she had directed QMA 3 to notify EMS, and that EMS had already been notified, and QMA 3 was instructed to remain in the resident's room until EMS arrived. Review of Resident E's Medication Administration History. dated 6/8/25, indicated QMA 3 had administered Resident E's morning medication and checked his blood sugar at 9:37 A.M. Review of the Emergency Medical Service report indicated they had received a call at 10:47 A.M. from the facility and were on the scene at 11 :12 A.M. The report indicated the facility reported an onset date of 6/8/25 at 9:30 A.M. and the chief complaint was suicidal ideation's with a plan. The report indicated the facility nurse had stated that after the patient had missed breakfast, she had checked on the patient and found the patient with a bag over his head at 9:30 A.M.,. in an attempt to commit suicide.			

	The nurse indicated the patient had made several statements about ending his life. While the crew was securing the patient onto the ambulance cot, the patient loosely grabbed onto one of the belts and stated, "here why don't we just do this," while attempting to wrap the belt around his neck. Resident E was transferred to the care of the ER on 6/8/25 at 11:35 A.M. The ER physician's note, dated 6/8/25 - 9/9/25, indicated the resident had presented to the ER after nursing staff found him with a plastic bag over his head and that the patient was trying to suffocate himself. The ER physician indicated Resident E required inpatient psychiatric evaluation and was admitted to psychiatry. A facility Nursing Progress Note, dated 6/17/25 at 4:11 P.M., indicated Resident E had returned to the facility from his hospital stay. A policy titled Falls, dated 9/30/22, was provided by the Administrator on 7/18/25 at 9:00 A.M. who indicated it was the current facility policy. The policy indicated, "...Each resident fall will be documented in the nursing notes and on the Incident Report by the licensed nurse in charge on the shift during which the fall occurred..."			

	A policy titled "Incident/Accident/Unusual Occurrence Investigation and Reporting," dated 9/30/22, was provided by the Administrator on 7/18/25 at 9:00 A.M., she indicated it was the current facility policy. The policy indicated, "...For the safety and well being of the residents, all incidents, accidents, and unusual occurrences will be handled in a uniform, prompt and efficient manner...completion of an incident report for internal use...The charge nurse will be responsible for immediate response to any incident...Documentation of the incident...in the resident's medical record, including i. Time, ii. place iii. assessment findings iv. immediate care rendered v.physician...notification vi. and additional interventions provided relative to the occurrence...the physician notification should take place first in order...			

	A policy titled "Resident Rights," dated 9/30/22, was provided by the Administrator on 7/18/25 at 9:00 A.M. and she indicated it was the current facility policy. The policy indicated, "...the facility must immediately consult the resident's physician...when the facility had noticed: (1) a significant decline in the resident's physical, mental, or psychosocial status..." This citation relates to Complaint IN00462643			
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings;	R 0090	2.All residents could have been affected, however in this case, no other residents were affected. 3.All nursing staff in-service completed 7/23/25 in regard to community's policy on falls, unusual occurrences, documentation and follow-up.Any staff found non-compliant will be re-educated and disciplined per facility policy. 4.DON/Designee will review PCC daily x5 days/week for six months to ensure procedure completed per policy for any and all falls.Fall Task form completed for all falls and completed by DON/Designee. Results of forms will be brought toExecutiveDirector weeklyfor review and/or recommendations 6. Executive Director will review incident reports daily x 5 days/week for six months to ensure investigation completion, timely	08/08/2025

	(C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the		State reporting, and proper documentation in PCC. A tracking log has been implemented to ensure every incident is documented, investigated, and tracked to completion before closure.	

public upon request

Based on interviews and record reviews, the facility failed to ensure one residents' fall and another resident's unusual occurance were fully investigated and reported to the State Agency as directed by their facility policy, for 2 of 3 residents reviewed for falls and unusual occurrances, (Residents C and E).

Findings include:

1. During an interview with Employee 4 on 7/17/25 at 10:22 A.M., she indicated Resident C had been admitted to the facility on 12/27/24 and was very involved in facility activities. Employee 4 indicated she had planned to visit the resident at the facility on 1/10/25 because the resident was new to the facility and she wanted to check on her. Employee 4 indicated she had asked the Activities Assistant to check on the resident earlier in the daybefore she had planned to arrive. Upon arrival, Employee 4 asked the Activities Assistant if she had checked on Resident C, and the Activities Assistant indicated she had knocked on the Resident's room door but there was no answer, so she left without checking the resident. Employee 4 indicated she and the Activities Assistant went to the resident's room and found

the resident seated in a wheelchair, in the bedroom, having what looked like a seizure. Employee 4 indicated she had instructed the Activities Assistant to get Licensed Practical Nurse (LPN) 5. When LPN 5 arrived she told the LPN to call an ambulance. Employee 4 indicated LPN 5 told her that an hour earlier, LPN 6 had observed the resident having a seizure and they were still trying to determine if an ambulance should be called. Employee 4 indicated she immediately called the Director of Nursing, who stated she would call and speak with LPN 5.

On 7/18/25 at 1:00 P.M., the Administrator indicated Resident C had had a fall on 1/10/25 at in the morning. She indicated she was found on the floor by LPN 6. The Administrator indicated LPN 6 had called Emergency Medical Services (EMS) to have the resident taken to the Emergency Room (ER) for an assessment, but when the ambulance arrived, the resident refused to go and stated she was okay. The Administrator indicated the EMTs had assessed the resident and indicated she was "okay" and had left without taking the resident. The Administrator indicated when LPN 5 had called the Director of Nursing, later that day, regarding how the resident was behaving, they

determined the resident was not at her normal baseline and the DON had instructed LPN 5 to send Resident C to the hospital. However, LPN 5 had not sent the resident to the hospital at that time as she had been instructed. The Administrator indicated there were no follow-up assessments charted after the resident's fall except what was in the Nursing Progress Notes and an incident report had not been completed. The Administrator indicated there had been no neurological assessment initiated after Resident C had fallen. The Administrator indicated there had not been an investigation into the reason for the fall and the State had not been notified of the fall.

On 7/18/25 at 1:17 P.M., during an interview with the Assistant Director of Nursing, she indicated the charting in the Nursing Progress Notes by nursing staff was confusing because most entries were late entries and the times where not entered correctly because staff had not always use military time and some events appeared to have happened at incorrect times. The Assistant Director of Nursing indicated there was a delay in sending the resident to the hospital after the Director of Nursing had instructed LPN 5 to send the resident to the hospital. She indicated LPN 5

had not called EMS services for over an hour after she had been instructed to send the resident to the hospital.

On 7/17/25 at 3:01 P.M., Resident C's clinical record was reviewed. Diagnoses included but were not limited to type 2 diabetes, low back pain, chronic kidney disease, occlusion and stenosis of her carotid arteries.

Resident C's assessment for Brief Interview for Mental Status (BIMS), dated 12/30/24, indicated the resident was not cognitively impaired. The resident's Service Plan also dated 12/30/24, indicated Resident C required assistance for her oxygen therapy, pacemaker status, and reminders for medication management. The resident required reminders of safety hazards due to a history of hoarding and was independent for the use of her wheelchair. Resident C's fall risk assessment indicated she was at high risk for falling.

Resident C's Nursing Progress Notes, included but were not limited to;

On 1/10/25 at 3:53 P.M., LPN 6 indicated on 1/10/25 at 8:00 A.M., a QMA had reported to LPN 6 that Resident C had been found on the floor, laying on her back with her head

against the wall. The wheelchair had been positioned next to her. The resident stated her legs had given way and she had fallen. The residnt denied hitting her head. A visual assessment was completed and the resident had normal range of motion to her upper and lower extremities, her vital signs were within normal limits, she had expressed no complaints of pain and the resident remained oriented. LPN had called emergency services for further evaluation and when fire department showed up, the resident stated she was okay. The resident's physician and responsible party were notified of the resident's fall but it was unclear when they had been notified.

In a subsequent note, created on 1/11/25 at 2:13 A.M., with an effective date of 1/10/25 at 9:30 A.M., LPN 5 indicated a post fall assessment had been completed and upon entering the room, she noted a pungent odor and found the resident near the window with her wheelchair close. LPN 5 indicated the resident answered some questions at the time, with some forgetfulness, and stated she was had been attempting to transfer herself and her legs had "gave out." Upon assessment, the resident had responded appropriatly to questions about her family and self. The resident's movements were at

baseline. LPN 5 indicated, at that time, the fire department had arrived and had asked several questions and the resident indicated she did not want to go to the hospital. The fire chief stated she seemed fine and he was leaving. Resident C's vital signs were assessed and the physician, family, and ED were notified of the incident. Again, it is unclear which time the physician, family and Adminstrator had been made aware of the resident's fall as the previous late entry for 8:00 A.M. indicated the physician and resident's family member had been notified of her fall.

A late entry created by LPN 5 on 1/11/25 at 11:53 A.M., indicated on 1/10/25 at 3:52 A.M., a post fall note had been created as a follow up to the note on 1/10/25 at 8:00 A.M., and indicated a post fall assessment had been completed with vitals and family and Administrator were notified of the incident. Again, this note seemed to reference a time frame prior to the reisdent's fall around 8:00 A.M. on 1/10/2025 and again referenced notifying the physician and family a third time. There were no physician's orders or mention of the physician and/or family members response to having been notified of the fall.

A late entry, created by the

Director of Nursing on 1/13/25 at 11:15 A.M., with an effective time of 1/13/25 at 3:17 A.M., indicated the Activities Department had sent her a text with concern for Resident C's status after visiting her in her apartment. The Director of Nursing indicated she immediately called nursing staff, instructed them to go Resident C's room and instructed nursing staff to immediately discharge the resident to the Emergency Room. The Director of Nursing indicated the nursing staff was assisted with the transfer by the Administrator and Activities staff. The times of the "effective" portion of the note did not fit correctly into the time line reported per interview by the Activity Director.

A late entry, created by the Director of Nursing on 1/13/25 at 11:12 A.M., with an effective date of 1/10/25 at 2:13 P.M., indicated she had received a phone call from LPN 5 at 2:13 P.M., requesting the DON's opinion regarding what Resident C's baseline behaviors and Activities of Daily living abilities were. It was determined that the resident was not at her baseline and the Director of Nursing had "encouraged" LPN 5 to send the resident to the hospital due to a significant change in her cognition.

A Nursing Progress Note, dated

1/10/25 at 3:30 P.M., created by LPN 5, indicated a QMA had gone to Resident C's room prior to end of her shift and had noted the resident slouching in the chair but she was able to respond to verbal stimuli. LPN 5 indicated she had started the procedure to transition the resident to the hospital due to lethargy and confusion and the Director of Nursing was consulted regarding the resident Baseline abilities.

2. During an interview with Employee 4 on 7/17/25 at 10:22 A.M., she indicated on 6/8/25, she was not scheduled to work but had gone to the facility to visit residents and to complete some paperwork. She indicated upon arrival, at approximately 10:00 A.M., she was approached by Qualified Medication Aide (QMA) 3, who asked her to go to the Nurse's Station next to the dining room. Employee 4 indicated while in the nurses station, QMA 3 told to her that she had gone to Resident E's room about an hour earlier to pass medication and found the resident with a plastic bag over his head in an attempt to commit suicide. Employee 4 indicated she asked QMA 3 if she had notified the Director of Nursing and QMA 3 indicated she had not, but that she had removed the plastic bag from the resident's head, administered his medication and

left the room. Employee 4 indicated she instructed QMA 3 to notify the Director of Nursing immediately. Employee 4 indicated QMA 3 did notify the DON at that time.

On 7/18/25 at 10:40 A.M., during an interview with the Administrator, she indicated on 6/8/25, Resident E was found in his room with a plastic bag over his head by QMA 3. The Administrator indicated Nursing Progress notes were all late entries, had not included the actual time the QMA had found the resident, when she had notified the Director of Nursing or when Emergency Medical Services (EMS) had been called. The Administrator indicated Resident E's physician had not been notified of the incident.

During an interview on 7/18/25 at 10:51 A.M., the Assistant Director of Nursing indicated Resident E's medical record lacked information regarding when the resident was found, when the Director of Nursing was notified, and when EMS was notified and when EMS transferred the resident to the Emergency Room (ER). The Assistant Director of Nursing indicated the late entries were made in Resident E's Electronic Medical Record (EMR) regarding the resident's incident, so exact times of the

events were unknown. The Assistant Director of Nursing indicated late entries that were entered showed the correct "Created Date," where the "Effective Date," was whatever the writer entered into that area on the computer. She indicated "Created Date" could not be altered and "Effective Dates," could be altered in the Electronic Medical Record. The Assistant Director on Nursing indicated there was no documentation to indicate the resident's physician was notified of the incident, though there should have been notification at the time of the incident.

On 7/16/25 at 3:54 P.M., Resident E's clinical record was reviewed. Diagnoses included but were not limited to type 2 diabetes, neuropathy, endocarditis, liver disease, hepatitis, squamous cell carcinoma to scalp and neck, and rhabdomylosis (a breakdown of muscle tissue, leading to the release of harmful substances into the bloodstream).

Resident E's Progress Notes included but were not limited to the following;

A late entry, created by QMA 3 on 6/8/25 at 11:53 A.M., with an effective date of 6/8/25 at 11:48 A.M., which indicated Resident E had not gone to breakfast, as

usual, so she had gone to check on the resident in his room and found him lying on the couch with a winter cap on and a plastic bag over his head and face. When QMA 3 asked him why he had a bag over his face, he ignored the question and told the QMA to bring his pills and check his blood. The entry indicated the resident had been sent to the hospital as directed by the Director of Nursing. There was no documentation the physician and/or the resident's representative was notified of the incident and transfer.

A late entry created by the Director of Nursing on 6/25/25 at 1:54 P.M., with an effective date of 6/8/25 at 10:36 A.M., indicated she had received a phone call from QMA 3, who indicated during the morning medication pass, she had gone to the resident's room because he had not gone down for breakfast in the dining room to receive his medication. The Director of Nursing indicated when QMA 3 entered the resident's room, she had observed a clear plastic small trash bag over his head and loosely open at the jaw line. She indicated the QMA was in the residents room at the time of the phone call notifying her and she had informed the Resident that she took all suicidal behavior seriously and EMS would be

	called to have him checked at the hospital. She also informed the resident he could return to the facility if the hospital deemed him as safe to return. The Director of Nursing indicated she had directed QMA 3 to notify EMS, and that EMS had already been notified, and QMA 3 was instructed to remain in the resident's room until EMS arrived.			

	A policy titled "Incident/Accident/Unusual Occurrence Investigation and Reporting," dated 9/30/22, was provided by the Administrator on 7/18/25 at 9:00 A.M., she indicated it was the current facility policy. The policy indicated, "...For the safety and well being of the residents, all incidents, accidents, and unusual occurrences will be handled in a uniform, prompt and efficient manner...completion of an incident report for internal use...The charge nurse will be responsible for immediate response to any incident...Documentation of the incident...in the resident's medical record, including i. Time, ii. place iii. assessment findings iv. immediate care rendered v.physician...notification vi. and additional interventions provided relative to the occurrence...the physician notification should take place first in order...			

	A policy titled "Resident Rights," dated 9/30/22, was provided by the Administrator on 7/18/25 at 9:00 A.M. and she indicated it was the current facility policy. The policy indicated, "...the facility must immediately consult the resident's physician...when the facility had noticed: (1) a significant decline in the resident's physical, mental, or psychosocial status...			

During an interview with Employee 4 on 7/17/25 at 10:22 A.M., she indicated Resident C was admitted to the facility on 12/27/24 and on 1/10/25 had planned to visit the resident because she was new to the facility and wanted to check on her. Employee 4 indicated she and the Activities Assistant went to the resident's room and found the resident sitting in a wheelchair in her bedroom having what looked like a seizure. Employee 4 indicated she instructed the Activities Assistant to get Licensed Practical Nurse (LPN) 5, and when LPN 5 arrived, she told the LPN to call an ambulance. Employee 4 indicated LPN 5 told her that an hour earlier LPN 6 had observed the resident having a seizure, and they were still trying to determine if an ambulance should be called. Employee 4 indicated she immediately called the Director of Nursing, who said she would call LPN 5.

On 7/18/25 at 1:00 P.M., the Administrator indicated Resident C had a fall on 1/10/25 at in the morning. She indicated she was found on the floor by LPN 6. The Administrator indicated LPN 6 called Emergency Medical Services (EMS) to have the resident taken to the Emergency Room (ER) for assessment, but when the ambulance arrived, the resident refused to go and

stated she was okay. The Administrator indicated the EMTs assessed the resident and indicated she was okay and then left. The Administrator indicated when LPN 5 called the Director of Nursing later that day about how the resident was behaving and they determined the resident was not at her normal baseline, the DON instructed LPN 5 to send Resident C to the hospital, but LPN 5 did not sent the resident to the hospital at that time as she should have. The Administrator indicated an incident report was not completed, there was no investigation of the fall, and the State was not notified of the fall.

On 7/18/25 at 1:17 P.M., during an interview the Assistant Director of Nursing indicated was a delay in sending the resident to the hospital after the Director of Nursing instructed LPN 5 to send the resident to the hospital, but LPN 5 did not call for EMS services for over an hour.

On 7/17/25 at 3:01 P.M., Resident C's clinical record was reviewed. Diagnoses included but were not limited to type 2 diabetes, low back pain, chronic kidney disease, occlusion and stenosis of her carotid arteries.

Resident C's assessment for Brief Interview for Mental Status

	(BIMS), dated 12/30/24, indicated the resident was not cognitively impaired. The resident's Service Plan also dated 12/30/24, indicated Resident C required assistance for her oxygen therapy, pacemaker status, and reminders for medication management. The resident required reminders of safety hazards due to a history of hoarding and was independent for the use of her wheelchair. Resident C's fall risk assessment indicated she was at high risk for falling. Resident C's Progress Notes included but were not limited to;			

On 1/10/25 at 3:53 P.M., LPN 6 indicated on 1/10/25 at 8:00 A.M., QMA reported to LPN 6 that the resident was found on the floor laying on her back with her head against the wall. The wheelchair was positioned next to her. The resident stated her legs gave way and she fell, denied hitting her head. A visual assessment indicated resident had normal range of motion to upper and lower extremities, vital signs were within normal limits, no pain was voiced and the resident remained oriented. LPN called emergency services for further evaluation, and when fire department showed up the resident stated she was okay. The resident's physician and responsible party were notified.

In a note created on 1/11/25 at 2:13 A.M., with an effective date of 1/10/25 at 9:30 A.M., LPN 5 indicated a post fall assessment was done and upon entering the room, she noted a pungent odor and found the resident near the window with her wheelchair close. LPN 5 indicated the resident answered some questions at the time with some forgetfulness and states she was trying to transfer and her legs gave out. Upon assessment the resident responded appropriate to questions about her family and self. Resident's movements were at baseline. LPN 5 indicated at that time the fire

department showed up and asked several questions and the resident indicated she did not want to go to the hospital, the fire chief stated she seemed fine and he was leaving. Vital signs were assessed and physician, family, and ED were notified of the incident.

A late entry created by LPN 5 on 1/11/25 at 11:53 A.M., indicated on 1/10/25 at 3:52 A.M., a post fall note was created as a follow up to the note on 1/10/25 at 8:00 A.M., and indicated a post fall assessment was completed with vitals and family and Administrator were notified of the incident.

A late entry created by the Director of Nursing on 1/13/25 at 11:15 A.M., with an effective time of 1/13/25 at 3:17 A.M., indicated the Activities Department sent her a text with concern for Resident C's status after visiting her in her apartment. The Director of Nursing indicated she immediately called nursing staff to go to the room and instructed nursing staff to immediately discharge the resident to the Emergency Room. The Director of Nursing indicated nursing staff was assisted by the Administrator and Activities for the transfer.

A late entry created by the

Director of Nursing on 1/13/25 at 11:12 A.M., with an effective date of 1/10/25 at 2:13 P.M., indicated she received a phone call from the LPN 5 at 2:13 P.M., requesting what Resident C's baseline behaviors and Activities of Daily living where, and it was determined that the resident was not at baseline. The Director of Nursing encouraged LPN 5 to sent the resident to the hospital due to a significant change in cognition.

Progress Note dated 1/10/25 at 3:30 P.M., created by LPN 5, indicated QMA went to resident's room prior to end of shift and noted the resident slouching in the chair but was able to respond to verbal stimuli. LPN 5 indicated she and started procedure to transition the resident to the hospital due to lethargy and confusion and the Director of Nursing was consulted on the resident Baseline.

Resident C's Emergency Room record indicated the resident arrived at the local hospital on 1/10/25 at 3:50 P.M. The Emergency Room report indicated she was admitted for altered mental status and a report that she had fallen in the morning and refused transport to ER. Later the resident was found unresponsive and Emergency Medical Services was called again. EMS initiated

a sternal rub that aroused the resident. The ER physician indicated the resident had a slight urinary tract infections by did not feel that would explain her mental status.

Resident C's Discharge Summary dated 1/17/25 indicated the resident's discharge summary included but were not limited to an acute cerebral accident (stroke), and urinary tract infection.

2. During an interview with Employee 4 on 7/17/25 at 10:22 A.M., she indicated on 6/8/25 she was not scheduled to work but had gone to the facility to complete some paperwork. She indicated upon arrival at approximately 10:00 A.M., she was approached by Qualified Medication Aide (QMA) 3, who asked her to go to the Nurse's Station next to the dining room. Employee 4 indicated while in the nurses station, QMA 3 told to her that she had gone to Resident E's room about an hour earlier to pass medication and found the resident with a plastic bag over his head in an attempt to commit suicide. Employee 4 indicated she asked QMA 3 if she had notified the Director of Nursing and QMA 3 indicated she had not, but that she had removed the plastic bag from the resident's head, administered his medication, and left the room. Employee 4

indicated she instructed QMA 3 to notify the Director of Nursing immediately which she did at that time.

On 7/18/25 at 10:40 A.M., during an interview with the Administrator, she indicated on 6/8/25, Resident E was found in his room with a plastic bag over his head by QMA 3. The Administrator indicated progress notes were all late entries, did not include an actual time the QMA found the resident, when she notified the Director of Nursing, or when Emergency Medical Services (EMS) was called. The Administrator indicated Resident E's physician was not notified of the incident, there was not an investigation, and the State was not notified of the unusual occurrance.

During an interview on 7/18/25 at 10:51 A.M., the Assistant Director of Nursing indicated Resident E's medical record lacked information regarding when the resident was found, when the Director of Nursing was notified, and when EMS was notified and when EMS transferred the resident to the Emergency Room (ER). The Assistant Director of Nursing indicated late entries were made in Resident E's Electronic Medical Record (EMR) regarding the resident's incident, so exact times of the events were unknown. The

Assistant Director of Nursing indicated late entries that were entered showed the correct "Created Date," where the "Effective Date," was whatever the writer entered into that area on the computer. She indicated "Created Date" could not be altered and "Effective Dates," could be altered in the Electronic Medical Record. The Assistant Director of Nursing indicated there was not a nurse in the building at the time of the incident, a nurse did not come to the facility to assessment the resident at the time of the incident, and QMAs were not allowed to assess the residents. The Assistant Director on Nursing indicated there was no documentation to indicate the Resident's physician was notified of the incident, though should have been notified at the time of the incident to obtain orders.

On 7/18/25 at 11:55 A.M., during an interview with QMA 3, she indicated on 6/8/25, she went to Resident E's room shortly after 9:00 A.M., and when she entered the resident's room, she found the resident laying on his couch with a plastic bag over his head. QMA 3 indicated she took the bag off of the residents head and left him to go 2 halls down the Nurses Station to call the Director of Nursing. QMA 3 indicated when she called the

Director of Nursing and reported the incident, the Director of Nursing instructed her to take the phone back to the resident's room so she could speak with the resident on the phone. QMA 3 indicated when the Director of Nursing finished talking on the phone with the resident, she spoke with the Director of Nursing who at that time gave her the phone number for the local EMS and instructed her to call and remain in the room with the resident until EMS arrived. QMA 3 indicated EMS told her it would be about 25 minutes before they would arrive. QMA 3 indicated there were no nurses in the facility to assess the resident and no nursing staff came in to assess the resident.

On 7/16/25 at 3:54 P.M., Resident E's clinical record was reviewed. Diagnoses included but were not limited to type 2 diabetes, neuropathy, endocarditis, liver disease, hepatitis, squamous cell carcinoma to scalp and neck, and rhabdomylosis (a breakdown of muscle tissue, leading to the release of harmful substances into the bloodstream).

Resident E was found to be cognitively intact on 5/15/25 when he was assessed for a Brief Interview for Mental Status (BIMS). Also evaluated on 5/15/25 was the resident's

Service Plan that indicated Resident E required medications to be administered two times daily and blood sugar checks one time daily by nursing staff. Resident E required behavior monitoring due to reluctance to accept care, and staff were to report any changes from base line behaviors.

Resident E's Progress Notes included but were not limited to the following;

A late entry created by QMA 3 on 6/8/25 at 11:53 A.M., with an effective date of 6/8/25 at 11:48 A.M., indicated Resident E did not go to breakfast as usual so she went to check on the resident in his room and found him lying on the couch with a winter cap on and with a plastic bag over his head and face. When QMA 3 asked why he had the bag over his face, he ignored the question and told the QMA to bring his pills and check his blood. The entry indicated the resident was sent to the hospital to get checked out as directed by the Director of Nursing.

A late entry created by the Director of Nursing on 6/25/25 at 1:54 P.M., with an effective date of 6/8/25 at 10:36 A.M., indicated she received a phone call from QMA 3 who indicated during the morning medication

pass she went to the resident's room because he had not gone down for breakfast in the dining room and to receive his medication. The Director of Nursing indicated when QMA 3 entered the resident's room she observed a clear plastic small trash bag over his head and loosely open to the jaw line. She indicated the QMA was in the residents room at the time of the phone call and indicated to the Resident that she took all suicidal behavior seriously and EMS would be called to have him checked at the hospital. The resident could return to the facility if the hospital deemed him as safe to return. The Director of nursing indicated she directed QMA 3 to notify EMS, and that EMS had already been notified, and to remain in the resident's room until EMS arrived.

Review of Resident E's Medication Administration History dated 6/8/25, the form indicated QMA 3 administered Resident E's morning medication and checked his blood sugar at 9:37 A.M.

Review of Resident E's EMS ambulance service report indicated the EMS services received a call from the facility at 10:47 A.M. and were on the scene at the facility at 11:12 A.M. The report indicated the facility reported an onset date of

6/8/25 at 9:30 A.M. and the chief complaint was suicidal ideation's with a plan. The nurse stated that after the patient had missed breakfast she checked on the patient and found the patient with a bag over his head at 9:30 A.M. in an attempt to commit suicide, and that the patient had made several statements about ending his life. While the crew was securing the patient onto the ambulance cot, the patient loosely grabbed on of the belts and stated, "here why don't we just do the," while attempting to wrap the belt around his neck. Resident E was transferred to the care of the ER on 6/8/25 at 11:35 A.M.

The ER physician's note dated 6/8/25 - 9/9/25, indicated the resident presented to the ER after nursing staff found him with a plastic bag over his head and that the patient was try to suffocate himself. The ER physician indicated Resident E would require inpatient psychiatric evaluation and would be admitted to psychiatry.

A facility Progress Note dated 6/17/25 at 4:11 P.M., indicated Resident E returned to the facility from his hospital stay.

A policy titled "Incident/Accident/Unusual Occurrence Investigation and Reporting," dated 9/30/22, was provided by the Administrator on

	7/18/25 at 9:00 A.M., and indicated it was the current facility policy. The policy indicated, "...For the safety and well being of the residents, all incidents, accidents, and unusual occurrences will be handled in a uniform, prompt and efficient manner...completion of an incident report for internal use...The charge nurse will be responsible for immediate response to any incident...Documentation of the incident...in the resident's medical record, including i. Time, ii. place iii. assessment findings iv. immediate care rendered v.physician...notification vi. and additional interventions provided relative to the occurrence...the physician notification should take place first in order...The Executive Director and the Director of Nursing will follow the Indiana State Department of Health's Reportable Incidient Policy for the protocol for reporting incident that are deemed serious and meet the roporting requirments...For all incident/accidents/unusual occurrences, the Director of Nursing will coordinate an investigation...Summary of facts of the investigation, including time line, bu the Director of Nursing...			

This citation relates to Complaint IN00462643

Based on interviews and record reviews, the facility failed to ensure one residents' fall and another resident's unusual occurance were fully investigated and reported to the State Agency as directed by their facility policy, for 2 of 3 residents reviewed for falls and unusual occurrances, (Residents C and E).

Findings include:

1. During an interview with Employee 4 on 7/17/25 at 10:22 A.M., she indicated Resident C had been admitted to the facility on 12/27/24 and was very involved in facility activities. Employee 4 indicated she had planned to visit the resident at the facility on 1/10/25 because the resident was new to the facility and she wanted to check on her. Employee 4 indicated she had asked the Activities Assistant to check on the resident earlier in the daybefore she had planned to arrive. Upon arrival, Employee 4 asked the Activities Assistant if she had checked on Resident C, and the Activities Assistant indicated she had knocked on the Resident's room door but there was no answer, so she left without checking the resident. Employee 4 indicated she and the Activities Assistant went to

the resident's room and found the resident seated in a wheelchair, in the bedroom, having what looked like a seizure. Employee 4 indicated she had instructed the Activities Assistant to get Licensed Practical Nurse (LPN) 5. When LPN 5 arrived she told the LPN to call an ambulance. Employee 4 indicated LPN 5 told her that an hour earlier, LPN 6 had observed the resident having a seizure and they were still trying to determine if an ambulance should be called. Employee 4 indicated she immediately called the Director of Nursing, who stated she would call and speak with LPN 5.

On 7/18/25 at 1:00 P.M., the Administrator indicated Resident C had had a fall on 1/10/25 at in the morning. She indicated she was found on the floor by LPN 6. The Administrator indicated LPN 6 had called Emergency Medical Services (EMS) to have the resident taken to the Emergency Room (ER) for an assessment, but when the ambulance arrived, the resident refused to go and stated she was okay. The Administrator indicated the EMTs had assessed the resident and indicated she was "okay" and had left without taking the resident. The Administrator indicated when LPN 5 had called the Director of Nursing, later that day, regarding how the

resident was behaving, they determined the resident was not at her normal baseline and the DON had instructed LPN 5 to send Resident C to the hospital. However, LPN 5 had not sent the resident to the hospital at that time as she had been instructed. The Administrator indicated there were no follow-up assessments charted after the resident's fall except what was in the Nursing Progress Notes and an incident report had not been completed. The Administrator indicated there had been no neurological assessment initiated after Resident C had fallen. The Administrator indicated there had not been an investigation into the reason for the fall and the State had not been notified of the fall.

On 7/18/25 at 1:17 P.M., during an interview with the Assistant Director of Nursing, she indicated the charting in the Nursing Progress Notes by nursing staff was confusing because most entries were late entries and the times where not entered correctly because staff had not always use military time and some events appeared to have happened at incorrect times. The Assistant Director of Nursing indicated there was a delay in sending the resident to the hospital after the Director of Nursing had instructed LPN 5 to send the resident to the

hospital. She indicated LPN 5 had not called EMS services for over an hour after she had been instructed to send the resident to the hospital.

On 7/17/25 at 3:01 P.M., Resident C's clinical record was reviewed. Diagnoses included but were not limited to type 2 diabetes, low back pain, chronic kidney disease, occlusion and stenosis of her carotid arteries.

Resident C's assessment for Brief Interview for Mental Status (BIMS), dated 12/30/24, indicated the resident was not cognitively impaired. The resident's Service Plan also dated 12/30/24, indicated Resident C required assistance for her oxygen therapy, pacemaker status, and reminders for medication management. The resident required reminders of safety hazards due to a history of hoarding and was independent for the use of her wheelchair. Resident C's fall risk assessment indicated she was at high risk for falling.

Resident C's Nursing Progress Notes, included but were not limited to;

On 1/10/25 at 3:53 P.M., LPN 6 indicated on 1/10/25 at 8:00 A.M., a QMA had reported to LPN 6 that Resident C had been found on the floor, laying

on her back with her head against the wall. The wheelchair had been positioned next to her. The resident stated her legs had given way and she had fallen. The residnt denied hitting her head. A visual assessment was completed and the resident had normal range of motion to her upper and lower extremities, her vital signs were within normal limits, she had expressed no complaints of pain and the resident remained oriented. LPN had called emergency services for further evaluation and when fire department showed up, the resident stated she was okay. The resident's physician and responsible party were notified of the resident's fall but it was unclear when they had been notified.

In a subsequent note, created on 1/11/25 at 2:13 A.M., with an effective date of 1/10/25 at 9:30 A.M., LPN 5 indicated a post fall assessment had been completed and upon entering the room, she noted a pungent odor and found the resident near the window with her wheelchair close. LPN 5 indicated the resident answered some questions at the time, with some forgetfulness, and stated she was had been attempting to transfer herself and her legs had "gave out." Upon assessment, the resident had responded appropriatly to questions about her family and self. The

resident's movements were at baseline. LPN 5 indicated, at that time, the fire department had arrived and had asked several questions and the resident indicated she did not want to go to the hospital. The fire chief stated she seemed fine and he was leaving. Resident C's vital signs were assessed and the physician, family, and ED were notified of the incident. Again, it is unclear which time the physician, family and Adminstrator had been made aware of the resident's fall as the previous late entry for 8:00 A.M. indicated the physician and resident's family member had been notified of her fall.

A late entry created by LPN 5 on 1/11/25 at 11:53 A.M., indicated on 1/10/25 at 3:52 A.M., a post fall note had been created as a follow up to the note on 1/10/25 at 8:00 A.M., and indicated a post fall assessment had been completed with vitals and family and Administrator were notified of the incident. Again, this note seemed to reference a time frame prior to the reisdent's fall around 8:00 A.M. on 1/10/2025 and again referenced notifying the physician and family a third time. There were no physician's orders or mention of the physician and/or family members response to having been notified of the fall.

A late entry, created by the Director of Nursing on 1/13/25 at 11:15 A.M., with an effective time of 1/13/25 at 3:17 A.M., indicated the Activities Department had sent her a text with concern for Resident C's status after visiting her in her apartment. The Director of Nursing indicated she immediately called nursing staff, instructed them to go Resident C's room and instructed nursing staff to immediately discharge the resident to the Emergency Room. The Director of Nursing indicated the nursing staff was assisted with the transfer by the Administrator and Activities staff. The times of the "effective" portion of the note did not fit correctly into the time line reported per interview by the Activity Director.

A late entry, created by the Director of Nursing on 1/13/25 at 11:12 A.M., with an effective date of 1/10/25 at 2:13 P.M., indicated she had received a phone call from LPN 5 at 2:13 P.M., requesting the DON's opinion regarding what Resident C's baseline behaviors and Activities of Daily living abilities were. It was determined that the resident was not at her baseline and the Director of Nursing had "encouraged" LPN 5 to send the resident to the hospital due to a significant change in her cognition.

A Nursing Progress Note, dated 1/10/25 at 3:30 P.M., created by LPN 5, indicated a QMA had gone to Resident C's room prior to end of her shift and had noted the resident slouching in the chair but she was able to respond to verbal stimuli. LPN 5 indicated she had started the procedure to transition the resident to the hospital due to lethargy and confusion and the Director of Nursing was consulted regarding the resident Baseline abilities.

2. During an interview with Employee 4 on 7/17/25 at 10:22 A.M., she indicated on 6/8/25, she was not scheduled to work but had gone to the facility to visit residents and to complete some paperwork. She indicated upon arrival, at approximately 10:00 A.M., she was approached by Qualified Medication Aide (QMA) 3, who asked her to go to the Nurse's Station next to the dining room. Employee 4 indicated while in the nurses station, QMA 3 told to her that she had gone to Resident E's room about an hour earlier to pass medication and found the resident with a plastic bag over his head in an attempt to commit suicide. Employee 4 indicated she asked QMA 3 if she had notified the Director of Nursing and QMA 3 indicated she had not, but that she had removed the plastic bag from the resident's head,

administered his medication and left the room. Employee 4 indicated she instructed QMA 3 to notify the Director of Nursing immediately. Employee 4 indicated QMA 3 did notify the DON at that time.

On 7/18/25 at 10:40 A.M., during an interview with the Administrator, she indicated on 6/8/25, Resident E was found in his room with a plastic bag over his head by QMA 3. The Administrator indicated Nursing Progress notes were all late entries, had not included the actual time the QMA had found the resident, when she had notified the Director of Nursing or when Emergency Medical Services (EMS) had been called. The Administrator indicated Resident E's physician had not been notified of the incident.

During an interview on 7/18/25 at 10:51 A.M., the Assistant Director of Nursing indicated Resident E's medical record lacked information regarding when the resident was found, when the Director of Nursing was notified, and when EMS was notified and when EMS transferred the resident to the Emergency Room (ER). The Assistant Director of Nursing indicated the late entries were made in Resident E's Electronic Medical Record (EMR) regarding the resident's

incident, so exact times of the events were unknown. The Assistant Director of Nursing indicated late entries that were entered showed the correct "Created Date," where the "Effective Date," was whatever the writer entered into that area on the computer. She indicated "Created Date" could not be altered and "Effective Dates," could be altered in the Electronic Medical Record. The Assistant Director on Nursing indicated there was no documentation to indicate the resident's physician was notified of the incident, though there should have been notification at the time of the incident.

On 7/16/25 at 3:54 P.M., Resident E's clinical record was reviewed. Diagnoses included but were not limited to type 2 diabetes, neuropathy, endocarditis, liver disease, hepatitis, squamous cell carcinoma to scalp and neck, and rhabdomylosis (a breakdown of muscle tissue, leading to the release of harmful substances into the bloodstream).

Resident E's Progress Notes included but were not limited to the following;

A late entry, created by QMA 3 on 6/8/25 at 11:53 A.M., with an effective date of 6/8/25 at 11:48 A.M., which indicated Resident

E had not gone to breakfast, as usual, so she had gone to check on the resident in his room and found him lying on the couch with a winter cap on and a plastic bag over his head and face. When QMA 3 asked him why he had a bag over his face, he ignored the question and told the QMA to bring his pills and check his blood. The entry indicated the resident had been sent to the hospital as directed by the Director of Nursing. There was no documentation the physician and/or the resident's representative was notified of the incident and transfer.

A late entry created by the Director of Nursing on 6/25/25 at 1:54 P.M., with an effective date of 6/8/25 at 10:36 A.M., indicated she had received a phone call from QMA 3, who indicated during the morning medication pass, she had gone to the resident's room because he had not gone down for breakfast in the dining room to receive his medication. The Director of Nursing indicated when QMA 3 entered the resident's room, she had observed a clear plastic small trash bag over his head and loosely open at the jaw line. She indicated the QMA was in the residents room at the time of the phone call notifying her and she had informed the Resident that she took all suicidal behavior

seriously and EMS would be called to have him checked at the hospital. She also informed the resident he could return to the facility if the hospital deemed him as safe to return. The Director of Nursing indicated she had directed QMA 3 to notify EMS, and that EMS had already been notified, and QMA 3 was instructed to remain in the resident's room until EMS arrived.

A policy titled "Incident/Accident/Unusual Occurrence Investigation and Reporting," dated 9/30/22, was provided by the Administrator on 7/18/25 at 9:00 A.M., she indicated it was the current facility policy. The policy indicated, "...For the safety and well being of the residents, all incidents, accidents, and unusual occurrences will be handled in a uniform, prompt and efficient manner...completion of an incident report for internal use...The charge nurse will be responsible for immediate response to any incident...Documentation of the incident...in the resident's medical record, including i. Time, ii. place iii. assessment findings iv. immediate care rendered v.physician...notification vi. and additional interventions provided relative to the occurrence...the physician notification should

take place first in order...

A policy titled "Resident Rights," dated 9/30/22, was provided by the Administrator on 7/18/25 at 9:00 A.M. and she indicated it was the current facility policy. The policy indicated, "...the facility must immediately consult the resident's physician...when the facility had noticed: (1) a significant decline in the resident's physical, mental, or psychosocial status...

During an interview with Employee 4 on 7/17/25 at 10:22 A.M., she indicated Resident C was admitted to the facility on 12/27/24 and on 1/10/25 had planned to visit the resident because she was new to the facility and wanted to check on her. Employee 4 indicated she and the Activities Assistant went to the resident's room and found the resident sitting in a wheelchair in her bedroom having what looked like a seizure. Employee 4 indicated she instructed the Activities Assistant to get Licensed Practical Nurse (LPN) 5, and when LPN 5 arrived, she told the LPN to call an ambulance. Employee 4 indicated LPN 5 told her that an hour earlier LPN 6 had observed the resident having a seizure, and they were still trying to determine if an ambulance should be called. Employee 4 indicated she immediately called the Director

of Nursing, who said she would call LPN 5.

On 7/18/25 at 1:00 P.M., the Administrator indicated Resident C had a fall on 1/10/25 at in the morning. She indicated she was found on the floor by LPN 6. The Administrator indicated LPN 6 called Emergency Medical Services (EMS) to have the resident taken to the Emergency Room (ER) for assessment, but when the ambulance arrived, the resident refused to go and stated she was okay. The Administrator indicated the EMTs assessed the resident and indicated she was okay and then left. The Administrator indicated when LPN 5 called the Director of Nursing later that day about how the resident was behaving and they determined the resident was not at her normal baseline, the DON instructed LPN 5 to send Resident C to the hospital, but LPN 5 did not sent the resident to the hospital at that time as she should have. The Administrator indicated an incident report was not completed, there was no investigation of the fall, and the State was not notified of the fall.

On 7/18/25 at 1:17 P.M., during an interview the Assistant Director of Nursing indicated was a delay in sending the resident to the hospital after the Director of Nursing instructed

LPN 5 to send the resident to the hospital, but LPN 5 did not call for EMS services for over an hour.

On 7/17/25 at 3:01 P.M., Resident C's clinical record was reviewed. Diagnoses included but were not limited to type 2 diabetes, low back pain, chronic kidney disease, occlusion and stenosis of her carotid arteries.

Resident C's assessment for Brief Interview for Mental Status (BIMS), dated 12/30/24, indicated the resident was not cognitively impaired. The resident's Service Plan also dated 12/30/24, indicated Resident C required assistance for her oxygen therapy, pacemaker status, and reminders for medication management. The resident required reminders of safety hazards due to a history of hoarding and was independent for the use of her wheelchair. Resident C's fall risk assessment indicated she was at high risk for falling.

Resident C's Progress Notes included but were not limited to;

On 1/10/25 at 3:53 P.M., LPN 6 indicated on 1/10/25 at 8:00 A.M., QMA reported to LPN 6 that the resident was found on the floor laying on her back with her head against the wall. The wheelchair was positioned next

to her. The resident stated her legs gave way and she fell, denied hitting her head. A visual assessment indicated resident had normal range of motion to upper and lower extremities, vital signs were within normal limits, no pain was voiced and the resident remained oriented. LPN called emergency services for further evaluation, and when fire department showed up the resident stated she was okay. The resident's physician and responsible party were notified.

In a note created on 1/11/25 at 2:13 A.M., with an effective date of 1/10/25 at 9:30 A.M., LPN 5 indicated a post fall assessment was done and upon entering the room, she noted a pungent odor and found the resident near the window with her wheelchair close. LPN 5 indicated the resident answered some questions at the time with some forgetfulness and states she was trying to transfer and her legs gave out. Upon assessment the resident responded appropriate to questions about her family and self. Resident's movements were at baseline. LPN 5 indicated at that time the fire department showed up and asked several questions and the resident indicated she did not want to go to the hospital, the fire chief stated she seemed fine and he was leaving. Vital signs were assessed and physician,

family, and ED were notified of the incident.

A late entry created by LPN 5 on 1/11/25 at 11:53 A.M., indicated on 1/10/25 at 3:52 A.M., a post fall note was created as a follow up to the note on 1/10/25 at 8:00 A.M., and indicated a post fall assessment was completed with vitals and family and Administrator were notified of the incident.

A late entry created by the Director of Nursing on 1/13/25 at 11:15 A.M., with an effective time of 1/13/25 at 3:17 A.M., indicated the Activities Department sent her a text with concern for Resident C's status after visiting her in her apartment. The Director of Nursing indicated she immediately called nursing staff to go to the room and instructed nursing staff to immediately discharge the resident to the Emergency Room. The Director of Nursing indicated nursing staff was assisted by the Administrator and Activities for the transfer.

A late entry created by the Director of Nursing on 1/13/25 at 11:12 A.M., with an effective date of 1/10/25 at 2:13 P.M., indicated she received a phone call from the LPN 5 at 2:13 P.M., requesting what Resident C's baseline behaviors and

Activities of Daily living where, and it was determined that the resident was not at baseline. The Director of Nursing encouraged LPN 5 to sent the resident to the hospital due to a significant change in cognition.

Progress Note dated 1/10/25 at 3:30 P.M., created by LPN 5, indicated QMA went to resident's room prior to end of shift and noted the resident slouching in the chair but was able to respond to verbal stimuli. LPN 5 indicated she and started procedure to transition the resident to the hospital due to lethargy and confusion and the Director of Nursing was consulted on the resident Baseline.

Resident C's Emergency Room record indicated the resident arrived at the local hospital on 1/10/25 at 3:50 P.M. The Emergency Room report indicated she was admitted for altered mental status and a report that she had fallen in the morning and refused transport to ER. Later the resident was found unresponsive and Emergency Medical Services was called again. EMS initiated a sternal rub that aroused the resident. The ER physician indicated the resident had a slight urinary tract infections by did not feel that would explain her mental status.

Resident C's Discharge Summary dated 1/17/25 indicated the resident's discharge summary included but were not limited to an acute cerebral accident (stroke), and urinary tract infection.

2. During an interview with Employee 4 on 7/17/25 at 10:22 A.M., she indicated on 6/8/25 she was not scheduled to work but had gone to the facility to complete some paperwork. She indicated upon arrival at approximately 10:00 A.M., she was approached by Qualified Medication Aide (QMA) 3, who asked her to go to the Nurse's Station next to the dining room. Employee 4 indicated while in the nurses station, QMA 3 told to her that she had gone to Resident E's room about an hour earlier to pass medication and found the resident with a plastic bag over his head in an attempt to commit suicide. Employee 4 indicated she asked QMA 3 if she had notified the Director of Nursing and QMA 3 indicated she had not, but that she had removed the plastic bag from the resident's head, administered his medication, and left the room. Employee 4 indicated she instructed QMA 3 to notify the Director of Nursing immediately which she did at that time.

On 7/18/25 at 10:40 A.M., during an interview with the

Administrator, she indicated on 6/8/25, Resident E was found in his room with a plastic bag over his head by QMA 3. The Administrator indicated progress notes were all late entries, did not include an actual time the QMA found the resident, when she notified the Director of Nursing, or when Emergency Medical Services (EMS) was called. The Administrator indicated Resident E's physician was not notified of the incident, there was not an investigation, and the State was not notified of the unusual occurrance.

During an interview on 7/18/25 at 10:51 A.M., the Assistant Director of Nursing indicated Resident E's medical record lacked information regarding when the resident was found, when the Director of Nursing was notified, and when EMS was notified and when EMS transferred the resident to the Emergency Room (ER). The Assistant Director of Nursing indicated late entries were made in Resident E's Electronic Medical Record (EMR) regarding the resident's incident, so exact times of the events were unknown. The Assistant Director of Nursing indicated late entries that were entered showed the correct "Created Date," where the "Effective Date," was whatever the writer entered into that area on the computer. She indicated

"Created Date" could not be altered and "Effective Dates," could be altered in the Electronic Medical Record. The Assistant Director of Nursing indicated there was not a nurse in the building at the time of the incident, a nurse did not come to the facility to assessment the resident at the time of the incident, and QMAs were not allowed to assess the residents. The Assistant Director on Nursing indicated there was no documentation to indicate the Resident's physician was notified of the incident, though should have been notified at the time of the incident to obtain orders.

On 7/18/25 at 11:55 A.M., during an interview with QMA 3, she indicated on 6/8/25, she went to Resident E's room shortly after 9:00 A.M., and when she entered the resident's room, she found the resident laying on his couch with a plastic bag over his head. QMA 3 indicated she took the bag off of the residents head and left him to go 2 halls down the Nurses Station to call the Director of Nursing. QMA 3 indicated when she called the Director of Nursing and reported the incident, the Director of Nursing instructed her to take the phone back to the resident's room so she could speak with the resident on the phone. QMA 3 indicated when the Director of

Nursing finished talking on the phone with the resident, she spoke with the Director of Nursing who at that time gave her the phone number for the local EMS and instructed her to call and remain in the room with the resident until EMS arrived. QMA 3 indicated EMS told her it would be about 25 minutes before they would arrive. QMA 3 indicated there were no nurses in the facility to assess the resident and no nursing staff came in to assess the resident.

On 7/16/25 at 3:54 P.M., Resident E's clinical record was reviewed. Diagnoses included but were not limited to type 2 diabetes, neuropathy, endocarditis, liver disease, hepatitis, squamous cell carcinoma to scalp and neck, and rhabdomylosis (a breakdown of muscle tissue, leading to the release of harmful substances into the bloodstream).

Resident E was found to be cognitively intact on 5/15/25 when he was assessed for a Brief Interview for Mental Status (BIMS). Also evaluated on 5/15/25 was the resident's Service Plan that indicated Resident E required medications to be administered two times daily and blood sugar checks one time daily by nursing staff. Resident E required behavior monitoring

due to reluctance to accept care, and staff were to report any changes from base line behaviors.

Resident E's Progress Notes included but were not limited to the following;

A late entry created by QMA 3 on 6/8/25 at 11:53 A.M., with an effective date of 6/8/25 at 11:48 A.M., indicated Resident E did not go to breakfast as usual so she went to check on the resident in his room and found him lying on the couch with a winter cap on and with a plastic bag over his head and face. When QMA 3 asked why he had the bag over his face, he ignored the question and told the QMA to bring his pills and check his blood. The entry indicated the resident was sent to the hospital to get checked out as directed by the Director of Nursing.

A late entry created by the Director of Nursing on 6/25/25 at 1:54 P.M., with an effective date of 6/8/25 at 10:36 A.M., indicated she received a phone call from QMA 3 who indicated during the morning medication pass she went to the resident's room because he had not gone down for breakfast in the dining room and to receive his medication. The Director of Nursing indicated when QMA 3 entered the resident's room she

observed a clear plastic small trash bag over his head and loosely open to the jaw line. She indicated the QMA was in the residents room at the time of the phone call and indicated to the Resident that she took all suicidal behavior seriously and EMS would be called to have him checked at the hospital. The resident could return to the facility if the hospital deemed him as safe to return. The Director of nursing indicated she directed QMA 3 to notify EMS, and that EMS had already been notified, and to remain in the resident's room until EMS arrived.

Review of Resident E's Medication Administration History dated 6/8/25, the form indicated QMA 3 administered Resident E's morning medication and checked his blood sugar at 9:37 A.M.

Review of Resident E's EMS ambulance service report indicated the EMS services received a call from the facility at 10:47 A.M. and were on the scene at the facility at 11:12 A.M. The report indicated the facility reported an onset date of 6/8/25 at 9:30 A.M. and the chief complaint was suicidal ideation's with a plan. The nurse stated that after the patient had missed breakfast she checked on the patient and found the patient with a bag over his head

at 9:30 A.M. in an attempt to commit suicide, and that the patient had made several statements about ending his life. While the crew was securing the patient onto the ambulance cot, the patient loosely grabbed on of the belts and stated, "here why don't we just do the," while attempting to wrap the belt around his neck. Resident E was transferred to the care of the ER on 6/8/25 at 11:35 A.M.

The ER physician's note dated 6/8/25 - 9/9/25, indicated the resident presented to the ER after nursing staff found him with a plastic bag over his head and that the patient was try to suffocate himself. The ER physician indicated Resident E would require inpatient psychiatric evaluation and would be admitted to psychiatry.

A facility Progress Note dated 6/17/25 at 4:11 P.M., indicated Resident E returned to the facility from his hospital stay.

A policy titled "Incident/Accident/Unusual Occurrence Investigation and Reporting," dated 9/30/22, was provided by the Administrator on 7/18/25 at 9:00 A.M., and indicated it was the current facility policy. The policy indicated, "...For the safety and well being of the residents, all incidents, accidents, and unusual occurrences will be

	handled in a uniform, prompt and efficient manner...completion of an incident report for internal use...The charge nurse will be responsible for immediate response to any incident...Documentation of the incident...in the resident's medical record, including i. Time, ii. place iii. assessment findings iv. immediate care rendered v.physician...notification vi. and additional interventions provided relative to the occurrence...the physician notification should take place first in order...The Executive Director and the Director of Nursing will follow the Indiana State Department of Health's Reportable Incidient Policy for the protocol for reporting incident that are deemed serious and meet the roporting requirments...For all incident/accidents/unusual occurrences, the Director of Nursing will coordinate an investigation...Summary of facts of the investigation, including time line, bu the Director of Nursing... This citation relates to Complaint IN00462643				

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