STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE AT PARKWOOD	1001 N GRANT ST LEBANON, IN 46052

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00430091. Complaint IN00430091-Federal/State deficiencies related to the allegations are cited at F626 and F740. Survey dates: March 21 and 22, 2024 Facility number: 000468 Provider number: 155378 AIM number: 100290270 Census bed type: SNF/NF: 86 Total: 86 Census payor type: Medicare: 9 Medicaid: 66 Other: 11 Total: 86 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 2, 2024.	F 0000	Preparation and/or execution of this plan of correction in general, does not constitute an admission of an agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is 3/23/2024	
F 0626 SS=D Bldg. 00	483.15(e)(1)(2) Permitting Residents to Return to Facility §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Lazar (Hurt)	Administrator	04/10/2024

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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	(i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.			
	Based on interview and record review, the facility failed to accept a cognitively impaired resident back to the facility following a transfer to the hospital for evaluation and treatment and failed to adequately document the reason for his discharge from the facility in his record for 1 of 3 residents reviewed for appropriate discharge (Resident B). Findings include: A confidential statement indicated Resident B was	F 0626	1 What corrective action will be accomplished for those residents found to have been affected by the deficient practices: a Resident B was discharged to Eskenazki Hospital on 3/03/2024. b Notice of Transfer and Discharge was sent with resident/ mailed to guardian, along with appeal rights and information to	03/23/2024

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	admitted to the emergency department at (Name of Hospital) after he eloped from the facility into the community. The guardian and the hospital requested for the resident to return to the facility for placement upon discharge from the hospital. The facility refused to accept the resident back despite issuing a 30-day written notice of involuntary discharge to the guardian and without assisting with obtaining alternative placement as was required by the facility. The resident remained at the hospital without a medical need to be there and was at risk of experiencing homelessness with nowhere else to go. He had diagnoses of a traumatic brain injury and a seizure disorder with frequent seizures and was not to be unsupervised in the community. Resident B's record was reviewed on 3/21/24 at 11:45 a.m. Diagnoses included, but were not limited to, cognitive communication deficit, encephalopathy, epilepsy (seizures), traumatic brain injury, protein-calorie malnutrition, difficulty in walking, need for assistance with personal care, and muscle weakness. The resident's record was reviewed for the reason for his transfer/discharge from the facility and there was no documentation from a physician or the facility for a permittable reason why he was permanently discharged from the facility. The resident's facesheet indicated he was discharged on 3/3/24 at 4:26 p.m., to (Name of hospital) for behavior problems. The documentation lacked specific information regarding the behavior problems. The facility did not provide a copy of the 30-day discharge notice that was faxed to the resident's representative, nor was it found in the resident's record.		contact Ombudsman and ISDH. 2 How other residents having the potential to be affected by the same alleged deficient practices will be identified and what corrective action will be taken: a All residents discharging from facility have the potential to be affected by the alleged deficient practice. b All residents who had discharged from the facility since 2/06/2024 were audited to ensure that proper documentation was given. c Ombudsman notification from March will be completed by 4/03/2024. 3 What measures will be put into place and what systemic changes will be made to ensue that the alleged deficient practice does not recur: a DON/or designee will re-educate Licensed staff on Transfer/Discharge Notice policy and the Indiana specific Notice of Transfer or Discharge by 3/23/2024. 4 How the corrective action will be monitored to ensure the alleged deficient practice will not recur, what quality assurance program will be put into place: a All residents discharging from facility will be audited upon discharge to ensure Notice of Discharge has been given to resident and/or responsible party and Ombudsman notified.	

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	A document titled, "Notice of Transfer or Discharge," dated 3/3/24, was included in the resident's transfer packet. The form indicated Resident B was transferred to "other" facility, which was (Name of hospital). The reason for the transfer or discharge indicated it was necessary to meet the resident's welfare and the facility was unable to meet the resident's needs. The document lacked specific information related to why the facility was unable to meet the resident's needs. A document titled, "Emergency Department [ED] Triage Notes," dated 3/3/24 at 5:50 p.m., indicated the resident was brought to the hospital from the extended care facility. The extended care facility indicated he had suicidal ideations and aggressive behavior. He had a history of a traumatic brain injury and he was not his own guardian. He denied suicidal or homicidal ideations for the Emergency Medical Services and the Registered Nurse. He had no aggressive behavior en route to the hospital or in the Emergency Room (ER). He presented to the hospital for a psychiatric evaluation. His past medical diagnoses included, but were not limited to, coma, intermittent explosive disorder, seizures, and traumatic brain injury. A hospital Social Worker's progress notes, dated 3/3/24 at 8:43 p.m., indicated she spoke to Resident B's court appointed guardian, who indicated he lived at the facility since he was released from the hospital on 2/14/24. The Executive Director (ED) indicated earlier that day she chased the resident a mile down the road after he eloped from the facility. The ED indicated the facility was unable to keep him safe and he was a threat to other residents. The ED indicated she		b Audit results will be submitted to the CEO/designee for review by the Quality Assurance Performance Improvement Committee monthly for 3 months, or until the QAPI Committee determines substantial compliance has been achieved. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.	

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	had faxed a 30-day eviction notice to the resident's court appointed Guardian's office on a Sunday night. The hospital Social Worker connected the ED from the facility and the resident's court appointed Guardian together to talk. The resident's Guardian indicated the facility would not accept him back. The Guardian indicated their legal office would not have received a fax on a Sunday night that the facility indicated they sent for the eviction of Resident B. The Guardian indicated the facility needed to provide a 30-day written notice for eviction from the facility. The facility would not accept the resident back that night. A hospital Social Worker's progress notes, dated 3/4/24 at 11:08 a.m., indicated she talked with the Facility Liaison, who informed her Resident B busted out a window in his room, escaped from the facility and ran to a gas station in town. The resident also had a metal rod in his hand and was threatening staff with it. When the hospital Social Worker asked her if the resident was able to return to the facility, the Liaison indicated she would need to follow back up with the facility administration. The hospital Social Worker was to follow back up with the Liaison that day after 10:30 a.m., rounds. A hospital Social Worker's progress notes, dated 3/4/24 at 4:30 p.m., indicated the hospital Social Worker received a call from the Facility Liaison and they discussed report from the 10:30 a.m. rounds and no safety concerns with the resident were present. The Liaison indicated she was following up with the ED and she would contact the Social Worker by 3 p.m., that day with a decision. The Hospital Social Worker received a text message from the Facility Liaison indicating she was awaiting a response back from the facility			

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	ED, so she will follow back up with her in the a.m. A hospital Social Worker's progress notes, dated 3/5/24 at 4:14 p.m., indicated she had contacted the Facility Liaison, who indicated that the facility ED declined Resident B's return to the facility. The Facility Liaison inquired if the resident had any incidents at the hospital. The hospital Social Worker informed the Facility Liaison he was medically ready to discharge and he had only refused labs with no other behavior issues. The Facility Liaison indicated she would follow up with the facility ED and provide an update by 10:45 a.m. The hospital Social Worker contacted the facility Liaison and informed her of the routine return referral, but no decision had been made as of yet. The hospital Social Worker submitted 81 silent referrals based on the hospitals zip code within a 20 mile radius. A hospital Social Worker's progress notes, dated 3/6/24 at 9:20 a.m., indicated the resident was denied 72 out of 81 silent referrals. A hospital Social Worker's progress notes, dated 3/6/24 at 4:20 p.m., indicated the resident was denied 76 out of 81 silent referrals. The Liaison texted the hospital Social Worker indicating "Good afternoon!! Ok sorry they ae [sic] in denial of payment and can not take him back unfortunately. I apologize for the delay." A document titled, "History and Physical," dated 3/3/24 at 10:04 p.m., indicated Resident B was brought to the hospital after escaping from his extended care facility. He had a court appointed guardian. He did not like the conditions of the extended care facility he was living at, so he pulled a knife and demanded to be taken back to Indianapolis. Emergency services was called and			

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	he was brought to the hospital. The Social Worker assessed the resident. His original extended care facility will not accept him back, so the resident was admitted for placement. Assessment and plan: Homelessness requiring placement: Since the resident brandished a knife and escaped from his old extended care facility, the facility was not willing to take him back. He will require placement again. A document titled, "ED Provider Notes," dated 3/3/24 at 11:17 p.m., indicated the resident was at the extended care facility, grabbed a knife and ran off in an attempt to get back to Indianapolis. At 8:28 p.m., the care facility at Lebanon would not take him back at that time. At 9:29 p.m., the resident was trying to leave the hospital, so he was chemically restrained for his and the staff's safety. The final diagnosis was aggressive behavior. During an interview on 3/21/24 at 1:15 p.m., the Vice President of Clinical Operations (VPCO), Executive Director (ED) and Director of Nursing (DON) were in attendance. The ED indicated the resident eloped from the facility with supervision of staff until he was returned to the facility. Staff remained within site of the resident the entire time he was walking in the community. There was a referral made to (Name of hospital) and the ambulance transported the resident to that hospital for an evaluation and treatment. She spoke with the resident's Guardian on that date (3/3/24) at approximately 10:30 p.m., indicating to the Guardian she was unable to take the resident back at that time because the facility was not able to meet his needs. When the VPOC, ED, and DON were informed there was no documentation in the progress notes indicating the resident had been transferred to the hospital or discharged, the			

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	VPOC indicated the information was documented on the change of condition form. When asked why the resident did not return to the facility when he was ready to be discharged from the hospital, the ED indicated the hospital never made a referral for the facility to take the resident back. The ED indicated as far as they knew he had been admitted to a traumatic brain injury center and was no longer at the hospital. During an interview on 3/21/24 at 3:00 p.m., the ED, DON, and VPCO were in attendance. The VPCO indicated the facility should have been more descriptive about the incident of the resident exiting the building and the reason for the resident's transfer and discharge on the change of condition form. During an interview on 3/22/24 at 3:17 p.m., the VPCO, ED, DON and Clinical Nurse Consultant were in attendance. The ED indicated they had received a referral from (Name of hospital) to accept the resident back, but they lost the referral because an inpatient psychiatry facility accepted him prior to them accepting him back to the facility. On 3/3/24, they transferred him to the hospital because he was a danger to himself and other residents. The ED indicated she faxed a 30-day notice to the Guardian on a Sunday night, after they realized the facility was unable to meet his needs. A current policy titled "Facility Bed-hold" dated 9/15/23, provided by the ED on 3/22/24 at 2:32 p.m., indicated "POLICY STATEMENT: The Facility will notify the resident and/or resident representative of the facility's bed-hold policy at admission and anytime a resident is transferred to the hospital or goes out on therapeutic leave. The Facility will also notify the resident /and/or			

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	resident representative in writing of the reason for transfer/discharge to another legally responsible institutional or non-institutional setting and about the resident's right to appeal the transfer/discharge. GUIDELINE: 1. The facility's bed-hold policy will be discussed with the resident/and/or resident representative and the facility will provide written notice of the bed-hold policy:..b. Before a resident's transfer to the hospital or for overnight therapeutic leave and included in the resident's transfer packet...The facility's Social Worker or Licensed Nurse will document verbal and written notification in the medical record. c. In an emergency, 'time of admission' or 'time of transfer' may mean up to 24 hours... 3. Regardless of payer source, the facility will impose and/or discontinue a bed-hold only with written notice from the resident/and/or resident representative...." A current policy titled, "Transfer/Discharge Notice" dated 9/15/23, provided by the ED on 3/21/24 at 12:27 p.m., indicated "...DEFINITIONS:.."Transfer and Discharge": Includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility. Specifically, transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility where the resident expects to return to the original facility. Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected. "Emergent Transfers to Acute Care": Residents who are sent emergently to the hospital are considered facility-initiated transfers because the			

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	resident's return is generally expected. GUIDELINE: 1. The facility will permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless: a. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility...c. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident...2. The facility should document the danger that failure to transfer, or discharge would pose in the medical record. DOCUMENTATION: 1. Documentation in the resident's medical record should include: a. The basis for the transfer b. The specific resident need(s) that cannot be met, the facility attempts to meet the resident need(s). 3. The physician should document in the medical record when transfer or discharge is necessary...FACILITY INITIATED DISCHARGE/TRANSFER: 1. The facility may decide to discharge/transfer a resident only for the reasons permitted under applicable federal and state law, which may include the following: Transferred/discharged for the sake of the resident's welfare and the resident's medical needs could not be met by the facility (Requires resident's physician documentation in the resident's medical record)... The safety of individuals in the facility would otherwise be endangered. (Requires a physician's documentation in the resident's medical record)...7. The facility will document the reason for the transfer or discharge in the clinical record...9. Resident transferred emergent to an acute care setting will be permitted to return to the facility unless the resident meets one of the criteria under which the facility can initiate discharge...EMERGENT TRANSFERS TO ACUTE CARE: 1. Resident who are sent emergently to the hospital are considered facility-initiated transfers because the resident's return is generally			

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	expected. 2. Residents who are sent to the emergency room, will be permitted to return to the facility unless the resident meets one of the criteria under which the facility can initiate discharge...4. In situations where the facility has decided to discharge the resident while the resident is still hospitalized, the facility will send a notice of discharge to the resident and/or resident representative and send a copy of the discharge notice to a representative of the Office of the State LTC [Long Term Care] Ombudsman. Notice to Ombudsman should occur at the same time the notice of discharge is provided to the resident and/or resident representative. This citation relates to Complaint IN00430091. 3.1-12(a)(4)(A)			
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on interview and record review, the facility failed to follow up with Psychiatric services to get Psychiatric care prior to the resident eloping from the facility and failed to adequately document the elopement in the resident's record for 1 of 3 residents reviewed for Psychiatric services (Resident B).	F 0740	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practices. a Resident B no longer resides at the facility. No corrections will be necessary.	03/23/2024

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	Findings include: A document titled, "Intake Information," dated 3/7/24, provided by the Indiana Department of Health on 3/7/24, indicated Resident B was admitted to the emergency department at (Name of Hospital) after he eloped from the facility with supervision into the community. He was diagnosed with a traumatic brain injury and a seizure disorder with frequent seizures and cannot be unsupervised in the community. Resident B's record was reviewed on 3/21/24 at 11:45 a.m. Diagnoses included, but were not limited to, cognitive communication deficit, encephalopathy, epilepsy (seizures), traumatic brain injury, protein-calorie malnutrition, difficulty in walking, need for assistance with personal care, and muscle weakness. A nurses note, dated 2/15/24 at 4:54 p.m., indicated Resident B was pacing up and down the hallways repetitively asking staff members to open the doors to let him out indicating he was getting out of the facility one way or another. He gathered his belongings from his room and started heading towards Maplewood exit double doors when RN 6 approached him. He became increasingly agitated indicating he was going to hurt anyone that came close to him and prevented him from going to Indianapolis. At one point the resident came toward RN 6 with closed fists asking if she was going to let him out of the facility. 911 was called and the police indicated they would come back if he hit a staff member or another resident. A new order was received for Haloperidol Injection (a medication used to calm an agitated person) one milliliter given in the right deltoid muscle. Social Services was to call		2 How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken: a All residents with a mental disorder have the potential to be affected by alleged deficient practice. b The medical records of residents with a mental disorder will be reviewed for completed documentation, and psychiatric referrals. Corrections will be made as indicated. 3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: a Licensed staff will be re-educated on charting and documentation policy. b IDT will review behaviors daily, Monday - Friday during clinical meeting for completed documentation and psychiatric referrals. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: a CEO/designee will conduct weekly audits of 5 residents for 4 weeks, then 5 residents monthly	

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(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
	Neuropsychiatry for a referral. A social service progress note, dated 2/15/24 at 6:51 p.m., indicated he spoke with the resident's Guardian who was agreeable to an inpatient psychiatric treatment stay. A referral was sent to an inpatient psychiatric treatment hospital. The intake staff at (Name of inpatient psychiatric hospital) indicated the Psychiatrist had reviewed the resident's status and at that time, his admission was being declined due to he did not meet inpatient admission criteria. A nursing progress note, dated 2/16/24 at 4:12 p.m., indicated the resident had been anxious most of the day. a new order to start Lorazepam (a medication used to relieve anxiety) one milligram by mouth twice a day as needed. A social service progress note dated 3/2/24 at 4:09 p.m., indicated the resident approached the Social Service Director (SSD) and indicated he wanted to leave the facility. Upon updating the nursing staff regarding the resident's status, the nursing staff indicated the resident had been voicing wanting to leave the facility before he spoke to the SSD. The resident had a care plan, dated 2/29/24, which indicated the resident had problems including a history of making false allegations, cursing at staff and others, being combative with staff, and exit seeking. The approaches included, but were not limited to, 2/16/24--Assist resident away from other residents as needed, 2/16/24--observe behavior: verbal statements "I'm leaving", packing belongings, following visitors closely as exiting or pushing on exit doors. The resident had a care plan dated 2/29/24, which addressed the problem of the resident being at		times 3 months to ensure residents with mental disorder have completed documentation and psychiatric referrals. b Audit results will be submitted to the CEO/designee for review by the Quality Assurance Performance Improvement Committee monthly for 3 months, or until the QAPI committee determines substantial compliance has been achieved. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	03/22/2024

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	risk for elopement due to exit seeking behavior. The approaches included, but were not limited to, 2/16/24--Ensure resident was residing in the correct level of care. There was no documentation found in Resident B's record to indicate any other Psychiatric hospitals or Psychiatric services were contacted to evaluate and treat him for his exit seeking behaviors prior to his elopement from the facility on 3/3/24. During an interview on 3/21/24 at 1:15 p.m., the Vice President of Clinical Operations (VPCO), Executive Director (ED) and Director of Nursing (DON) were in attendance. The ED indicated the resident eloped from the facility with supervision of staff until he was returned to the facility. Staff remained within site of the resident the entire time he was walking in the community. There was a referral made to (Name of hospital) and the ambulance transported the resident to that hospital for an evaluation and treatment. The ED was asked if there were any other Psychiatric hospitals contacted to take Resident B or if the facility had Psychiatric services come into the facility to evaluate the resident when he was exit seeking and aggressive because there was no documentation in the resident's record regarding any further attempt to obtain Psychiatric services for the resident. The ED indicated she would have to check to verify if there were any other Psychiatric services offered to the resident or any other Psychiatric hospitals contacted. The VPCO indicated at the start of his exit seeking behaviors, the resident was placed on 15 minute checks and remained on them until he was transferred to the hospital on 3/7/24. During an interview on 3/22/24 at 3:17 p.m., the			

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	ED, DON, VPCO and Clinical Nurse Specialist were in attendance. The DON indicated because of Resident B's age, there were no Psychiatric service companies who would come to the facility to treat him. The facility was unable to get another Psychiatric hospital to admit him for an evaluation. The resident's medical physician was treating his exit seeking behaviors. The DON indicated there was no documentation in the resident's record to indicate the number of Psychiatric hospitals or Psychiatric service companies the Social Worker contacted trying to get services for him. This citation relates to Complaint IN00430091. 3.1-43(a)(1)			