STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155270	A. BUILDING 00 B. WING	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORE OF DALE	510 W MEDCALF ROAD DALE, IN 47523

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00429748 and IN00429084 Complaint IN00429748: Deficiencies related to the allegations are cited at F744. Complaint IN00429084: No deficiencies related to the allegations are cited. Survey dates: March 6, 7, & 8, 2024 Facility number: 000170 Provider number: 155270 AIM number: 100287490 Census Bed Type: SNF/NF: 37 Total: 37 Census Payor Type: Medicare: 1 Medicaid: 34 Other: 2 Total: 37 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on March 14, 2024.	F 0000		
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Charles Brazzell	Administrator	03/29/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	well-being. Based on observation, interview, and record review, the facility failed to provide necessary treatment and services for 2 of 3 residents diagnosed with dementia with behavioral disturbances. Residents' plan of care were not updated following persistent behaviors, recommended treatments and orders were not followed, outside services were not updated on continuing behaviors, and residents were left unsupervised. (Resident B, Resident C, Resident D, Resident F) Findings include: 1. A facility reported incident dated 3/2/24 at 7:01 A.M., included that a nurse entered the main dining room and noticed Resident B standing over Resident D with his hands around his neck. A handwritten note signed by the ADON (Assistant Director of Nursing), dated 3/2/24, included that when the ADON entered the main dining room they witnessed Resident B at Resident D's table choking him. ADON removed Resident B's hands from Resident D and separated them. An order was received to send Resident B to the emergency room for a Psychiatric Evaluation. During a review of facility reported incidents on 3/6/24 at 11:45 A.M., an incident dated 3/1/24 at 7:40 A.M., included that an altercation occurred in the main dining room between Resident B and Resident F. A handwritten description of the incident signed by the DON (Director of Nursing), dated 3/1/24, included that Resident F was blocking the walk way and Resident B was trying to get past while using a walker and began hitting Resident F's wheelchair with his walker. Resident F pushed the walker away from his wheelchair, then Resident B hit Resident F on the back with	F 0744	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. It is the policy of this facility to provide necessary treatment and services for residents diagnosed with Dementia and Behavior Disturbances. 1 Immediate action(s) taken for the resident(s) found to have been affected include: **Residents' plans of care were not updated following persistent behaviors.** A resident who displays Dementia is to receive appropriate treatment, services to meet his or hers highest practicable physical, mental, and psychosocial well-being. Social Services will complete an Audit of residents who have the Diagnosis of Dementia and complete a review of their risk assessment and the need for a new assessment. Social Services will review their history of behaviors, their current behaviors to determine the symptoms and	04/05/2024

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	an open hand and grabbed his shirt. Resident F stood from the wheelchair and hit Resident B on the left side of his face. Both residents began shoving each other and both lost their balance before staff intervened. During record review on 3/7/24 at 8:45 A.M., Resident B's diagnoses included, but were not limited to dementia with psychotic disturbance, anxiety, major depressive disorder, bipolar disorder, and conduct disorder. Resident B's most recent MDS (Minimum Data Set) assessment dated 2/5/24, included that the resident had delusions, displayed physical behaviors directed towards others, and exhibited other behaviors not directed towards others. Resident B's care plan included, but was not limited to resident is supervised for meeting emotional, intellectual, physical, and social needs due to dementia and resident has a behavior problem, is physically / verbally aggressive and has suicidal ideation (dated 11/17/23). An intervention included, Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. No new behavioral interventions had been put in place since 11/17/23. Resident B's progress notes included: 11/29/23 at 12:08 P.M. - Resident continues to show aggressive behaviors towards Resident D due to Resident D smiles and points at him. Resident says, "If he keeps looking at me and smiling I'm going to knock him out." Nurse told res that nobody was knocking anyone out, and to just not look at him. Residents are separated from one another, however resident B hasn't stopped		triggers to develop interventions to those behaviors and update care plan. **Outside services were not updated on continuing behaviors**. Nursing staff In-serviced on procedure for notifications. **Staff in-serviced on dining room monitoring.** 03/22/2024 No residents are to be left unsupervised in the dining room during mealtimes. 2 Identification of other residents having the potential to be affected was accomplished by: The facility has determined that __ALL_____ residents have the potential to be affected. **3 Actions taken/systems put into place to reduce the risk of future occurrence include:** Social Services will review all other residents to assess risk for behaviors and review care plans for interventions. All Nursing staff were in-serviced on following recommendations and treatment orders, nursing staff also in-serviced on procedure for updating outside services on continued behaviors.	

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	being upset. Resident B currently on 15 minute checks. 11/30/23 at 3:28 P.M. - Resident B in the main dining room when Resident D approached him and looked straight into Resident B's face. This caused this resident to yell out loud at Resident D. He then raised his fist at Resident D as if to strike at him. A staff member intervened and prevented this resident from striking peer. Resident B started on 15 minute checks. 11/30/23 at 5:32 P.M. - Resident B in the main dining room with increased aggression towards another resident because he heard the resident calling him a "dumb a--." Resident B's mood was unstable and with an angry affect, he lunged at the resident and got a hold of the the resident's arm. It took several staff to pull him away form that resident and to de-escalate Resident B. Resident B then attempted to hit the nurse. He then succeeded in kicking another one the residents in the shin and was hitting several other staff members while trying to de-escalate him. Resident discharged to emergency room for evaluation. A routine Psychiatric Nurse Practitioner (NP) visit, dated 2/14/24, included that while discussing a previous suicide attempt, Resident B denied having current suicidal ideation, but put his belt around his neck twice and attempted to a third time before the Psychiatric NP removed his belt and brought it to the nurse's station. The visit notes included that Resident B was at that time a threat to himself and others, and the Psychiatric NP ordered Resident B to be on 15 minute checks and made a referral to see a psychotherapist. A review of Resident B's 15 minute checks from		All staff in-service was done on 03/22/2024 dining room monitoring; No residents are to be left unsupervised in the dining room during mealtimes. **New policy on Behavior Management. Attachment A1** **New policy on Dementia Care. Attachment B1** **4 How the corrective action(s) will be monitored to ensure the practice will not recur:** Social Services will Audit and track behaviors and update care plans for interventions 5x/ week X 4 weeks. Social Services will Audit and track behaviors and update care plans for interventions 4x/ week X 4 weeks. Social Services will Audit and track behaviors and update care plans for interventions 3x/ week X 4 weeks. Social Services will Audit and track behaviors and update care plans for interventions 2x/ week X 4 weeks. Social Services will Audit and track behaviors and update care plans for interventions 1x/ week X 12 weeks. **Recommended treatments and orders were not followed**. a Psych NP to send all orders and concerns to DON to avoid miscommunication (per	

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	the incident on 11/29/23 to the following incident on 11/30/23 included a 15 minute check sheet completed on 11/29/23 and ending on 11/30/23 at 2:45 P.M. No 15 minute checks were documented from the incident on 11/30/23 at 3:28 P.M. to the incident on 11/30/23 at 5:32 P.M. No 15 minute checks were documented as completed following the psychiatric NP visit on 2/14/24. During an interview on 3/6/23 at 12:20 P.M., the ADON indicated that when they walked into the dining room to find Resident B standing over Resident D and choking him on 3/2/24, that no other staff were in the dining room with the residents. During an interview on 3/7/24 at 10:30 A.M. the DON indicated that no 15 minute checks were completed following the Psychiatric NP visit on 2/14/24, and that Resident B had not yet been seen by the Psychotherapist. During an interview on 3/7/24 at 2:00 P.M., LPN 4 indicated that Resident B had referenced to her a previous suicide attempt and indicated that maybe he should try it again. LPN 4 indicated that she would make a nurse's progress note in Resident B's chart. During an interview on 3/7/24 at 2:05 P.M., the MDS nurse indicated that residents care plans should be updated following specific behaviors or altercations, and that a resident should be placed on 1 on 1 observation following comments about suicidal ideation. During an observation and interview on 3/7/24 at 2:15 P.M., CNA 6 indicated that Resident B was in		conversation with DON and psych NP Sara Hatfield). b All nursing staff are educated on proper communication to all providers. c All progress notes from psych or primary care provider in facility visits will be reviewed by DON or designee to ensure any new orders or recommendations are in place. d This will be an ongoing process to ensure that orders are received and implemented. **Outside services were not updated on continuing behaviors**. e Nursing staff educated on procedure for notifications. f DON or designee will audit communications with providers/outside services regarding resident behaviors as follows: Behavior documentation will be reviewed 5 x a week x 4 weeks to ensure that outside services are aware of continuing behaviors. Behavior documentation will be reviewed 3 x a week x 4 weeks to ensure that outside services are aware of continuing behaviors x 4 weeks. Behavior documentation will be reviewed 2 x a week x 4 weeks to ensure that outside services are aware of continuing behaviors. Behavior documentation will be reviewed 1 x a week x 14 weeks to ensure that	

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	his room. At that time, Resident B was not in his room, but LPN 4 was in his room and stated that Resident B was in an activity in the dining room. At that time, Resident B was not in an activity in the dining room. Resident B was observed in the Physical Therapy Department with Physical Therapist (PT) 8. During an interview on 3/8/24 at 8:30 A.M., the Psychotherapist indicated that she did not receive a referral to see Resident B following the NP's visit on 2/14/24. The facility requested that Psychotherapy see Resident B the day prior (3/7/24). 2. During record review on 3/7/24 at 12:40 P.M., Resident D's diagnoses included, but was not limited to dementia with other behavioral disturbance, anxiety, paraphilia, mood disorder, psychosis, major depressive disorder, and insomnia. Resident D's most recent MDS (Minimum Data Set) assessment dated 12/30/23, included that the resident had not exhibited any behaviors and was cognitively intact. Resident D's care plan included, but was not limited to the resident has a behavior problem with inappropriate sexual behavior. An intervention included monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes (dated 11/17/23). The resident has impaired cognitive function/impaired thought processes due to alcohol-induced persisting dementia. Resident requires cues and supervision and supervision for safe and appropriate decision making.		outside services. Residents were left unsupervised. g Staff in-serviced on dining room monitoring; No residents are to be left unsupervised in the dining room during mealtime. h Management monitoring the dining room throughout the day. i DON or designee to do dining room audits as follows: Audit staff in the dining room at various mealtimes and activities 5 x a week for 4 weeks. Audit staff in the dining room at various mealtimes and activities 3 x a week for 4 weeks. Audit staff in the dining room at various mealtimes and activities 2 x a week for 4 weeks. Audit staff in the dining room at various mealtimes and activities 1 x a week for 14 weeks. The (DON and Social Services Director) will complete weekly audits for at least 26 consecutive weeks. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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	Resident D's nurse's progress notes included, but were not limited to: 11/29/23 at 12:27 P.M. - Resident invading other residents' personal space, then laughing. Resident will point his finger at them and smile or laugh, touching residents by rubbing their cheeks, shaking their hand, and rubbing the top of their heads. Resident's over friendly behavior is distressing other residents. 11/30/23 at 3:51 P.M. - Resident was in the dining room at 12:30 P.M. Resident walked up to Resident B's table and looked into the face of this resident staring and smiling at him. This made Resident B extremely angry. Resident B held up his fist as if to strike Resident D. A staff member intervened. 12/8/23 at 6:02 P.M. - Resident noted to bully other residents all day. He will either stand over them very close. Stare at them smiling, or walk towards them very fast. He was also observed by nursing to be another residents room today stealing food. 12/10/23 at 3:58 P.M. - Resident continuously getting in other peoples space, touching them by the hand, arm, and patting tops of heads. 12/12/23 at 9:07 A.M. - Resident continues to get in others space. Continues to laugh at others and touch others in a nice manner, but is upsetting others by doing such. 12/14/2023 at 4:08 P.M. - Resident was in dining room. He went to two different people and stared at them with a big smile. This annoyed the patients.			

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	2/27/2024 at 1:09 P.M. - Resident was eating lunch in dining area, when he was finished he was walking out and stopped at another resident's table and bent over staring at him and smiling. Resident has a history of taunting other residents attempting to agitate other peers. Peer verbally expressed he did not like him starring at him. Continued to agitate resident even after peer expressing to him he did not want him close. 2/27/24 at 1:29 P.M. - Resident sitting in front of other residents and smiling causing the other residents to get upset. Resident enjoying making them angry. Resident tormenting other residents. 3/2/24 at 12:09 P.M. - Staff entered main dining room and witnessed Resident D sitting down and Resident B standing over him choking him. Staff able to get in between residents and removed Resident B's hands from Resident D's neck. A small scratch was noticed on Resident D's right cheek. A social service interview, dated 3/4/24, included that Resident D stated that Resident B had choked him in the dining room after he approached Resident B and smiled at him. Resident denied pain from the incident and displayed no signs or symptoms of psychosocial distress. During an interview on 3/6/24 at 10:15 A.M., LPN 4 indicated that Resident B and Resident D should not be left unsupervised when together due to both of the residents' behaviors. During an interview on 3/8/24 at 9:25 A.M., the Facility Administrator indicated that residents should not be left unattended in the dining room.			

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	3. During a review of facility reported incidents on 3/6/24 at 11:45 A.M., an incident dated 2/28/24 included that staff entered a room to find Resident C standing in front of another resident with his pants down and asking the resident to perform oral sex. During record review on 3/8/24 at 10:00 A.M., Resident C's diagnoses included, but were not limited to dementia with other behavioral disturbance, impulsiveness, and anxiety. Resident C's most recent MDS (Minimum Data Set) Assessment dated 1/13/24, included that the resident had not exhibited any behaviors. Resident C's care plan included, but was not limited to, resident has impaired cognitive function or impaired thought process due to dementia, and resident has a behavior problem due to inappropriate sexual behaviors, resident has behaviors of exposing himself in front of others (11/30/23). An intervention included Psychiatric NP to evaluate and treat for inappropriate sexual behaviors as needed. No new interventions added to behavioral care plan since 11/30/23. Resident C's physician orders included, but were not limited to, Seroquel 25 mg (milligrams) one tablet by mouth two times a day for sexually inappropriate behaviors (started 11/30/23 and discontinued 1/11/24). Resident C's progress notes included: 11/28/23 at 6:52 P.M. - Resident was outside smoking with supervision and walked up to another male resident and asked if he wanted to touch his penis.			

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12/4/2023 at 2:39 P.M. - Resident was found in another resident room with his pants down standing in front of other resident.

12/8/23 at 6:02 P.M. - Resident was observed pulling out his penis and shaking it at another resident while walking down the hall.

Resident C's routine Psychiatric NP visits included a visit, dated 12/20/23, that included that nursing reports that resident has been "real good since starting Seroquel," saying he has not had any inappropriate sexual behaviors since starting Seroquel (on 11/30/23).

During an interview on 3/7/24 at 11:45 A.M., the Psychiatric NP indicated that there was a concern with the facility communicating resident behaviors effectively in order for psychiatric services to provide to best treatment.

On 3/8/24 at 12:30 P.M., the DON supplied a facility policy titled Care Plan Policy and Procedure, dated 7/2017. The policy included, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and time frames that are identified in the comprehensive assessment. Procedure: ...3. (Interdisciplinary team) IDT will meet weekly on all incident/accident occurrences and updated care plans accordingly..."

This citation relates to complaint IN00429748.

3.1-37(a)