

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2025
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINTE GARDENS		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 UTICA SELLERSBURG ROAD, JEFFERSONVILLE, , 47130			
(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 IN00455361 and IN00455663. Complaint IN00455361 - No deficiencies related to the allegations are cited. Complaint IN00455663 - State deficiencies related to the allegation are cited at R0051, R0052, and R0243. Survey date: April 7 and 8, 2025 Facility number: 015122 Residential Census: 101 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 14, 2025.	R 0000			
R 0051	Residents' Rights - Offense 410 IAC 16.2-5-1.2(u)	R 0051	R0051 What Corrective action (s) will be accomplished for those	05/02/2025	

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(u) Residents have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

Based on observation, interview and record reviewed, the facility failed to ensure a resident (Resident B) was free of a chemical restraint related to an anti-psychotic medication administration without exhibited behaviors for use, resulting in over sedation into the next day for 1 of 3 residents reviewed for resident rights.

Findings include:

The clinical record for Resident B was reviewed on 4/8/25 at 9:50 a.m. The resident's diagnoses included, but were not limited to, dementia and anxiety.

The incident report, dated 3/8/25 at 9:49 a.m., indicated the Director of Nursing (DON) was onsite at approximately 9:49 p.m. after receiving a call from the facility that Resident B was throwing tables, chairs and was inconsolable. The DON called the on-call nurse practitioner for an emergency anti-psychotic.

On 4/8/25 at 6:10 p.m., the resident was observed sitting up in a chair in front of the nurse's station. The resident was

residents found to have been affected by the deficient practice; The former DON associated with this deficient practice was terminated on 3/21/2025. Going forward, all newly hired/appointed DONs or designees to track antipsychotics given to residents to ensure Physicians orders are being followed. This will be done with regular management oversight. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents on antipsychotics have a potential to be affected by this deficient practice. The former DON associated with this deficient practice was terminated on 3/21/2025. Newly hired/appointed DON or designee will audit antipsychotic usage for residents. This will be completed with management oversight, as will The DON or designee will track antipsychotics given to residents daily for 1 week, 2x week for 1 month and 1x month for 3 months. Clinical management oversight to review regularly. What measures will be put in place or what systemic changes will you make to ensure that the

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conversing with staff, laughing and showed no signs of behaviors or psychosocial distress. The progress note, dated 3/8/25 at 9:49 a.m., completed by the DON indicated she was informed on Resident B's behaviors and went to the facility to assess the resident. The resident was aggressive, non-consolable and was constantly attempting to ambulate, throw chairs, exit, fight with staff and move tables. The on-call nurse practitioner was notified and an order was received for a one-time dose of Haldol (anti-psychotic medication) 4.5 mg (milligrams). The medication was pulled from the emergency drug kit (EDK) and administered to the resident. After approximately 35 minutes, the resident had calmed down and the aide was able to assist him to lay down. The clinical record lacked documentation of the resident behaviors prior to the documented note from the DON on 3/8/25 at 9:49 p.m. On 4/8/25 at 1:33 p.m., the following was observed during review of the video footage on 3/8/25 related to the incident: -At 8:06 p.m., Certified Nursing Aide (CNA) 4 ambulated with the resident, out of view from	deficient practice does not recur;The former DON associated with this deficient practice was terminated on 3/21/2025. All licensed clinical staff have been in-serviced on Resident Rights, to include chemical restraints. Audits were put in place to ensure antipsychotic use is in compliance with physicians orders. DON or designee to track and audit compliance, and will be done so with regular clinical management oversight and review.How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e..., what quality assurance program will be put into practice?With clinical management oversight (regional clinical director) The DON or designee will track antipsychotics given to residents daily for 1 week, 2x week for 1 month and 1x month for 3 months to ensure they are given as written by the physician. Review of tracking/audits will take place at the monthly QA meetings, regularly reviewed by management oversight, and Findings suggestive of 100% compliance may result in cessation of monitoring plan after 6	
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the video footage, down the hall towards Resident B's room.

-At 8:09 p.m., Resident B ambulated up towards the nurse's station, turned around, and then ambulated, out of view from the video footage, towards his room.

-At 8:33 p.m., Qualified Medication Aide (QMA) 9 pushed the medication cart out of the view of video footage, down towards Resident B's room on the opposite side of the hall.

-At 8:55 p.m., QMA 9 pushed the medication cart back up the hall to the nurse's station.

-At 8:57 p.m., Resident B ambulated with his rollator walker up towards the nurses station, stopped midway there and CNA 4 put a chair behind the resident so he could sit down.

-At 8:59 p.m., Resident B stood up from the chair, ambulated approximately 6 to 7 feet, stopped, then CNA 4 put a chair behind the resident so he could sit down.

-At 9:13 p.m., the DON was observed to come on the hall and turn right towards the nurse's station.

-At 9:15 p.m., Resident B was observed to stand, at which

months.

Date of Compliance
5/2/25

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time, the DON walked over towards the resident. The DON was in front of the resident and in close proximity to the resident's face. The DON pointed with her right finger down towards the chair and then pointed her right finger towards herself. Resident B then sat back down in the chair. The DON then began to pull the chair backwards towards a table. CNA 5 assisted from the front of the chair and turned the chair around to face the table. The DON fiddled with several activity items on the table for approximately 30 seconds and walked away towards the nurse's station. CNA 5 and CNA 7 then removed the resident from the table. Both CNA 5 and CNA 7 turned around and looked towards the nurse's station and then assisted Resident B out of video view towards the resident's room. The video ended at this time.

During the video observation, between 8:06 p.m. and 9:15 p.m., Resident B exhibited no aggressive behaviors or threw any tables or chairs.

During an interview, on 4/7/25 at 6:11 p.m., Licensed Practical Nurse (LPN) 6 indicated Resident B's behaviors consisted of looking for his truck keys, exit seeking and just typical sundowning. She had never witnessed nor had she

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heard that the resident threw any furniture.

During an interview, on 4/7/25 at 6:17 p.m., CNA 4 indicated she was unaware of any staff member calling the DON due to Resident B's behaviors. She was back on the memory care unit and never witnessed Resident B throw tables or chairs. He had not been aggressive at all that night. He moved from chair to chair all the time at night which was his normal routine before he went to bed.

The undated written statement from CNA 4 indicated, on the night of 3/8/25 at the beginning of the shift, Resident B was observed sitting in a chair in the hallway on the memory care unit. CNA 4 exited the memory care unit to answer a call light. CNA 4 met the DON in the hallway who told CNA 4 she was at the facility to check on a few things. After CNA 4 answered the call light she went back on the memory care unit and heard the DON on the phone trying to get some medicine. After the DON got off the phone she looked through the EDK and the medication dose was not available so the DON called the physician back. The physician said it was ok to use a lower dose. After the DON hung up the phone she asked the staff back who Resident B

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knew better and CNA 4 responded that he knew her better. Resident B was asleep on his couch in his room, but woke up and took the medicine for the DON. After that, CNA 4 assisted the resident into his pajama's and to bed. When CNA 4 left Resident B's room, the DON was already gone.

During an interview, on 4/7/25 at 6:30 p.m., CNA 5 indicated on 3/8/25, she worked the memory care unit and at no time did Resident behave aggressively or throw tables and chairs. When the DON came to the memory care unit that evening, Resident B was sitting in a chair with his rollator walker in front of him. Resident B attempted to stand and the DON walked over to him and said, "you are not to ambulate, you are to sit still. I am the boss". The DON asked Resident B what he was going to do and he told the DON that he was going over to the table. The DON then proceed to pull the chair the resident was sitting in backwards towards the table. CNA 5 intervened and assisted because she was worried the resident would fall out of the chair. Resident B stood back up at which time CNA 7 walked over and the DON walked back behind the nurse's station. The DON asked CNA 5 and CNA 7, as they were taking Resident B back to his room, if they had

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contacted the family and they told her no. After they took Resident B back to his room, CNA 5 observed the DON remove medication from the EDK and then went to the resident's room with the medication. The resident had not had any behaviors and for the DON to give him Haldol was uncalled for.

During an interview, on 4/7/25 at 7:31 p.m., QMA 9 indicated on the night of 3/8/25, she was in orientation. The agency nurse called in so it was just herself and QMA 12 passing medications in the facility. She never witnessed Resident B with any behaviors. During her medication pass that evening, Resident B wandered into another room, however, she easily redirected him out without any problems. Once she finished her medication pass, she went over to the assisted living side to finish her orientation.

During a telephone interview, on 4/8/25 at 1:26 p.m., CNA 7 indicated Resident B was asleep in the chair when the DON came back on the unit between 9:00 p.m. and 9:30 p.m. The DON said she was not going to deal with Resident B's behaviors, which he was not having at that moment. Resident B then stood up and the DON walked over to him. She told

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him she was the boss and he was not going to get up and walk. She and CNA 5 intervened and took Resident B to his room and got him situated for the night. When she walked up towards the nurse's station she heard the DON on the phone and then she was digging around in the EDK and removed medications from it. The resident did have some behaviors on day shift but had not had any since around 3:00 p.m. or 4:00 p.m. He had not had any behaviors of aggressiveness or throwing furniture on her shift. When she came in the next evening for work, the resident was still in bed from the night before.

The written statement from QMA 12, dated 3/17/25, indicated on 3/8/25, she was orientating another QMA. The agency nurse had called and cancelled which left the night shift with herself, QMA 9 and 3 aides. The DON texted QMA 12 that she would be in. She and QMA 9 were administering medications on the AL side when the DON arrived and she went right back to the memory care unit. CNA 5 and CNA 7 reported to QMA 12 that they witnessed the DON approach Resident B, whom was sitting in a chair in the hallway. The DON got in his face and yelled at the resident that she was the boss and he needed to go to his

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room and go to sleep. The DON then called the physician and reported Resident B was having behaviors of aggression towards staff and property. The physician gave the DON an order for Haldol. The DON administered it to the resident. QMA 12 did not witness any behaviors from Resident B or did she communicate to the DON with regards to behaviors. The DON reported to QMA 12 that she had given a one-time as needed order of Haldol to Resident B. The DON also reported to QMA 12 that she was not going to put up with his "shit" behaviors. After this, the DON communicated some other work stuff and then left with her daughter. QMA 12 then walked over to the memory care unit to follow up on what had taken place. The CNA's reported to her what had transpired between the DON and Resident B and what they had witnessed. Later in the shift, QMA 12 reviewed what the DON had documented and read it aloud to CNA 5 and CNA 7 who reported none of what was documented behavior wise had happened. At shift change on 3/9/25, QMA 12 reported to LPN 6 and LPN 10 about the situation. QMA 12 was informed that on day shift on 3/8/25, the resident had behaviors of exit seeking way earlier in the day, but that was normal for the resident. QMA 12 had never witnessed Resident

12 act out in the way the DON had documented in the note. Resident B's behaviors were normally asking to go home, he needed to get his truck, exit seeking at times, packing up his room and wandering the halls. Those were the only behaviors she had personally experienced with Resident B.

On 4/8/25 at 4:10 p.m., the Executive Director indicated the facility did not have a policy on chemical restraints.

This Citation relates to Complaint IN00455663

Based on observation, interview and record reviewed, the facility failed to ensure a resident (Resident B) was free of a chemical restraint related to an anti-psychotic medication administration without exhibited behaviors for use, resulting in over sedation into the next day for 1 of 3 residents reviewed for resident rights.

Findings include:

The clinical record for Resident B was reviewed on 4/8/25 at 9:50 a.m. The resident's diagnoses included, but were not limited to, dementia and anxiety.

The incident report, dated 3/8/25 at 9:49 a.m., indicated the Director of Nursing (DON) was onsite at approximately

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9:49 p.m. after receiving a call from the facility that Resident B was throwing tables, chairs and was inconsolable. The DON called the on-call nurse practitioner for an emergency anti-psychotic.

On 4/8/25 at 6:10 p.m., the resident was observed sitting up in a chair in front of the nurse's station. The resident was conversing with staff, laughing and showed no signs of behaviors or psychosocial distress.

The progress note, dated 3/8/25 at 9:49 a.m., completed by the DON indicated she was informed on Resident B's behaviors and went to the facility to assess the resident. The resident was aggressive, non-consolable and was constantly attempting to ambulate, throw chairs, exit, fight with staff and move tables. The on-call nurse practitioner was notified and an order was received for a one-time dose of Haldol (anti-psychotic medication) 4.5 mg (milligrams). The medication was pulled from the emergency drug kit (EDK) and administered to the resident. After approximately 35 minutes, the resident had calmed down and the aide was able to assist him to lay down.

The clinical record lacked documentation of the resident

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behaviors prior to the documented note from the DON on 3/8/25 at 9:49 p.m.

On 4/8/25 at 1:33 p.m., the following was observed during review of the video footage on 3/8/25 related to the incident:

-At 8:06 p.m., Certified Nursing Aide (CNA) 4 ambulated with the resident, out of view from the video footage, down the hall towards Resident B's room.

-At 8:09 p.m., Resident B ambulated up towards the nurse's station, turned around, and then ambulated, out of view from the video footage, towards his room.

-At 8:33 p.m., Qualified Medication Aide (QMA) 9 pushed the medication cart out of the view of video footage, down towards Resident B's room on the opposite side of the hall.

-At 8:55 p.m., QMA 9 pushed the medication cart back up the hall to the nurse's station.

-At 8:57 p.m., Resident B ambulated with his rollator walker up towards the nurses station, stopped midway there and CNA 4 put a chair behind the resident so he could sit down.

-At 8:59 p.m., Resident B stood up from the chair, ambulated

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approximately 6 to 7 feet, stopped, then CNA 4 put a chair behind the resident so he could sit down.

-At 9:13 p.m., the DON was observed to come on the hall and turn right towards the nurse's station.

-At 9:15 p.m., Resident B was observed to stand, at which time, the DON walked over towards the resident. The DON was in front of the resident and in close proximity to the resident's face. The DON pointed with her right finger down towards the chair and then pointed her right finger towards herself. Resident B then sat back down in the chair. The DON then began to pull the chair backwards towards a table. CNA 5 assisted from the front of the chair and turned the chair around to face the table. The DON fiddled with several activity items on the table for approximately 30 seconds and walked away towards the nurse's station. CNA 5 and CNA 7 then removed the resident from the table. Both CNA 5 and CNA 7 turned around and looked towards the nurse's station and then assisted Resident B out of video view towards the resident's room. The video ended at this time.

During the video observation, between 8:06 p.m. and 9:15

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p.m., Resident B exhibited no aggressive behaviors or threw any tables or chairs.

During an interview, on 4/7/25 at 6:11 p.m., Licensed Practical Nurse (LPN) 6 indicated Resident B's behaviors consisted of looking for his truck keys, exit seeking and just typical sundowning. She had never witnessed nor had she heard that the resident threw any furniture.

During an interview, on 4/7/25 at 6:17 p.m., CNA 4 indicated she was unaware of any staff member calling the DON due to Resident B's behaviors. She was back on the memory care unit and never witnessed Resident B throw tables or chairs. He had not been aggressive at all that night. He moved from chair to chair all the time at night which was his normal routine before he went to bed.

The undated written statement from CNA 4 indicated, on the night of 3/8/25 at the beginning of the shift, Resident B was observed sitting in a chair in the hallway on the memory care unit. CNA 4 exited the memory care unit to answer a call light. CNA 4 met the DON in the hallway who told CNA 4 she was at the facility to check on a few things. After CNA 4 answered the call light she went

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back on the memory care unit and heard the DON on the phone trying to get some medicine. After the DON got off the phone she looked through the EDK and the medication dose was not available so the DON called the physician back. The physician said it was ok to use a lower dose. After the DON hung up the phone she asked the staff back who Resident B knew better and CNA 4 responded that he knew her better. Resident B was asleep on his couch in his room, but woke up and took the medicine for the DON. After that, CNA 4 assisted the resident into his pajama's and to bed. When CNA 4 left Resident B's room, the DON was already gone.

During an interview, on 4/7/25 at 6:30 p.m., CNA 5 indicated on 3/8/25, she worked the memory care unit and at no time did Resident be behave aggressively or throw tables and chairs. When the DON came to the memory care unit that evening, Resident B was sitting in a chair with his rollator walker in front of him. Resident B attempted to stand and the DON walked over to him and said, "you are not to ambulate, you are to sit still. I am the boss". The DON asked Resident B what he was going to do and he told the DON that he was going over to the table. The DON then proceed to pull

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the chair the resident was sitting in backwards towards the table. CNA 5 intervened and assisted because she was worried the resident would fall out of the chair. Resident B stood back up at which time CNA 7 walked over and the DON walked back behind the nurse's station. The DON asked CNA 5 and CNA 7, as they were taking Resident B back to his room, if they had contacted the family and they told her no. After they took Resident B back to his room, CNA 5 observed the DON remove medication from the EDK and then went to the resident's room with the medication. The resident had not had any behaviors and for the DON to give him Haldol was uncalled for.

During an interview, on 4/7/25 at 7:31 p.m., QMA 9 indicated on the night of 3/8/25, she was in orientation. The agency nurse called in so it was just herself and QMA 12 passing medications in the facility. She never witnessed Resident B with any behaviors. During her medication pass that evening, Resident B wandered into another room, however, she easily redirected him out without any problems. Once she finished her medication pass, she went over to the assisted living side to finish her orientation.

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During a telephone interview, on 4/8/25 at 1:26 p.m., CNA 7 indicated Resident B was asleep in the chair when the DON came back on the unit between 9:00 p.m. and 9:30 p.m. The DON said she was not going to deal with Resident B's behaviors, which he was not having at that moment. Resident B then stood up and the DON walked over to him. She told him she was the boss and he was not going to get up and walk. She and CNA 5 intervened and took Resident B to his room and got him situated for the night. When she walked up towards the nurse's station she heard the DON on the phone and then she was digging around in the EDK and removed medications from it. The resident did have some behaviors on day shift but had not had any since around 3:00 p.m. or 4:00 p.m. He had not had any behaviors of aggressiveness or throwing furniture on her shift. When she came in the next evening for work, the resident was still in bed from the night before.

The written statement from QMA 12, dated 3/17/25, indicated on 3/8/25, she was orientating another QMA. The agency nurse had called and cancelled which left the night shift with herself, QMA 9 and 3 aides. The DON texted QMA 12 that she would be in. She and

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QMA 9 were administering medications on the AL side when the DON arrived and she went right back to the memory care unit. CNA 5 and CNA 7 reported to QMA 12 that they witnessed the DON approach Resident B, whom was sitting in a chair in the hallway. The DON got in his face and yelled at the resident that she was the boss and he needed to go to his room and go to sleep. The DON then called the physician and reported Resident B was having behaviors of aggression towards staff and property. The physician gave the DON an order for Haldol. The DON administered it to the resident. QMA 12 did not witness any behaviors from Resident B or did she communicate to the DON with regards to behaviors. The DON reported to QMA 12 that she had given a one-time as needed order of Haldol to Resident B. The DON also reported to QMA 12 that she was not going to put up with his "shit" behaviors. After this, the DON communicated some other work stuff and then left with her daughter. QMA 12 then walked over to the memory care unit to follow up on what had taken place. The CNA's reported to her what had transpired between the DON and Resident B and what they had witnessed. Later in the shift, QMA 12 reviewed what the DON had documented and read it aloud to

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	CNA 5 and CNA 7 who reported none of what was documented behavior wise had happened. At shift change on 3/9/25, QMA 12 reported to LPN 6 and LPN 10 about the situation. QMA 12 was informed that on day shift on 3/8/25, the resident had behaviors of exit seeking way earlier in the day, but that was normal for the resident. QMA 12 had never witnessed Resident 12 act out in the way the DON had documented in the note. Resident B's behaviors were normally asking to go home, he needed to get his truck, exit seeking at times, packing up his room and wandering the halls. Those were the only behaviors she had personally experienced with Resident B. On 4/8/25 at 4:10 p.m., the Executive Director indicated the facility did not have a policy on chemical restraints. This Citation relates to Complaint IN00455663			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse;	R 0052	R0052What Corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice;The former DON associated with this deficient practice was terminated on 3/21/2025. All staff were in-serviced on Resident	05/02/2025

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- (4) corporal punishment;
- (5) neglect; and
- (6) involuntary seclusion.

Based on observation, interview and record reviewed, the facility failed to ensure staff to resident (Resident B) verbal abuse did no occure for 1 of 3 residents reviewed for resident rights.

Findings include:

The written statement from QMA 12, dated 3/17/25, indicated on 3/8/25, she was orientating another QMA. The agency nurse had called and cancelled which left the night shift with herself, QMA 9 and 3 aides. The DON texted QMA 12 that she would be in. She and QMA 9 were administering medications on the AL side when the DON arrived, and she went right back to the memory care unit. CNA 5 and CNA 7 reported to QMA 12 that they witnessed the DON approach Resident B, who was sitting in a chair in the hallway. The DON got in his face and yelled at the resident that she was the boss, and he needed to go to his room and go to sleep. The DON reported to QMA 12 that she was not going to put up with his (Resident B's) "shit" behaviors.

The clinical record for Resident B was reviewed on 4/8/25 at

Rights- to include verbal abuse, on 5/2/2025.

Going forward, the DON or designee will conduct regular Abuse inservices and education for all staff, and will be done after management has reviewed the information to be presented to all staff. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have a

potential to be affected by this deficient practice. The former DON associated with the deficient practice was terminated on 3/21/2025. All staff were in-serviced on Resident Rights- to include verbal abuse, on 5/2/2025.

Going forward newly hired or appointed DON's or designees will be reviewing company abuse policy regularly with clinical management. Future deficient practices will result in

termination if findings are substantiated through investigation. What measures will be put

in place or what systemic changes will you make to ensure that the deficient practice does not recur; The former DON associated with this deficient practice was terminated on 3/21/2025. All

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9:50 a.m. The resident's diagnoses included, but were not limited to, dementia and anxiety

On 4/8/25 at 6:10 p.m., the resident was observed sitting up in a chair in front of the nurse's station. The resident was conversing with staff, laughing and showed no signs of behaviors or psychosocial distress.

The progress note, dated 3/8/25 at 9:49 a.m., completed by the DON indicated she was informed on Resident B's behaviors and went to the facility to assess the resident. The resident was aggressive, non-consolable and was constantly attempting to ambulate, throw chairs, exit, fight with staff and move tables. The on-call nurse practitioner was notified, and an order was received for a one-time dose of Haldol (anti-psychotic medication) 4.5 mg (milligrams). The medication was pulled from the emergency drug kit (EDK) and administered to the resident. After approximately 35 minutes, the resident had calmed down and the aide was able to assist him to lay down.

On 4/8/25 at 1:33 p.m., the following was observed during review of the video footage on 3/8/25 related to the incident:

staff were in-serviced on Resident Rights- to include verbal abuse, on 5/2/2025. Regular in-services will be conducted monthly by DON or designee for 3 months to cover Resident Right and Abuse, to include verbal, and will be reviewed by clinical management regularly prior to and after inservices. All inservices will be reviewed during monthly QA meetings for 3 months or longer if findings suggest less than 100% compliance. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e..., what quality assurance program will be put into practice? Newly appointed/hired DON or designee will in-service all staff on Resident Rights and/or Abuse monthly for 3 months and will be reviewed at monthly QA meetings, and will be reviewed by clinical management support. Abuse, to include verbal abuse, will not be tolerated by the company. Future deficiencies of this nature will result in termination when findings from investigation are substantiated.

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-At 9:13 p.m., the DON was observed to come on the hall and turn right towards the nurse's station.

-At 9:15 p.m., Resident B was observed to stand, at which time, the DON walked over towards the resident. The DON was in front of the resident and in close proximity to the resident's face. The DON pointed with her right finger down towards the chair and then pointed her right finger towards herself. Resident B then sat back down in the chair. The DON then began to pull the chair backwards towards a table.

During the video observation, between 8:06 p.m. and 9:15 p.m., Resident B exhibited no aggressive behaviors.

During an interview, on 4/7/25 at 6:17 p.m., CNA 4 indicated Resident B had not been aggressive at all that night. He moved from chair to chair all the time at night which was his normal routine before he went to bed.

During an interview, on 4/7/25 at 6:30 p.m., CNA 5 indicated on 3/8/25, she worked the memory care unit and at no time did Resident B behave aggressively or throw tables and chairs. When the DON came to the memory care unit that evening,

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Resident B was sitting in a chair with his rollator walker in front of him. Resident B attempted to stand, and the DON walked over to him and said, "you are not to ambulate, you are to sit still. I am the boss". The DON asked Resident B what he was going to do, and he told the DON that he was going over to the table. The DON then proceed to pull the chair the resident was sitting in backwards towards the table. CNA 5 intervened and assisted because she was worried the resident would fall out of the chair.

During an interview, on 4/7/25 at 7:31 p.m., QMA 9 indicated on the night of 3/8/25, she was in orientation. The agency nurse called in, so it was just herself and QMA 12 passing medications in the facility. She never witnessed Resident B with any behaviors.

During a telephone interview, on 4/8/25 at 1:26 p.m., CNA 7 indicated Resident B was asleep in the chair when the DON came back on the unit between 9:00 p.m. and 9:30 p.m. The DON said she was not going to deal with Resident B's behaviors, which he was not having at that moment. Resident B then stood up and the DON walked over to him. She told him she was the boss, and he was not going to get up and

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walk. She and CNA 5 intervened and took Resident B to his room and got him situated for the night.

On 4/8/25 at 10:19 a.m., the Executive Director provided a current, undated copy of the document titled "Abuse Prevention Policy and Procedure". It included, but was not limited to, "Policy ...shall prohibit abuse, mistreatment ...of residents ..." "Verbal abuse" is defined as the use or oral ...gestured language that willfully includes disparaging ...terms to resident or family members, or within their hearing distance, regardless of their age, ability to comprehend"

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Based on observation, interview and record reviewed, the facility failed to ensure staff to resident (Resident B) verbal abuse did no occure for 1 of 3 residents reviewed for resident rights.

Findings include:

The written statement from QMA 12, dated 3/17/25, indicated on 3/8/25, she was orientating another QMA. The agency nurse had called and cancelled which left the night shift with herself, QMA 9 and 3 aides. The DON texted QMA 12 that she would be in. She and QMA 9 were administering

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medications on the AL side when the DON arrived, and she went right back to the memory care unit. CNA 5 and CNA 7 reported to QMA 12 that they witnessed the DON approach Resident B, who was sitting in a chair in the hallway. The DON got in his face and yelled at the resident that she was the boss, and he needed to go to his room and go to sleep. The DON reported to QMA 12 that she was not going to put up with his (Resident B's) "shit" behaviors.

The clinical record for Resident B was reviewed on 4/8/25 at 9:50 a.m. The resident's diagnoses included, but were not limited to, dementia and anxiety

On 4/8/25 at 6:10 p.m., the resident was observed sitting up in a chair in front of the nurse's station. The resident was conversing with staff, laughing and showed no signs of behaviors or psychosocial distress.

The progress note, dated 3/8/25 at 9:49 a.m., completed by the DON indicated she was informed on Resident B's behaviors and went to the facility to assess the resident. The resident was aggressive, non-consolable and was constantly attempting to ambulate, throw chairs, exit, fight with staff and move tables.

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The on-call nurse practitioner was notified, and an order was received for a one-time dose of Haldol (anti-psychotic medication) 4.5 mg (milligrams). The medication was pulled from the emergency drug kit (EDK) and administered to the resident. After approximately 35 minutes, the resident had calmed down and the aide was able to assist him to lay down.

On 4/8/25 at 1:33 p.m., the following was observed during review of the video footage on 3/8/25 related to the incident:

-At 9:13 p.m., the DON was observed to come on the hall and turn right towards the nurse's station.

-At 9:15 p.m., Resident B was observed to stand, at which time, the DON walked over towards the resident. The DON was in front of the resident and in close proximity to the resident's face. The DON pointed with her right finger down towards the chair and then pointed her right finger towards herself. Resident B then sat back down in the chair. The DON then began to pull the chair backwards towards a table.

During the video observation, between 8:06 p.m. and 9:15 p.m., Resident B exhibited no aggressive behaviors.

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During an interview, on 4/7/25 at 6:17 p.m., CNA 4 indicated Resident B had not been aggressive at all that night. He moved from chair to chair all the time at night which was his normal routine before he went to bed.

During an interview, on 4/7/25 at 6:30 p.m., CNA 5 indicated on 3/8/25, she worked the memory care unit and at no time did Resident B behave aggressively or throw tables and chairs. When the DON came to the memory care unit that evening, Resident B was sitting in a chair with his rollator walker in front of him. Resident B attempted to stand, and the DON walked over to him and said, "you are not to ambulate, you are to sit still. I am the boss". The DON asked Resident B what he was going to do, and he told the DON that he was going over to the table. The DON then proceed to pull the chair the resident was sitting in backwards towards the table. CNA 5 intervened and assisted because she was worried the resident would fall out of the chair.

During an interview, on 4/7/25 at 7:31 p.m., QMA 9 indicated on the night of 3/8/25, she was in orientation. The agency nurse called in, so it was just herself and QMA 12 passing medications in the facility. She

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never witnessed Resident B with any behaviors.

During a telephone interview, on 4/8/25 at 1:26 p.m., CNA 7 indicated Resident B was asleep in the chair when the DON came back on the unit between 9:00 p.m. and 9:30 p.m. The DON said she was not going to deal with Resident B's behaviors, which he was not having at that moment. Resident B then stood up and the DON walked over to him. She told him she was the boss, and he was not going to get up and walk. She and CNA 5 intervened and took Resident B to his room and got him situated for the night.

On 4/8/25 at 10:19 a.m., the Executive Director provided a current, undated copy of the document titled "Abuse Prevention Policy and Procedure". It included, but was not limited to, "Policy ...shall prohibit abuse, mistreatment ...of residents ..." "Verbal abuse" is defined as the use or oral ...gestured language that willfully includes disparaging ...terms to resident or family members, or within their hearing distance, regardless of their age, ability to comprehend"

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FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on interview and record review, the facility failed to ensure a one-time order for an antipsychotic medication was in place, and documented as administered, for 1 of 3 residents reviewed for medical records. (Resident B) Findings include: The clinical record for Resident B was reviewed on 4/8/25 at 9:50 a.m. The resident's diagnoses included, but were not limited to, dementia and anxiety. The incident report, dated 3/8/25 at 9:49 a.m., indicated the Director of Nursing (DON) was onsite at approximately 9:49 p.m. after receiving a call from the facility that Resident B	R 0243	R0243 What Corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; The former DON associated with this deficient practice was terminated on 3/21/2025. In addition, All one time orders of antipsychotic medication will be checked by the DON or designee to ensure the medication was documented as administered, and will be done so with regular management oversight and review. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All resident receiving one time orders of antipsychotic medication could be affected by this deficient practice. The DON associated with this deficiency was terminated on 3/21/2025. All one time orders of medication will be checked by the newly appointed/hired DON or	05/09/2025
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was throwing tables, chairs and inconsolable. The DON called the on-call nurse practitioner for an emergency anti-psychotic.

The progress note, dated 3/8/25 at 9:49 a.m. and completed by the DON, indicated she was informed on Resident B's behaviors and went to the facility to assess the resident. The resident was aggressive, non-consolable and was constantly attempting to ambulate, throw chairs, exit, fight with staff and move tables. The on-call nurse practitioner was notified and an order received for a one-time dose of Haldol (anti-psychotic medication) 4.5 mg (milligrams). The medication was pulled from the emergency drug kit (EDK) and administered to the resident.

The March 2025 medication administration record lacked documentation of the one time order or documented administration of the medication.

On 4/8/25 at 11:15 a.m., Licensed Practical Nurse (LPN) 10 indicated all orders should be documented on the medication administration record. When a medication was administered, the nurse should initial the medication as administered.

On 4/8/25 at 4:10 p.m., the Executive Director provided a

designee to ensure the medication was documented as administered, and will be done so with regular clinical management oversight and review. Clinical regional director to review documentation and administration regularly after QA monthly meetings are held.

What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur;

Time, name of medication/treatment, dosage (if applicable) and name or initials of the person administering the drug or treatment will be confirmed. This will be daily for 1 week, 2x week for 1 month and 1x month for 3 months and reviewed by clinical management team along with newly hired/appointed DON or designee. **Also, newly hired/appointed DON or designee to follow process for notifying on-call NP when/if an antipsychotic medication may need to be administered.**

How will the corrective action (s) will be monitored to ensure

current copy of the document titled "Physician Orders" dated 2/13. It included, but was not limited to,
"Verbal/Telephone/Facsimile Order Procedure...The licensed nurse who receives a physician's order...per telephone...will accurately write the order on the three-part telephone order slips utilized by the facility...The nurse...will accurately transcribe all medication...orders on to the medication...administration records...."

On 4/8/25 at 3:48 p.m., the Executive Director provided a current. undated copy of the document titled "Medication Assistance Record: Routine Medication Pass". It included, but was not limited to,
"Procedure...Initial the appropriate place on the medication sheet in the MAR to document that you have witnessed the resident taking the medication...."

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Based on interview and record review, the facility failed to ensure a one-time order for an antipsychotic medication was in place, and documented as administered, for 1 of 3 residents reviewed for medical records. (Resident B)

the deficient practice will not recur, i.e..., what quality assurance program will be put into practice?

The DON associated with this deficient practice was terminated on 3/21/2025. Going forward, With management oversight, newly appointed DON and/or designee to audit one time orders for antipsychotic medication to include time, name of medication/treatment, dosage (if applicable) and name or initials of the person administering the drug or treatment will be confirmed. This will be daily for 1 week, 2x week for 1 month and 1x month for 3 months. If findings are less than 100% compliant during that time, tracking and review will continue for 1 year or until 100% compliance is achieved. Clinical management support will review findings regularly.

Date of compliance 5/9/25

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Findings include:

The clinical record for Resident B was reviewed on 4/8/25 at 9:50 a.m. The resident's diagnoses included, but were not limited to, dementia and anxiety.

The incident report, dated 3/8/25 at 9:49 a.m., indicated the Director of Nursing (DON) was onsite at approximately 9:49 p.m. after receiving a call from the facility that Resident B was throwing tables, chairs and inconsolable. The DON called the on-call nurse practitioner for an emergency anti-psychotic.

The progress note, dated 3/8/25 at 9:49 a.m. and completed by the DON, indicated she was informed on Resident B's behaviors and went to the facility to assess the resident. The resident was aggressive, non-consolable and was constantly attempting to ambulate, throw chairs, exit, fight with staff and move tables. The on-call nurse practitioner was notified and an order received for a one-time dose of Haldol (anti-psychotic medication) 4.5 mg (milligrams). The medication was pulled from the emergency drug kit (EDK) and administered to the resident.

The March 2025 medication administration record lacked

documentation of the one time order or documented administration of the medication.

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witnessed the resident taking the medication...." This Citation relates to Complaint IN00455663			
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	