STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155664	A. BUILDING _____ B. WING _____	C 05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE CREEK HEALTHCARE CENTER	4102 SHORE DR INDIANAPOLIS, IN 46254

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00353535, IN00353549, IN00352155, IN00351332, and IN00351267. Complaint IN00353535 - Substantiated. Federal/State deficiencies related to the allegations are cited at F602, F755, and F761. Complaint IN00353549 - Substantiated. Federal/State deficiencies related to the allegations are cited at F623, F624, and F845. Complaint IN00352155 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00351332 - Unsubstantiated due to lack of evidence. Complaint IN00351267 - Substantiated. Federal/State deficiencies related to the allegations are cited at F624 and F845. Unrelated deficiencies are cited. Survey dates: May 12, 13, and 14, 2021. Facility number: 010666 Provider number: 155664 AIM number: 200229930 Census Bed Type: SNF/NF: 4 Total: 4 Census Payor Type: Medicaid: 4	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 000	Continued From page 1 Total: 4 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 25, 2021.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident (Resident F) did not abuse another resident (Resident E) resulting in harm when Resident F's verbal abuse escalated to physical abuse, Resident E received a reddened area to his face and a cut on his hand, and feared Resident F for 1 of 4 residents reviewed for abuse. The facility failed to prevent sexual abuse and psychosocial harm for a resident (Resident J) who was sexually assaulted by another resident (Resident H) for 1 of 4 residents reviewed for abuse.	F 600		

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Findings include:

1. On 5/12/21 at 10:50 a.m., Resident E was observed in his room sitting up in his wheelchair. He indicated he was very upset over an incident that happened where he had been "attacked" by another resident. He pointed to a folded yellow card on his dresser and indicated it was a Police Report Summary. The report, dated 4/21/21, indicated, "battery." Resident E indicated he and another resident, Resident F, used to be good friends, but one day Resident F started yelling at him about giving back his money. Resident F continued to "get mad" and over several days kept coming down to Resident E's room yelling at him to give him money. Resident F threatened Resident E saying, "I'm going to slice your f---ing throat!" Resident E indicated, he reported the yelling and threats to the staff, but Resident F kept getting past the nurses' station. On 4/21/21 Resident F came to his room several times, but eventually he got into the room and attacked him. Resident F leaned over Resident E because he had been in his wheelchair. Resident E tried to push Resident F away with his cane, but as they wrestled, Resident F was able to punch him and slapped Resident E's arm away which hit the bottom of the bed and caused a skin tear. Resident E indicated he was really mad Resident F was able to keep coming down to his room. The staff never stopped him even though everyone knew Resident F had made threats about hurting Resident E. Resident F was taken to jail and gone for several days, but the facility allowed him to come back. Resident E was afraid for his safety, especially because no one told him Resident F had returned. He feared for his safety and was afraid to be attacked again.

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Resident E played a voice recording on his phone. Shuffling and rustling sounds were heard, and Resident E yelled, "get out of my room, get the f--- out of my room!" several times. Louder rustling, shuffling, and heavy breathing sounds were heard, and Resident E yelled, "Staff! Staff! Staff!" Resident E indicated "He just came down here and assaulted me!" An unidentified staff member asked who and then indicated, "You're going to be going out of here in cuffs today, you've been acting out all evening...."

Resident E indicated he had a recording of the conversation with the detective and played it. Resident E indicated on the recording, " ...yesterday he came down here threatening me, he's fruit loops. He came down here again today. He punched me in the eye, and I got a cut here." An unidentified detective indicated, "I see a red mark there on your cheek." Resident E, "yes, that's where he hit me."

During a confidential interview, the interviewee indicated Resident F had verbally assaulted Resident E a couple days before the verbal assaults boiled into the physical altercations. Resident F hit Resident E in the face. Resident F went to jail for a couple days. When he was released from jail the facility brought him back. Resident E was upset about Resident F's return. Resident E did not feel safe, so the facility moved Resident F to the other side of the building. However, both residents smoked, and they had to share the same smoking areas.

During a confidential interview, the interviewee indicated Resident F had behaviors. He would have arguments with other residents, and yell at

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other residents. Initially Resident E and F were best friends until something happened and Resident F thought Resident E owed him a lot of money. Probably for at least three days, Resident F kept going to Resident E and demanded to get some money back. He would yell and get in his face. Resident F's anger increased until the fight happened. Resident F went to Resident E's room and attacked him. He hit Resident E in the face, and Resident E got a cut on his hand. The police came and arrested Resident F. When he was released from jail he came back to the facility. He was moved to the other side of the building, but Resident E was still very upset and still was upset.

During a confidential interview, the interviewee indicated Resident E and F were friends, but somehow Resident F started to think Resident F owed him money. On the evening of 4/21/21, Resident F went to Resident E's room and asked for money. They were heard arguing, Then Resident E started yelling for help. Resident F hit Resident E in the face. Resident F stayed pretty "belligerent" for a while after the assault which was why the police were called. Resident F threatened to "knock his [Resident E] head off." When the police came, they took Resident F to jail because of an outstanding warrant.

During a confidential interview, the interviewee indicated almost everyone knew Resident F was upset with Resident E. Resident F kept going to Resident E's door and would bang on the door and yell about getting his money. Resident F was told not to go to the door, but he kept trying to get in. The last time he went to the door, he "busted in", and staff heard Resident E yelling for help. Resident F had to be physically removed by two

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staff members from Resident E's room, he fought and swung at the staff to get to Resident E.

On 5/12/21 at 2:11 p.m. Resident E's medical record was reviewed. The most recent comprehensive assessment was a quarterly minimum data set (MDS) assessment dated 3/19/21. The MDS indicated Resident E was cognitively intact with a BIMS (brief interview for mental status) score of 15 of 15. No behaviors were coded, and he was independent with all activities of daily living (ADLs) and only required minimal assistance from staff.

A nursing progress note, dated 4/21/21 at 9:18 p.m., indicated a change in condition related to trauma after a resident to resident alleged altercation in which he received a small cut to his right hand.

A nursing progress note, dated 4/21/21 at 9:18 p.m., indicated the resident had been assaulted in his room by another resident over an alleged debt. Police were called to the scene and the attacker was taken away. Resident E stated he suffered a punch in the face and a minor cut on their right hand in the struggle.

A Change in Condition Evaluation, dated 4/21/21 at 9:18 p.m., indicated, Resident E had calmed down, a small laceration to the back of his right hand was noted.

Resident E had no comprehensive care plans related to disruptive behaviors, altercation with peers, or making false allegations.

On 5/12/21 at 2:26 p.m. Resident F's medical record was reviewed. The most recent

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comprehensive assessment was an admission MDS assessment dated 3/3/21. Resident F's cognitive status was not assessed, no behaviors were coded, and he was independent with all ADLS and only required minimal assistance from staff.

A nursing progress note, dated 3/23/21 at 5:58 p.m. indicated, "...Resident is alert and confused with wandering conversation, unable to answer a question without getting off topic. He constantly made statements such as "they are all liars here" and "they are not giving me my medicine," "I am not getting therapy," and "the diagnosis that they have for me is incorrect, I am here because I am an alcoholic," "they are stealing my medication." Resident had to be redirected back to the questions on the interview with every response. Social services notified for psych services as needed.

A nursing progress note, dated 3/25/2 at 7:27 a.m., indicated, Resident F was threatening another resident. Aggravation and yelling occurred. No physical altercations occurred. Nurse separated residents immediately.

A nursing progress note, dated 4/21/21 at 6:55 p.m., indicated Resident F was reported pounding on another resident's door making loud outburst "you owe me money!" The SSD spoke with Resident F regarding his behavior. Resident F reported he loaned the resident money, and the resident was supposed to have paid him back within two weeks. SSD spoke with Resident F until he was calm. SSD encouraged him to get the loan agreement in writing. Resident F was grateful, and his mood was calm.

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A nursing progress note, dated 4/21/21 at 6:58 p.m., indicated Resident F was complaining that he gave some money to another resident. He kept going to the resident's room, banging on his door, and threatened him. He eventually went in the room and assaulted the other resident.

A nursing progress note, dated 4/21/21 at 7:25 p.m., indicated Resident F was calm and reported he regretted what he did and was concerned about if he was "getting in trouble." Later the resident was apprehended by the police on unrelated charges.

A nursing progress note, dated 4/27/21 at 2:07 p.m., indicated Resident F was re-admitted to the facility.

A nursing progress note, dated 5/3/21 at 11:16 a.m., indicated Resident F was observed slurring his words and acting belligerent. He admitted he had taken three large drinks of vodka and a CBC ball. He deflected his behaviors upon others, yelled and screamed for medication.

A nursing progress note, dated 5/4/21 at 5:05 p.m., indicated Resident F had been transferred to another facility.

Resident F had no comprehensive care plans related to disruptive behaviors, altercation with peers, or making false allegations.

During an interview on 5/13/21 at 3:51 p.m., the Executive Director (ED), indicated she had been made aware of the altercation between Resident E and F. It had been reported to the state and the police came out to investigate and removed Resident F from the building because of an

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outstanding warrant. The ED got a call that night and indicated the residents had been separated, and Resident F had been placed on one to one until he was removed from the facility. The ED indicated nothing had been reported to her about prior arguments or altercations between the residents, so it was a shock when Resident F attacked Resident E. The residents were interviewed separately and agreed it was all just a misunderstanding. Neither resident sustained any injuries, and they were kept separate until Resident F was discharged from the facility.

On 5/13/21 at 4:00 p.m., the ED provided a copy of the state reported incident related to Resident E and F's altercation. Incident 365 was reviewed at this time. A brief description of the incident indicated: Residents E and F had "an unpleasant exchange of words." Resident F "made contact with [Resident E] with an open hand." The residents were separated immediately by staff. There was no injury noted. A follow up added on 4/27/21 indicated, "Investigation concluded. [Resident F] (BIMS 15) states, 'it was just a disagreement. He said I hit him, and I didn't ... [Resident E] (BIMS 15) states, 'he looked very aggressive. He was going to hit me.' This writer asked [Resident E] if [Resident F] made contact with him. [Resident E] stated, 'almost.' [Resident E and F] state their differences have been 'worked out.'"

On 5/13/21 at 4:00 p.m., the ED provided a copy of the facilities investigation interviews with Residents E and F related to their altercation. The first interview, with Resident E indicated, "on 4/22/21, this writer spoke with [Resident E] regarding incident 365. This writer asked [Resident E] if he could recall the incident from

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the previous night. [Resident E] stated, "Yeah. He's all mad at me about the fish I bought him, He gave me money to buy him a novelty fish, I bought it, gave it to him and he didn't like it. I told him he should get a return and I could help. He started yelling at me and almost hit me." This writer asked [Resident E] where he was his. [Resident E] stated, "well, he didn't hit me, but he was really aggressive. I thought he was going to." This writer acknowledged [Resident E] and he stated, "everything is fine now. I helped him return it and all is well. He's been my friend since he got here. We just had a little tiff. I appreciated you guys taking it so seriously. Makes me feel safe." The statement was signed by the ED. Resident E did not sign the statement.

The written interview with Resident F indicated, "on 4/22/21, this writer spoke with [Resident F] regarding incident 365. [Resident F] stated, "I gave him money to get me one of those fish statues that he has. I thought it looked really neat. Well, when I got it back from him, it didn't match the picture, so I felt lied to. I confronted him about it and he told me it wasn't his problem. That made me mad because we were supposed to be friends. Anyways, we exchanged some choice words with each other, and he started yelling that I hit him. I never hit him, the staff came over right away and separated us and I went back to my room. I never hit him. Anyways, we've made up since then. Everything is worked out. He's returning the fish to get me my money back." This writer acknowledged [Resident F]'s statement. This writer educated [Resident F] on best practice if having any difficulties with other residents and to allow staff to intervene. [Resident F] states, We're adults. I didn't think it was going to turn into that but I will get staff if something like this

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happens again." This writer thanked [Resident F] for his time and exited the room." The statement was signed by the ED. Resident F did not sign the statement. No explanation was provided on how the interview was conducted on 4/22/21 when Resident F was not in the facility. He had been removed by police after the assault and did not return until 4/27/21.

During an interview on 5/14/21 at 7:20 p.m., Detective 14 indicated he conducted a follow up interview with Resident E after he had been attacked by another resident. He followed up with Resident E over the phone and Resident E described the attack. Resident F came into his room and was demanding money. Resident F attacked him and hit him in the face. Detective 14 indicated during the phone call, Resident E was relieved that Resident F had been removed from the facility and taken to jail, and he was fine as long as Resident F did not come back to the facility because he was afraid of being attacked again.

On 5/14/21 at 7:37 p.m., Detective 14 provided a copy of the responding Police Report Investigation Notes related to Resident E and F's altercation. The report was dated 4/21/21 at 10:22 p.m., the police narrative indicated, "On April 21. 2021 [Officer 15] with the [local police department name] was dispatched to investigate a battery at [Name of the facility] ... Upon arriving and while recording on Body Worn Camera, [Officer 15] spoke with [LPN, (Licensed Practical Nurse) 16] a nurse at the facility, who stated that one resident had attacked another. [Officer 15] then spoke with [Resident E] who stated that he and another resident down the hall, [Resident F] had punched him in the left cheek after a verbal

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argument. [Resident E] stated that he and [Resident F] had a verbal argument regarding [Resident E] providing rides for [Resident F] in his vehicle on 4/20/21, which continued on 4/21/21 in [Resident E]'s suite. [Resident E] states that nursing staff at the facility took [Resident F] back to his room; however, approximately 30 minutes later, [Resident F] was back in [Resident E]'s suite to continue the argument. During the argument, [Resident E] states that [Resident F] punched him in the face and wrestled him on the bed. [Officer 15] observed a bruise under [Resident E]'s left eye and a small cut on [Resident E]'s right hand, which he stated are a result of the altercation. [Officer 15] then spoke with [Resident F] who stated that the two did have a verbal argument; however, the altercation never became physical. [Resident F] states that the argument was reference an investment of $3,200 that [Resident F] had made in [Resident E]'s fish related business. [Resident F] stated that he did tell [Resident E] "I'll put your lights out" but did not strike nor wrestle [Resident E]. [Resident F] stated that [Resident E] had struck him in the chest several times with his cane. Officer 15 then spoke with [LPN 16] who stated that they had separated [Resident E and F] from verbal arguments; however, she did not witness the alleged physical altercation. [LPN 16] stated that while separating the two for the final argument, [Resident F] did 'swing on' staff member..."

2. During an interview, on 5/12/21 at 10:50 a.m., Resident E indicated lots of residents had been treated badly at the facility. The staff could not control the residents and the same day he was attacked by Resident F, another female resident had been sexually assaulted by another resident. He heard about it, because the female resident

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came out to smoke with him and told him that this other guy had come into her room and assaulted her. They "whisked her out of here fast."

During a confidential interview, the interviewee indicated Resident H was caught in Resident J's room, and he was touching her. Several staff knew about but kept it a secret and got the residents out of the building as soon as they could

During a confidential interview, the interviewee indicated Resident J was sexually assaulted by Resident H. He came into her room while he was drunk and "groped" her and tried to have sex with her.

During a confidential interview, the interviewee indicated Resident J was a new admission to the facility. She was in one room, but she and that roommate did not get along, so Resident J moved to another room which was closer to Resident H. The night it happened, Resident H walked into Resident J's room, he was "really drunk," and he started to "feel her up," touching her breasts and reached between her legs, but the nurse intervened before things go further. Resident J said the next day, she was really upset because Resident H told her he wanted her to perform oral sex on him and told her, "I want to put my d--- in your mouth." She was very anxious after the incident, and she kept coming out of her room saying, "I just got assaulted, I need to smoke." She kept repeating that over and over. The police came out the night of the incident and were here for a really long time. Resident J was upset for several days after the incident.

During an interview on 5/13/21 at 9:58 a.m.,

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EAGLE CREEK HEALTHCARE CENTER	4102 SHORE DR INDIANAPOLIS, IN 46254

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
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Resident J's family member indicated, they were made aware of the incident. Apparently, this guy followed her back to her room, he was drunk, and was in her room for about 4 to 5 minutes. Resident J told them he asked her to perform oral sex on him and according to her he grabbed her breasts. Resident J's memory was not good due to some recent heath issues, but the family member indicated Resident J had been sexually assaulted by a family member when she was younger, and this incident triggered some PTSD (post-traumatic stress disorder). The family member indicated they talked with Resident J the day after the incident, and she was very upset, and cried. She was very upset for several days following the incident and still gets upset about it if someone talks to her about it.

During a confidential interview, the interviewee indicated Resident H did not have many behaviors. He was mostly quiet and did his own thing. Nurses were given report about the incident and were told Resident H tried to have sex with Resident J. She was upset and remained upset through the next day. The police were in the building and responded to the incident, but no charges were made. Resident J had some confusion and Resident H kept denying he had done anything when the police interviewed him. He was supposed to stay away from her, so staff provided one on one supervision to make sure the residents stayed separated. But they both left the facility shortly after the incident.

During a confidential interview, the interviewee indicated, Resident H was found in Resident J's room. He sat on the bed beside her, and his arm was around her, his hand groped her breasts, and his other hand reached between her legs.

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The residents were separated, and Resident H was belligerent and kept trying to go back to her room, he was suspected to be drunk. The police were already in the building, so an officer approached Resident H as he continued to be belligerent and he swung at the officer, so he wound up in handcuffs. The police took over from there. Resident J was upset at first, but when she calmed down, she kept saying she just had a headache and wanted to sleep.
During a confidential interview, the interviewee indicated Residents H and J would sign out of the facility and go and come as they pleased. The liquor store was near the facility. The night of the incident Resident H was intoxicated just wandering the building. As staff was dealing with the incident of physical abuse between two other residents, Resident H was observed sitting on Resident J's bed. Both residents were fully dressed. He had his arm around her and was touching her and they were talking. Staff thought it was inappropriate, so they provided one on one observation for Resident H. He kept trying to go back in her room. The police were in the building for the physical abuse allegation related to two other residents and saw that Resident H was being belligerent. The police officer addressed Resident H and he became belligerent with the police officer. So, they put him in handcuffs. He was in handcuffs for a couple hours and was left in his room with a police officer and a CNA. Resident J was just sitting in her room. Staff monitored Resident J after the incident and she repeatedly indicated she was "ok" and just had a headache and wanted to sleep. Resident H left the same night and went to the hospital. He did not come back he to the facility. The interviewee indicated Resident J may have been drinking that night as well because she seemed "altered" that

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night. The police interviewed both residents and did not believe anything "bad" happened and just wanted staff to make sure Resident H did not go into Resident J's room because she wanted to sleep.

During an interview on 5/13/21 at 8:23 p.m. Detective 17 indicated he responded to an allegation of sexual abuse at the facility. He indicated when he arrived, Resident J was upset and kept repeating, "I'm a married woman," but was not distraught. She was cognitively intact, so Detective 17 felt comfortable relying on her wishes and her statement. When he asked her what happened, Resident J told him Resident H had come into her room while she was upset about having a migraines and not feeling well. He put his arms around her and started fondling her and asked her to perform oral sex on him. She did not want to do that because she was married. She did not want to press charges and just wanted him to leave her alone. She was very concerned about anyone spreading rumors that she was promiscuous, and she did not want her husband to find out what happened. Staff were very responsive and clear on what Resident J's wishes were. She did not want to press charges. Detective 17 had been told by the initial responding officers that Resident H was intoxicated. Detective 17 spoke with Resident H and told him that Resident J did not want him to go around her anymore and he needed to leave her alone.

During an interview on 5/14/21 at 3:51 p.m., the ED indicated shortly after she was notified of an incident between Resident E and F, she was notified of a second altercation between Resident H and J. Staff walked into Resident J's room and

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saw Resident H on her bed touching Resident J. They were fully clothed, but the nurse determined it was inappropriate and separated the residents. Resident H touched Resident J's chest and breasts. She kept repeating, "I'm a married woman" and did not want her husband to find out. The police were called, but already in the building since they responded to the first incident. Resident H was aggressive with the police and he was put in handcuffs. After the police left, the resident was placed on one on one observation until later that night he called 911 and left to go to the ER. He was admitted for pancreatitis and did not return to the facility. Initially Resident J did not want to tell her husband because she did not want him to know of the incident, but later the next day she agreed to tell him. Her husband was contacted and they spent two hours on phone. He let us know Resident J had experienced a series of sexual assaults and traumas from a family member in her past, and this incident may have touched too close to home and made her relive the traumatic experiences from her past.

On 5/13/21 at 4:00 p.m., the ED provided a copy of the state reportable related to Resident H and J's altercation. Incident 366 was reviewed. A brief description of the incident indicated, "... while rounding, staff reported [Resident H] was inappropriately touching [Resident J]. Staff asked [Resident H] to leave the vicinity, in which he complied. [Resident J] denies any inappropriate touching. Both residents are alert and oriented. Both residents are their own representative. IMDP contacted. [Resident J] denies inappropriate touching to IMPD. [Resident H] denying any inappropriate touching. [Resident J] encouraged to go to ER for eval (evaluation) by IMPD and facility. [Resident J] refused. [Resident J] not

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displaying any signs/symptoms of psychosocial distress. [Resident J] assessed; no injury noted. [Resident J] stating she does not want her husband contacted regarding alleged incident. [Resident H] placed on 1:1 observation...."

On 5/13/21 at 4:00 p.m., the ED provided a copy of a written statement between the ED and Detective 17. The statement indicated, "... Detective 17 reported that he had spoken with [Resident J] ... she is a good historian. Mentally stable... per his recorded interview with [Resident J] she stated they are friends and they often smoke together. She complained of a migraine to him and he gave her a hug. he then asked her to perform oral sex on him. She said no..."

On 5/13/21 at 4:00 p.m., the ED provided a copy of a written statement from CNA (certified nursing assistant) 18. The statement indicated, "I [CNA 18] witnessed [Resident H] going into [Resident J]'s room. I asked him to come out of her room, he got upset but he did come out, so I went back to working soon as [Resident H] saw me walk away he proceeded to go back into her room so I again asked him to come out. This happened at least 4 or 5 times the last time I went in she was laying in her bed and he was sitting on her bed I told him a little more forcefully to come out of her room, he did talking (sic) very badly to me, so I stood outside her bedroom door...."

On 5/13/21 at 4:00 p.m., the ED provided a copy of a written statement from LPN 16. The statement indicated, "Patient was confused and acting off. So I got her settled in the bed. Went back to check on her about 30 minutes and found [Resident H] sitting on her bed with his arms wrapped around her and rubbing on her chest. I

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removed patient from the room and explained to him he was not allowed to be in her room. I stepped away to attend to another patient and find CNA to sit with her and by time I returned [Resident H] again was back in [Resident J]'s bed. When I asked him to leave again he became aggressive. Second nurse came to assist and aid placed in room [Resident H] remained on 1:1 the remainder of shift..."

On 5/13/21 at 9:55 a.m., Resident J's Medical record was reviewed. The most recent comprehensive assessment was an admission MDS assessment dated 4/26/21. The MDS indicated Resident J was moderately cognitively impaired with a BIMS score of 10 of 15. She scored a 23 out of 27 on the PHQ9 (a screening tool for depression), no behaviors were coded. She was independent for all ADLs and only required minimal staff assistance.

A nursing progress noted, dated 4/21/21 at 8:24 p.m., indicated, "...resident got sexually grappled in her room by another drunk resident. Resident was in shock and tearful. She was medicated for pain and anxiety...."

A nursing progress noted, dated 4/22/21 at 5:00 p.m., indicated Resident J was tearful and had increased anxiety. She was administered a onetime order of hydroxyzine (and antihistamine that can be used to treat anxiety) 50 mg (milligrams).

A nursing progress note, dated 4/23/21 at 10:33 a.m., indicated the ED spoke with Resident J's husband who expressed concerns related to events in Resident J's past, prior to their marriage which may be causing increased anxiety and

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confusion... he requested Resident J be followed by a psychologist for PTSD...."

A comprehensive care plan was initiated on 4/22/21 and indicated, Resident J's psychosocial wellbeing was at risk related to an incident with a male peer.

A second comprehensive care plan was initiated on 4/22/21 and indicated Resident J had potential PTSD related to historical events per her husband.

On 5/13/21 at 9:15 a.m., Resident H's medical record was reviewed. The most recent comprehensive assessment was an admission MDS assessment dated 4/19/21. The MDS indicated Resident H was cognitively intact with a BIMS score of 12 of 15. He scored a 17 out of 27 on the PHQ9 and no behaviors were coded. He was independent with all ADLS and only required minimum assistance from staff.

A nursing progress note, dated 4/21/21 at 9:30 p.m., indicated Resident H had called 911 himself. He stated he had severe stomach pain and back pain. He showed signs of intoxication, and he was taken to a local hospital upon his request.

A nursing progress note, dated 4/21/21 at 11:14 p.m., indicated Resident H was intoxicated and had gone into a female resident's room and made inappropriate contact with the resident. Police had arrived at the facility and spoke with the resident and recommended the resident should stay in his room for the remainder of the night. He was placed on 1:1 observation.

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A nursing progress note, dated 4/21/21 at 11:20 p.m., indicated Resident H appeared intoxicated and had been found in another female resident's room, and touched her inappropriately.

The record lacked documentation of Resident H's current behaviors or history of behaviors.

On 5/12/21 at 10:15 a.m., the ED provided a copy of current facility policy titled, "Abuse & Neglect & Misappropriation of Property," dated 5/14/2020. The policy indicated, " ... it is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. It is the intent of the facility to prevent the abuse, mistreatment, or neglect of residents or the misappropriation of their property, corporal punishment and/or involuntary seclusion and to provide guidance to direct staff to manage any concerns or allegations of abuse ... the facility will be alert for conspicuous activity that may indicate abuse activities by visitors, contractors, volunteers, or others that may be in the facility and have direct contact with residents regardless of resident voicing such incidents ... the accurate and timely identification of any event which would place our residents at risk is a primary concern of the facility ... each occurrence of resident incident, bruise, abrasion, or injury of unknown source or reports of alleged abuse ... will be identified and reported to the supervisor and investigated timely ... when the alleged abuse involves a resident to resident altercation, the residents will be separated by the staff and the appropriate physical assessments will be completed on each resident...."

3.1-27(a)(1)

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F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident was protected from misappropriation of personal property (Resident W) when the Activity Director used the resident's bank card for personal purchases without the resident's consent for 1 of 3 residents reviewed for misappropriation of property. Findings include: On 5/12/21 at 3:09 p.m. during an interview with Resident W's family member, they indicated the resident had not been reimbursed by the facility for $1,800 taken from the resident's bank card by a facility employee. The facility had told them it would be reimbursed. On 5/13/21 at 9:00 a.m., Resident W's medical record was reviewed. The diagnoses included but were not limited to cerebral infarction (stroke), hemiplegia and hemiparesis (paralysis on one side), acute respiratory failure, and aphasia (difficulty speaking). A progress, dated 4/20/21 at 10:44 a.m., indicated Resident W had "brought forward	F 602		

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concerns related to his funds. [Local Police Department], Family, MD [Medical Doctor] and ISDH [Indiana State Department of Health] notified."

On 5/12/21 at 2:15 p.m., during and interview, the Administrator (ADM) provided the investigation report for the former Activity Director (AD). She indicated it had been reported to the State, and the employee was terminated. The AD director used the company credit card for activity purchases and trips. The card would be returned with a receipt for purchases. There were no facility financials in question. Resident W had given the AD his debit card to purchase a phone for him. She purchased the phone, then returned the card and phone to the resident.

The investigation report was reviewed. A "Concern Form," dated 4/20/21, indicated Resident W had money missing from his debit card. Actions to resolve the concern: "Money to be reimbursed." It was signed by the ADM.

A typed statement indicated on 4/20/21 Resident W brought forth concerns regarding a missing debit card. When he called the bank, there were 3 Amazon purchases on the card. Resident W denied making any Amazon purchases. The receptionist had reported 2 Amazon packages had arrived last week for the AD. The AD indicated she did not have the card. She had purchased a phone for the resident, per his request (the resident acknowledged the purchase). After further questioning the AD then admitted to using the card for unauthorized purchases, with the ADM and BOM (Business Office Manager) present. The police were called, and a police report was filed.

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F 602	Continued From page 23 On 5/12/21 at 2:15 p.m., the ADM provided a current policy, dated 5/30/19, titled "Indiana Abuse & Neglect & Misappropriation of Property." This policy indicated "...the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's property or money without the resident's consent...an employee who is alleged or accused of being a party to abuse, neglect, misappropriation of property will be immediately removed from the area(s) of resident care, interviewed by facility leadership for a written statement and not left alone...." This Federal tag relates to Complaint IN00353535.	F 602		
F 623 SS=F	3.1-28(a) Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		

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F 623	Continued From page 24 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;	F 623		

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F 623	Continued From page 25 (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by:	F 623		

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	155664	A. BUILDING _____ B. WING _____	C 05/14/2021

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Based on interview and record review, the facility failed to ensure residents were provided notices as required before their transfer and discharge from a facility during a facility-initiated closure for 74 of 76 residents residing in the building (Residents B, C, D, E, X, Y, Z, AA, K, F, L, M, N, P, Q, R, and S).

Findings include:

1. During an interview, on 5/13/21 at 12:08 p.m., the Administrator indicated the facility did not provide the residents with transfer discharge notices because the residents voluntarily moved out of the facility due to the facility-initiated closure.

An email from the Ombudsman, during the survey indicated she had several concerns with the facility-initiated transfer and discharge of residents. She interviewed 20 of 27 residents transferred to the company's sister facility (nursing home owned by the same company). Of the 20 residents questioned all of them stated they were given 30 minutes to prepare their belongings because they were moving.

During an interview, on 5/12/21 at 6:08 p.m., the State Long-Term Ombudsman indicated she visited the facility on 5/10/21 to inform the facility residents of their rights. She had packets ready for the residents and was prepared to assist as needed with enforcing their rights. When she got to the facility, she found only 8 of 76 residents still residing in the building. Those 8 residents had been told they were also to be transferred to a sister facility. The residents were not informed of their rights to choose from other facilities. There were no 30-day notices given to the residents.

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The residents were unaware they could contact the Ombudsman about the transfers. Staff indicated to the local Ombudsman that corporate wanted all residents out by the end of the month, which was not in accordance with the letter received regarding their closure. The residents were not given their due process.

On 5/13/21 at 12:10 p.m., the Administrator provided a document she indicated was provided to the residents by the Ombudsman during her visit on 5/10/21. The Ombudsman document, provided by the Administrator was titled, "Know our Rights During Your Nursing Home Closure," with no date. A review of this document indicated, "You have the right to written notice of the closure at least 60 days in advance that also includes the facility's closure plan and where they will be transferring you. Assurances that you will be transferred to the most appropriate facility of your choice or a setting with comparable quality, services, and location. Your needs and choices honored ...Contact information for the Long-Term Care Ombudsman Program, any concerns or questions information shared with the receiving provider, such as care plan goals discharge summary, special instruction, etc. Make sure you have the following: Items when you move: all medication, complete medical record, including comprehensive care plan, personal funds with full accounting and any identification, family or legal representative contact information, legal papers, such as power of attorneys and advance directives, personal property with inventory list, identification ...." Only 8 of 76 residents remained in the building on 5/12/21. So only Residents B, C, D, E, X, Y, Z, and AA received resident rights documentation from the Ombudsman. Sixty-eight residents had been moved out of the building

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prior to the Ombudsman's arrival.

2. During an interview, on 5/12/21 at 10:08 a.m., Resident B indicated the facility called all the residents into the activity room about a week ago. Residents were told the facility was closing and everyone had to be out by July 1st. Then, it went from July 1st to the first week of May. She was told on Friday, May 7th, that the residents needed to be out by Monday and Tuesday (5/10 - 5/11/21).

A record review was completed for Resident B on 5/12/21 at 11:20 a.m. Resident B diagnoses included, but were not limited to, morbid obesity (severely overweight), diabetes mellitus (inability of the body to process sugar correctly), asthma (reactive airway), insomnia, and gastro-esophageal reflux disease (increased stomach acid flows into esophagus).

A Social Service note, on 5/5/21 at 3:30 p.m., informed the resident she was accepted at (name of other facility). Resident was to decide when to transfer.

A Social Services note, on 5/10/21 at 5:34 p.m. indicated she spoke with Resident B regarding her transfer. Resident B was notified she would be transferring to (name of sister facility).

A Social Services note, on 5/11/21 at 10:27 p.m., indicated Resident B was informed she would be transferring to (name of sister facility) on Wednesday, 5/12/21.

A Social Services note, on 5/12/21 at 10:45 a.m., indicated she informed the resident of time and day of transfer, 5/13/21, at 6:15 a.m.

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A physician's order indicated; Resident B was "OK" to discharge to facility of choice.

3. During an interview, on 5/12/21 at 10:16 a.m., Resident C indicated she was only offered the sister facility to go to and it was out of the scope of where her family could travel.

A record review was completed for Resident C on 5/12/21 at 11:00 a.m. Resident C diagnoses included, but were not limited to, diabetes mellitus, hyperkalemia (high potassium levels), and acquired absence of left leg below the knee.

A Social Services note, on 5/6/21 at 3:54 p.m., indicated Resident C informed about transfer date. Resident reports she did not want to transfer to another facility. " ...Resident was informed her day to transfer is scheduled for 5/13/21 to [name of sister facility] ...."

A Social Services note, on 5/10/21 at 5:47 p.m., indicated the Social Services Director (SSD) spoke to Resident C, " ...about transferring to [name of sister facility] after her doctor's visit on Wednesday.

4. After a facility wide announcement of a facility-initiated closure on 4/30/21, Resident K was transferred to a sister facility (another facility both owned by the same company). On 5/13/21 at 3:19 p.m., Resident K indicated no one told her of her resident rights regarding a facility closure.

5. After an announcement of a facility-initiated closure on 4/30/21, Resident F was transferred to a sister facility. On 5/13/21 at 3:24 p.m., Resident F indicated he was told he had 30 minutes to

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pack his belongs because he was moving immediately. The facility just told him where he was going, he had no choice. He did not know his resident rights regarding a facility closure.

6. After an announcement of a facility-initiated closure on 4/30/21, Resident L was transferred to a sister facility. On 5/13/21 at 3:33 p.m., Resident L indicated he did not have a choice of which facility to go to. He was not informed of his resident rights regarding his current building closing. One day, the facility staff just said to, "get ready, you are going." He was told the building was closing and in less than 48 hours, he was on his way to the other facility.

7. After an announcement of a facility-initiated closure on 4/30/21, Resident M was transferred to a sister facility. On 5/13/21 at 3:39 p.m., Resident M indicated management just told her she was moving to (sister facility), it was going to be her new home. She didn't have much time to pack. No one informed her of her resident rights regarding a facility closure. She was upset and hurt, it happened so fast.

8. After an announcement of a facility-initiated closure on 4/30/21, Resident N was transferred to a sister facility. On 5/13/21 at 3:45 p.m., Resident N indicated he was not informed of his resident rights regarding facility closure.

9. After an announcement of a facility-initiated closure on 4/30/21, Resident P was transferred to a sister facility. On 5/13/21 at 3:47 p.m., Resident P indicated he had no choice of facility and did not know his resident rights regarding a facility closure.

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10. After an announcement of a facility-initiated closure on 4/30/21, Resident Q was transferred to a sister facility. On 5/13/21 at 3:49 p.m., Resident Q indicated he didn't know he had a choice of where to go.

11. After an announcement of a facility-initiated closure on 4/30/21, Resident R was transferred to a sister facility. On 5/13/21 at 3:57 p.m., Resident R indicated she was told by her previous facility (closing facility) that she would have a larger room and they talked her into coming to this current (sister) facility. She was upset because the room she was in was a double occupancy room and currently she was the only resident residing in it. She indicated her former facility was not truthful. Her voice was raised, and she was agitated.

12. After an announcement of a facility-initiated closure on 4/30/21, Resident S was transferred to a sister facility. On 5/13/21 at 4:06 p.m., Resident S indicated he did not know his resident rights regarding a facility closure.

During an interview, on 5/14/21 at 11:16 a.m., the Administrator indicated she did not know why the residents needed transfer discharge papers if it was their choice to leave.

During an interview, on 5/14/21 at 11:33 a.m., the Regional Consultant indicated the residents had a choice to stay at the facility until July 1st. The residents chose the facility they wanted to discharge to. Since, they were choosing to leave on their own, no notice was needed for a discharge, when the resident chose the facility they go to.

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F 623	Continued From page 32 A current policy, titled, "Eagle Creek Healthcare Center Closure Plan," with no date, indicated, " ... The IDT (Inter-Disciplinary Team) will consider each resident's individual needs, choices, and best interests in the selection of the relocation facility ...The IDT will provide the resident ...with pertinent information regarding nursing facilities in the resident's geographic area of choice, including facility consumer reports and publicly available standardized quality information ...The IDT will make every reasonable effort to accommodate each resident's goals preference, and relocation needs, including but not limited to: Assistance with arranging transportation for any resident who wishes to visit a prospective relocation facility ...This Closure Plan will serve as the policy and procedure for the closure phase ...." This Federal tag relates to Complaint IN00353549. 3.1-12(a)(6)(A) 3.1-12(a)(6)(B) 3.1-12(a)(7) 3.1-12(a)(9)(A) 3.1-12(a)(9)(B) 3.1-12(a)(9)(C) 3.1-12(a)(9)(D) 3.1-12(a)(9)(G)	F 623		
F 624 SS=E	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the	F 624		

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facility. This orientation must be provided in a form and manner that the resident can understand.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure residents were sufficiently oriented prior to leaving their current facility due to a facility-initiated closure for 20 of 27 residents moved within 30 minutes notice, and for 11 of 11 residents interviewed for discharge from facility (Residents BB, CC, Q, DD, GG, EE, B, FF, C, K, F, L, M, P, Q, R, S and V).

Findings include:

1. An email from the Ombudsman, during the survey, indicated she had several concerns with the facility-initiated transfer and discharge of residents. She interviewed 20 of 27 residents transferred to (name of company) sister facility (nursing home owned by the same company). Of the 20 residents questioned all of them stated they were given 30 minutes to prepare their belongings because they were moving. No one was given choices outside the sister facilities. After she interviewed the residents, she indicated some of her other concerns were as follows:
a. Resident BB was still waiting on his personal property.
b. Resident CC was missing personal pillows.
c. Resident Q wanted to move to the east side of Indianapolis but was sent to the sister facility not on the east side.
d. Resident DD was missing clothes.
e. Resident GG was missing clothes and paperwork needed for a social security hearing.
f. Resident EE was missing a lamp.
g. Resident B was missing clothes and her

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bariatric (extra-large) wheelchair.
h. Resident FF was missing medication. She was 22 years old and placed in a room with a resident who had dementia.

During an interview, on 5/12/21 at 6:08 p.m., the State Long-Term Ombudsman indicated she visited the facility on 5/10/21 to inform the facility resident of their rights, had packets ready for the residents and was prepared to assist as needed with enforcing their rights. When she got to the facility, she found only 8 of 76 residents still residing in the building. They had been told they were also to be transferred to a sister facility. The residents were not informed of their rights to choose from other facilities. There were no 30-day notices given to the residents. The Ombudsman's office did not receive any notices of transfer discharge for the resident's before they were moved and did not receive weekly updates. The residents were unaware they could contact the Ombudsman about the transfers. Staff indicated to the local Ombudsman that corporate wanted all residents out by the end of the month, which was not in accordance with the letter received regarding their closure. The ombudsman indicated the residents were not given their due process.

On 5/13/21 at 12:10 p.m., the Administrator provided a document she indicated was provided to the residents by the Ombudsman during her visit on 5/10/21. The Ombudsman document, provided by the Administrator was titled, "Know our Rights During Your Nursing Home Closure," with no date. A review of this document indicated, "You have the right to written notice of the closure at least 60 days in advance that also includes the facility's closure plan and where they will be

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transferring you. Assurances that you will be transferred to the most appropriate facility of your choice or a setting with comparable quality, services, and location. Your needs and choices honored...Contact information for the Long-Term Care Ombudsman Program, any concerns or questions information shared with the receiving provider, such as care plan goals discharge summary, special instruction, etc. Make sure you have the following: Items when you move: all medication, complete medical record, including comprehensive care plan, personal funds with full accounting and any identification, family or legal representative contact information, legal papers, such as power of attorneys and advance directives, personal property with inventory list, identification ...." There were only 8 of 76 residents left residing in the building on 5/120/21, so only Residents B, C, D, E, X, Y, Z, and AA received resident rights documentation from the Ombudsman. Sixty-eight residents had been moved out of the building prior to the Ombudsman's arrival.

During an interview, on 5/14/21 at 11:18 a.m., the Administrator indicated the residents were talked to about other facilities, offered tours, and provided consumer information. Representatives from other buildings were present and available to talk to the residents the day they announced the closing of the facility to the residents, including 7 facilities, home health, and an assisted living.

A current policy, titled, "Eagle Creek Healthcare Center Closure Plan," with no date, did not indicate residents should have been oriented for transfer or discharge.

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The Indiana State Rules, titled, "Health Facilities; Licensing and Operational Standards," dated 9/11/13, indicated, "410 IAC 16.2-3.1-12: Transfer and discharge rights, Section 12. (a) The transfer and discharge rights of residents of a facility are as follows: (21) The facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility."

2. During an interview, on 5/12/21 at 10:08 a.m., Resident B indicated the facility called all the residents into the activity room about a week ago. Residents were told the facility was closing and everyone had to be out by July 1st. Then, it went from July 1st to the first week of May. She was told on Friday, May 7th, that the residents needed to be out by Monday and Tuesday (5/10 - 5/11/21). Resident B indicated she was not provided a list of local nursing homes to choose from. She would have preferred not to move away from her family. She was told no other facility wanted her because she was a smoker. She indicated the facility made her feel like "garbage," and they were just throwing out the "garbage."

A record review was completed for Resident B on 5/12/21 at 11:20 a.m. Resident B diagnoses included, but were not limited to, morbid obesity (severely overweight), diabetes mellitus (inability of the body to process sugar correctly), asthma (reactive airway), insomnia, and gastro-esophageal reflux disease (increased stomach acid flows into esophagus).

A Social Service note, on 5/5/21 at 3:30 p.m., informed the resident she was accepted at (name of other facility). Resident to decide when to

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transfer.

A Social Services note, on 5/6/21 at 3:54 p.m., indicated Resident B informed about transfer date. Resident reports she did not want to transfer to another facility. " ...Resident was informed her day to transfer is scheduled for 5/13/21 to (name of sister facility). Resident stated, "I am not going to another facility." SSD re-iterated to resident that the facility will be closing soon and resident needs to start looking soon ...."

A Social Services note, on 5/10/21 at 5:34 p.m. indicated she spoke with Resident B regarding her transfer. Resident B was notified she would be transferring to (name of sister facility).

A Social Services note, on 5/11/21 at 10:27 p.m., indicated Resident B was informed she would be transferring to (name of sister facility) on Wednesday, 5/12/21.

A Social Services note, on 5/12/21 at 10:45 a.m., indicated she informed the resident of time and day of transfer, 5/13/21, at 6:15 a.m.

A physician's order indicated Resident B was "OK" to discharge to facility of choice.

3. During an interview, on 5/12/21 at 10:16 a.m., Resident C indicated she was only offered the sister facility to go to and it was out of the scope of where her family could travel. She was feeling emotional because she felt safe at the current facility and did not want to leave.

A record review was completed for Resident C on 5/12/21 at 11:00 a.m. Resident C diagnoses

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included, but were not limited to, diabetes mellitus, hyperkalemia (high potassium levels), and acquired absence of left leg below the knee.

A Social Services note, on 5/10/21 at 5:47 p.m., indicated the Social Services Director (SSD) spoke to Resident C, " ...about transferring to [name of sister facility] after her doctor's visit on Wednesday. Resident response, "I do not know if I want to go, I may just go to a shelter" ...SSD informed resident about facility closing and it was necessary for her to make a decision so arrangements can be made ...."

A physician's order indicated Resident C was "OK" to discharge to facility of choice.

4. After an announcement of a facility-initiated closure on 4/30/21, Resident K was transferred to a (sister) facility (transferred from one facility to another facility both owned by the same company). On 5/13/21 at 3:19 p.m., Resident K indicated she was not given a choice of where to live after she learned her current facility was closing and no one told her of her resident rights regarding a facility closure.

5. After an announcement of a facility-initiated closure on 4/30/21, Resident F was transferred to a sister facility. On 5/13/21 at 3:24 p.m., Resident F indicated he was told he had 30 minutes to pack his belongs because he was moving immediately. The facility just told him where he was going, he had no choice. He did not know his resident rights regarding a facility closure.

6. After an announcement of a facility-initiated closure on 4/30/21, Resident L was transferred to a sister facility. On 5/13/21 at 3:33 p.m., Resident

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L indicated he did not have a choice of which facility to go to. He was not informed of his resident rights regarding his current building closing. One day, the facility staff just said to, "get ready, you are going." He was told the building was closing and in less than 48 hours, he was on his way to the other facility.

7. After an announcement of a facility-initiated closure on 4/30/21, Resident M was transferred to a sister facility. On 5/13/21 at 3:39 p.m., Resident M indicated she did not have a choice of which building to move to. Management just told her she was moving to (sister facility), it was going to be her new home. She didn't have much time to pack. No one informed her of her resident rights regarding a facility closure. She was upset and hurt, it happened so fast.

8. After an announcement of a facility-initiated closure on 4/30/21, Resident P was transferred to a sister facility. On 5/13/21 at 3:47 p.m., Resident P indicated he had no choice of facility and did not know his resident rights regarding a facility closure.

9. After an announcement of a facility-initiated closure on 4/30/21, Resident Q was transferred to a sister facility. On 5/13/21 at 3:49 p.m., Resident Q indicated he didn't know he had a choice of where to go.

10. After an announcement of a facility-initiated closure on 4/30/21, Resident R was transferred to a sister facility. On 5/13/21 at 3:57 p.m., Resident R indicated she was told by her previous facility (closing facility) that she would have a larger room and they talked her into coming to this current (sister) facility. She was upset because

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the room she was in was a double occupancy room and currently she was the only resident residing in it. She indicated her former facility was not truthful. Her voice was raised, and she appeared agitated.

11. After an announcement of a facility-initiated closure on 4/30/21, Resident S was transferred to a sister facility. On 5/13/21 at 4:06 p.m., Resident S indicated he did not know his resident rights regarding a facility closure.

12. On 5/12/21 at 10:40 a.m., during an interview, Resident V's family member indicated on April 30, 2020 the facility had sent out a letter, they were closing. She had received it in the mail on May 1st, 2 Fridays ago. Last Thursday, May 6th, she had received a phone call saying they were closing this Friday, May 14th. On the day she received the letter in the mail there was a care plan meeting. During the care plan meeting she told the facility she wanted to make arrangements to bring her mother home. She contacted (Name of Agency) to help with arrangements. They (agency) were working with her. It would take a couple weeks to get everything in place. Then, the facility told her they were closing this Friday, May14, and resident had to be out. They were transferring only to other (Corporate Name) buildings and they chose where she was going. They chose (Sister Facility Name). Resident V had been discharged from the facility to another (sister) facility with the same company, on 5/10/21. The facility where the resident had gone (Sister Facility) told her they received no paperwork when the resident arrived, and her g-tube (gastric feeding tube) was clogged.

On 5/12/21 at 11:30 a.m., the medical record was

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reviewed for Resident V. The diagnoses included, but were not limited to, hemiplegia and hemiparesis (one sided paralysis) following cerebral infarction (stroke) affecting the right dominant side, aphasia (difficulty with speech), dysphasia (impaired swallowing) and diabetes type 2.

On 5/6/21 at 3:04 p.m., a Social Services Note indicated SSD [Social Service Department] contacted resident's daughter [Name] regarding resident's discharge. Resident's daughter's [sic] decided they wanted to take the resident home. [Daughter's Name] had made a second interview with [Name of agency helping with home arrangements]. [Daughter's Name] reports [Agency Name] will be in place in approximate 2-3 weeks. SSD informed [Daughter's Name] the facility possibly could be closed before that time frame. SSD encouraged [Daughter's Name] to select a facility to transfer resident to while working on resident's discharge to home. [Daughter's Name] requested to have time to talk over the place of transfer with her sister. SSD will follow up."

A Care Plan, dated as initiated on 5/6/21 and revised on 5/11/21, indicated, "Resident wished to be transferred to [Name of company's sister facility]." The goal indicated "Resident will verbalize / communicate an understanding of the discharge plan." The interventions included, "Discuss feelings and concerns of resident, and resident representative, with impending discharge. Discuss with rehab any special equipment needs. Facilitate obtaining. Establish a pre-discharge plan. Evaluate progress and revise plan as needed. Notify medical provider of discharge plans."

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On 5/10/21 at 3:00 p.m., a Nurses Note indicated "Pt. [patient] transferred per stretcher and EMS [emergency medical service] services to accepting facility."

On 5/10/21 at 1:17 p.m., a Social Services Transfer Note indicated "Resident will be transferring today via [Name of transport company] via stretcher to [name and address of sister facility]. Resident Family aware resident will be transferring today."

On 5/10/21 at 1:17 p.m., an IDT [interdisciplinary team] Note indicated, "Discussed facility closing and resident needs upon transferring pt. Pt./family has chose [sic] to discharge to [Name of sister facility]. Pt. orders will be sent with the pt., along with a discharge summary. Pt. is unable to voice and understanding in regards to transfer. She is emotionally stable and is anticipating discharge."

During an interview, on 5/14/21 at 11:18 a.m., the Administrator indicated the residents were talked to about other facilities, offered tours, and provided consumer information. Representatives from other buildings were present, she named 7 facilities, home health, and an assisted living were available to talk to the residents.

A current policy titled, "Eagle Creek Healthcare Center Closure Plan," with no date, indicated, "... The IDT (Inter-Disciplinary Team) will consider each resident's individual needs, choices, and best interests in the selection of the relocation facility...The IDT will provide the resident...with pertinent information regarding nursing facilities in the resident's geographic area of choice,

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F 624	Continued From page 43 including facility consumer reports and publicly available standardized quality information...The IDT will make every reasonable effort to accommodate each resident's goals preference, and relocation needs, including but not limited to: Assistance with arranging transportation for any resident who wishes to visit a prospective relocation facility...This Closure Plan will serve as the policy and procedure for the closure phase...." This Federal tag relates to Complaints IN00353549 and IN00351267.	F 624		
F 684 SS=D	3.1-12(a)(21) Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement effective interventions to prevent a resident (Resident T) from obtaining alcohol, becoming intoxicated and repeatedly falling, failed to follow up with the resident in a timely manner for substance abuse counseling, and failed to complete full sets of neurological (neuro) checks which resulted in falls with head injuries, and a fall with a 3 cm (centimeter) by 3 cm area to her face and head	F 684		

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for 1 of 3 residents reviewed for falls.

Findings include:

During a confidential interview, during the survey, the interviewee indicated Resident T was "drunk" 7 days a week. The facility continued to allow her to obtain alcohol, even though her drinking was "out of control." When Resident T was transferred to another long term care facility, she had a laceration on her forehead and 2 black eyes. It was suspected she sustained those injuries after her many, repeated falls while in the former facility. It it was known that residents would have "runners" to go get alcohol for them, and several hid alcohol in toilet tanks. The Administrator had been notified but "never did anything about it."

During an interview, on 5/12/21 at 10:50 a.m., Resident E indicated he had seen multiple residents drunk in the facility. Residents were able to leave the building whenever they wanted, and he often left the building and would be gone overnight. As long as a resident could sign themselves out, they were allowed to leave, but most residents never signed out. The smoking courtyard was the easiest to get in and out of because the codes were posted on the doors, and the codes were the same to get in and out of the fence.

On 5/12/21 at 11:30 a.m., Resident E was observed sitting in his wheelchair outside on the ramp entrance at the end of 100 hall. He and another unidentified resident were smoking cigarettes. At this time, LPN (Licensed Practical Nurse) 5 asked Resident E what the code to the lockbox was to get back inside the building. Resident E indicated a 4 digit number, and LPN 5

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entered the number. The door unlocked.

On 5/13/21 at 10:45 a.m., the smoking courtyard was observed. The locked door at the end of the hall was observed to have a keypad lock system. A rectangular red piece of paper was observed beside it with a 4 digit code and a large arrow pointed to the keypad lock. The code was entered, and the door unlocked. The same door from the outside was observed. A large rectangular white piece of paper with the code on it was observed beside the keypad lock. The code was entered, and the door unlocked for re-entry into the building. There was a white fence enclosure around the smoking courtyard. The same codes were entered to unlock the white fence.

During a confidential interview, during the survey, the interviewee indicated Resident T was probably "drunk" 5 out of 7 days of the week and she was falling all the time. She was falling faster than staff could chart them all, so there probably was not a complete set of neuro checks documented. Staff used to chart that residents were "drunk" or intoxicated" but then staff were instructed not to do that anymore. They were instead supposed to chart, observations like, "the resident had slurred words," but it was obvious Resident T was "drunk," all the time. No one knew where she got the alcohol, but it was suspected her boyfriend, (another resident), would go to the liquor store around the corner and bring it back for her. She would always deny being "drunk," or that she had any alcohol, but she was. She fell all the time. Several times she hit her head or bruised her face. The last time she got really drunk, she was threatened, to either go to the hospital, or she would be sent to

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jail. So, she went to the hospital. When residents were suspected of abusing drugs or alcohol, staff were instructed to have the resident sign a copy of the facilities policy on Substance Abuse, but" that never did any good." If residents continued to abuse drugs or alcohol, they were supposed to be given a 30 day notice of transfer or discharge because they could be a danger to themselves or others, but that never happened. Resident T had "so many" falls, no new interventions were put in place, and it would not have done any good. The facility did not have an effective behavior management program for Resident T, or any other residents.

During a confidential interview, the interviewee indicated, residents could really just do what they wanted, and come and go as they pleased. Many of them could sign themselves out, leave the facility and get whatever drug of choice they wanted. There was Resident T who would get so "drunk," she would fall 3-4 times in one day. She probably got alcohol from her boyfriend (unidentified male resident). She had started to get "real sad," that's when her drinking really started, it didn't use to be that bad. She started going on binges, and it got so out of control, the facility told her she either had to go to the hospital or she would be sent to jail. They couldn't manage her.

During an interview, on 5/14/21 at 1:20 p.m., the Social Service Director (SSD), indicated she spent most of her time with Resident T, talking to her and being a mentor. The biggest issues for Resident T would have been her drinking binges, but every time the SSD tried to ask her about it, Resident T just denied that she had been drinking. Resident T had been offered substance

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abuse counseling, but later refused treatment. Resident T had been a resident at the facility for quite a while, but the drinking had not always been a problem. The SSD indicated the binges probably started late of last year, in the October/November range when a family member who used to work at the facility moved away, and she really missed her family. She began to have suicidal thoughts, and her depression screen was very high. Her stories were always inconsistent, and she always denied any drinking. She was given an AA (Alcoholics Antonymous) coping skills book.

During an interview, on 5/14/21 at 1:36 p.m., the Administrator (ADMIN), indicated Resident T had been a resident longer than she had been the Administrator, but she knew that drinking had not always been a problem for the resident. Resident T was alert and oriented and always adamantly denied having a drinking problem. She never left the building, so no one knew where she was getting alcohol. The nurses were educated on how to document objectively, so instead of charting that residents were "drunk" or "intoxicated" they should have been describing the resident's behaviors and observations instead. The Administrator indicated, she honestly did not think Resident T had a problem, and the nurses were just charting beyond their scope of practice. Resident T's binge drinking seemed to start around October of last year and may have corresponded with some difficult family dynamics. The Administrator indicated, while Resident T may have had a history of drinking, and abusing alcohol, she would not classify Resident T's issues and binge drinking, but instead she just had a lot going on emotionally which contributed to her decline and altered mental status.

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On 5/14/21 at 9:00 a.m., Resident T's medical record was reviewed. Resident T had active diagnoses to include, but were not limited to, alcohol cirrhosis of the liver, epilepsy, and other psychoactive substance abuse.

She had a comprehensive care plan initiated on 10/7/2020 which indicated, she was at risk for falls related to incontinence and potential alcohol use. Interventions in place for the plan of care included: anticipate and meet her needs, attend substance abuse counseling, call light within reach and prompt assistance required, keep her walker close by, she should wear "Hipsters" as skin and bone protection, obtain labs to rule out unwitnessed seizures, bright colored tape on her call light, and Social Services should consult with her to discuss drug policy/alcohol use.

She had a comprehensive care plan initiated on 10/7/2020 which indicated, she had a history of alcohol substance abuse. Interventions in place for the plan of care included, but were not limited to: if she was exhibiting any mental status change, ask if she ingested medications or drugs that were not prescribed, assess her for the following symptoms, which included, but were not limited to: stumbling, rambling, sleepy, erratic behaviors, hostile ... if she was intoxicated, remove her from the area of other resident and inform the physician for further directive, inform/educate family and friends not to bring inappropriate items into the center, review facility policy and ensure understanding of potential consequences.

The record lacked documentation of a comprehensive care plan for Resident T's

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non-compliance with the drug and alcohol policy.

Resident T's nursing progress notes were reviewed and revealed the following:

On 10/8/20 at 3:48 p.m., the SSD spoke with the resident regarding psychosocial well-being, and the resident was encouraged to consider an inpatient alcohol rehabilitation facility. Resident reported, " I will think about it." The SSD contacted several facilities and would follow up.

On 10/9/20 at 7:44 p.m., the SSD observed the resident standing in hallway speaking loudly and making outbursts. Resident T "appeared intoxicated" but denied any consumption of alcohol beverages. The resident sat on her rollator walker in front of her door, and continued to cry out for help, but resisted offered resources of substance abuse counseling. The SSD would follow up. There was no documentation the physician had been notified of Resident T's suspected intoxication.

On 10/14/20 at 8:52 a.m., nursing staff reported to the SSD, they found a Vodka bottle in resident's hand. The SSD re-educated the resident on facility substance abuse policy. The resident verbalized understanding and signed substance abuse policy. The SSD spoke with the resident about making wise choices and encouraged her to think about an in-patient substance abuse program. The resident presented tired, and her gait unsteady so the SSD encouraged her to lay down and rest. There was no documentation the physician had been notified of Resident T's suspected intoxication.

On 10/16/20 at 11:04 p.m., the SSD observed

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Resident T cursing and yelling in hallway. Her gate was unsteady, and her speech appeared slurred. The SSD asked Resident T if she had been drinking and the resident denied drinking. The SSD encouraged the resident to lay down and refrain from further outburst. The SSD encouraged resident to focus on making wiser choices since after her last episode, she had been sent to jail. There was no documentation the physician had been notified of Resident T's suspected intoxication.

On 10/18/20 at 3:13 p.m., it was reported to nursing staff, Resident T had, "altered mental status," and her body was jerking. The resident indicated she wanted to go to the hospital, so 911 was called. An empty bottle of Dimitri Premium Vodka was found on the resident's bedside table. Resident T had a seizure and became unresponsive.

On 10/25/20 at 2:56 p.m., a blank physician notification for a fall had been entered, with no corresponding details. The record lacked documentation of a post fall assessment, neuro checks, vital signs, pain assessment, skin assessment, or any new fall interventions.

On 10/25/20 at 3:23 p.m., Resident T was re-admitted to the facility.

The following day on 10/26/21 at 7:15 p.m., the SSD spoke with Resident T after it had been reported by the doctor she was "drunk" earlier that afternoon. The resident denied any alcohol consumption, and the SSD indicated she would follow up.

On 10/27/20 at 8:25 p.m., the SSD re-educated

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EAGLE CREEK HEALTHCARE CENTER	4102 SHORE DR INDIANAPOLIS, IN 46254

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Resident T regarding the facilities substance abuse policy and the resident verbalized understanding. Resident T spoke with the SSD about entering an alcohol rehabilitation facility, and the SSD would follow up with the POA to discuss options.

On 11/1/20 at 2:56 p.m., there was another re-admission entry, which indicated Resident T returned to the facility from the hospital. There was no corresponding documentation or details about what or why she had been discharged.

On 11/4/20 at 11:44 p.m., a progress note indicated Resident T's right hand x-ray had been reviewed by the NP (nurse practitioner) earlier that day. The conclusion indicated an age-indeterminate fracture of the neck of the 2nd metacarpal (finger) with mild displacement of the distal fragment. A new order was placed for Resident T to wear a soft splint until follow up evaluation with orthopedic.

On 12/23/20 at 2:37 p.m., the SSD entered Resident T's room to speak with her about a concerns related to missing money. Resident T indicated, alcohol would be found, and gave the SSD a cup of red liquid. The SSD educated the resident on the facilities substance abuse policy, and the resident acknowledged understanding and signed a copy of the policy. The resident stated, "I promise not to do that anymore."

On 1/8/21 8:12 p.m., Resident T was seen by in-patient psych services on 1/7/2021. Her depression appeared uncontrolled, and she was placed on a two week trial to increase Fluoxetine (antidepressant) to 60 mg (milligrams) daily and start melatonin (treats sleep wake cycle) 5 mg at

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bedtime.

On 2/26/21 at 7:01 p.m., the Resident voiced concerns about missing her family and she was afraid they did not know where she was. She reported she had thoughts she would be better off dead. The physician was notified, and she was to be monitored closely and sent to ER (emergency room) if necessary.

On 4/6/21 at 8:30 p.m., an altered mental status note indicated Resident T should lie down and sleep off the alcohol. A corresponding nurses note with the same date and time indicated, Resident T was noted to slur her words and had decreased cognition. She admitted to drinking alcohol and was sleepy. She would not state where she got the alcohol, but the convenience store was around the corner. There was no documentation the physician had been notified of Resident T's suspected intoxication.

On 4/6/21 at 8:33 p.m., Resident T admitted to the SSD she had been drinking alcohol and agreed to attend substance abuse counseling and signed a consent form. The SSD would follow up.

On 4/12/21 at 2:06 p.m., a late entry progress note was entered for a fall. Resident T fell on 4/12/21 at 1:30 p.m. She was found on the floor and appeared intoxicated which was the reason for her fall. She sustained an injury, a hematoma (bruise) to the back of her head, a noted raised area to left side of head. She was belligerent and agitated with staff.

On 4/12/21 at 4:59 p.m., Resident T was found on the floor after a second fall, and stated she hit

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her head.

On 4/12/21 at 5:03 p.m., Resident T had slurred words, poor balance and had admitted to drinking that morning. She has fallen twice in less than 8 hours. An assessment concluded the falls were a result of EtOH (alcohol) abuse. She had two falls and struck her head both times.

On 4/12/21 at 5:30 p.m., Resident T was transferred to the ER.

On 4/13/1 at 1:03 a.m., Resident T returned to the facility with a diagnosis of alcohol intoxication.

On 4/15/21 at 5:22 p.m., Resident T sustained another fall. She stated she had 1/5 of vodka today prior to the event. She denied any pain post event, but possible bruising was noted by staff to her head.

On 4/16/21 at 11:02 a.m., the SSD spoke with the resident to get permission to contact resident's POA to update her regarding Resident T's condition. She gave permission and the POA was contacted. The SSD informed POA that the resident was signed up for a substance abuse counseling session for 4/19/2021.

On 4/17/21 at 11:24 a.m., a change of mental status note was entered and indicated, Resident T was intoxicated again, and an order was placed to send her to the ER.

On 4/17/21 at 12:16 p.m. a late entry post-fall evaluation was entered. Resident T fell on 4/17/21 at 11:24 a.m., the reason for her fall was evidence of intoxication and sustained a 3 cm by 3 cm bruise/abrasion to her face and lips.

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On 4/17/21 7:45 p.m., Resident T was transferred to the ER.

On 4/19/21 at 10:02 a.m., Resident T remained in the hospital, and was not able to attend her substance abuse counseling.

When Resident T agreed to think about substance abuse counseling on 10/8/20, 193 days passed before her first appointment was set for 4/19/21.

When Resident T spoke to the SSD about substance abuse counseling on 10/27/21, 174 days passed before her first appointment was set for 4/19/21.

When Resident T signed a consent for to receive substance abuse counseling on 4/6/21, 13 days passed, she sustained two back to back falls with head injuries, and a third fall with injuries to her face and lips, before her first appointment was set for 4/19/21.

Resident T's comprehensive care plan was not revised or updated to include new interventions after each fall.

Resident T signed education on the facilities substance abuse policy on 10/28/21, 1/13/21, and 2/18/21.

On 5/13/21 at 12:15 p.m., the Administrator provided copies of current facility policy. A policy titled, "Resident Substance Abuse in Facility," dated 8/20/18, indicated, "... it is the policy of the facility to provide resident centered care that meets the psychosocial, physical and emotional

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needs and concerns of the residents. Safety is a primary concern for our residents, staff and visitors. the purpose of this policy is to provide guidance to the staff when substance abuse is confirmed or suspected in a resident and not intended to be a step-by-step procedure. Each resident will be provided care based on their individual medical and emotional needs and on their physical ability to self-perform or have assistance to perform the operation. A facility may admit a resident who has a history or diagnosis of substance abuse. However, residents may not possess, use or provide any illicit drugs or abuse drugs in any manner, any may not have drug related paraphilia in their possession while a resident in the facility. Being under the influence or illicit or illegal drugs or alcohol places the resident at risk for overdose, falls, and respiratory depression and places other residents at risk for injury by a resident under the influence of illicit or illegal drugs or alcohol. The facility will safeguard the resident under the influence of illicit or illegal drugs to the extent possible, as well as provide a safe environment for other residents, staff, and visitors. this may include up to discharge of the substance abusing ...follow up care for a resident abusing substances ...iii. Resident may be given a 30-day discharge notice upon first offense ...Care plan and education ...i. Provide options for treatment available to resident/representative including but not limited to: 1. psychosocial evaluation and/or counseling 2. Medical evaluation and/or counseling ...ii. Care plan resident specific triggers for abusing drugs if known..."

This Federal tag relates to Complaint IN00352155.

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F 684	Continued From page 56 3.1-37(a)	F 684		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 755		

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review, the facility failed to ensure medications for discharged residents were counted and documented on pharmacy return forms per pharmacy policy for 1 of 2 random medication storage observations. This deficient practice had the potential to effect 28 of 28 discharged residents.

Findings include:

On 5/13/21 at 9:55 a.m., during a random medication storage observation, with Licensed Practical Nurse (LPN) 5, the 200 Hall medication storage room, medication, and treatment carts were observed.

LPN 11 was observed sitting on a stool, inside the medication storage room. She had a large box of random medication cards and containers labeled for various discharged residents, in front of her, on the floor. She was stuffing the medications in large gray plastic bags and sealing them shut with the self-adhesive strip. The plastic bags indicated "Pharmacy Returns" on the front, in large black letters. There were 10 sealed bags on the medication room counter.

During an interview, at that time, LPN 11 indicated she did not know the procedure for pharmacy returns. She was not aware if any forms or paperwork needed to have been completed for the medication returns. She was not counting medications, just putting them into the return bags.

On 5/13/21 at 10:58 a.m., during an interview the Interim Director of Nursing (IDON) indicated the proper procedure for returning medications to the pharmacy was to list the medications or pull the

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sticker from the medication container or card and place it on the pharmacy return sheet. Place all the medications in their original packaging in a sealed bag and return to the pharmacy. The pharmacy gave some credit to the residents for returned medications. She had been at the facility for 3 weeks to help with the closing. Part of her job was drug disposal and she had not gotten to all of them yet. If LPN 11 was putting medications in pharmacy bags and sealing them that was not the proper procedure for medication return. They had to be listed and counted on the paper form before return to pharmacy, or destruction.

On 5/12/21 at 2:20 p.m., the Administrator (ADM) provided a current undated policy titled, "Medication Destruction for Non-Controlled Medications." This policy indicated, "Discontinued medications and medications left in the facility after a resident's discharge which do not qualify for pharmacy credit, are destroyed. Destruction methods comply with state laws and regulations for medication destruction...Medication destruction occurs only in the presence of at least two licensed healthcare professionals or according to regulation and applicable law. The licensed healthcare professionals witnessing the destruction ensure the following information is entered on the Drug Destruction form: date of destruction, resident's name, name and strength of the medication, prescription number, if applicable, amount of medication destroyed, signature of witnesses...."

This Federal tag relates to Complaint IN00353535.

3.1-25(o)
3.1-25(p)

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F 755	Continued From page 59 3.1-25(q) 3.1-25(r) 3.1-25(s)(1) 3.1-25(s)(2) 3.1-25(s)(3) 3.1-25(s)(4) 3.1-25(s)(5) 3.1-25(s)(6) 3.1-25(s)(7) 3.1-25(s)(8)	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure medications were labeled properly for 1 of 2 random medication storage observations, and failed to ensure medications were securely locked inside a medication storage room or cart when a resident was discharged for 1 of 1 observations of medications found in a resident room closet (Resident J).

Findings include:

1. On 5/13/21 at 9:55 a.m., during a random medication storage observation, with Licensed Practical Nurse (LPN) 5, the 200 Hall medication storage room, medication and treatment carts were observed.

The refrigerator contained 3 vials of Tuberculin (TB) testing serum (used for TB skin tests) - 2 vials were unopened. The third vial was opened and was not dated. LPN 5 indicated the bottle should have had an open date on the label space which indicated "date opened." It was blank.

The freezer contained a pint of ice cream and a frozen dinner. LPN 5 indicated food should not have been in the medication room freezer, or refrigerator.

On 5/13/21 at 12:15 p.m., the Administrator (ADM) provided a current undated policy, titled "Storage of Medications." This policy indicated " Medications and biologicals are stored securely, and properly, following manufacturer's recommendations or those of the supplier...supplies are locked when not attended

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by persons with authorized access...medication storage areas are kept clean...and separate from fruit juices, applesauce, and other foods...certain medications...multiple dose injectable vials...once opened, require an expiration date shorter than the manufacturer's expiration date to ensure medication purity and potency...."

2. On 5/12/21 at 11:00 a.m., in a discharged Resident J's closet, a plastic bag was found with prescription medication inside it. LPN 5 pulled a biohazard bag out of the plastic bag and indicated the medication inside was diclofenac sodium 1% gel (treats pain and inflammation). The remaining medications in the plastic bag were mupirocin 2% (topical antibiotic for the skin) and proctofoam (treats discomfort caused by hemorrhoids). LPN 5 bagged the medications in a red plastic bag and took them to the medication storage room so they can they sent back to the pharmacy.

On 5/14/21 at 11:22 a.m., the Regional Consultant indicated all medication should have been under the control of a licensed nurse.

A current policy, titled, "Storage of Medications," with no date, was provided by the Administrator on 5/13/21 at 12:15 p.m. A review of the policy indicated, " ...Medications and biologicals are stored safely, securely, and properly...The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications...."

This Federal tag relates to Complaint IN00353535.

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F 761	Continued From page 62 3.1-25(j) 3.1-25(k) 3.1-25(m)	F 761		
F 845 SS=F	Facility Closure - Administrator CFR(s): 483.70(l)(1)-(3) §483.70(l) Facility closure-Administrator. Any individual who is the administrator of the facility must: §483.70(l)(1) Submit to the State Survey Agency, the State LTC ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure: (i) At least 60 days prior to the date of closure; or (ii) In the case of a facility where the Secretary or a State terminates the facility's participation in the Medicare and/or Medicaid programs, not later than the date that the Secretary determines appropriate; §483.70(l)(2) Ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and §483.70(l)(3) Include in the notice the plan, that has been approved by the State, for the transfer and adequate relocation of the residents of the facility by a date that would be specified by the State prior to closure, including assurances that the residents would be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident. This REQUIREMENT is not met as evidenced	F 845		

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by:
Based on interview and record review, the facility failed to ensure the State Long-Term Ombudsman was notified of the facility closure plan, residents were notified of their rights during the facility closure, failed to ensure residents were relocated to the most appropriate setting based on the residents' needs, choices, and interests. This deficient practice had the potential to effect 76 of 76 resident residing in the building.

Findings include:

On 4/30/21, the Administrator provided a current policy, dated 4/30/21, titled [Name of Facility] Closure Plan," to the Indiana Department of Health. This policy indicated [Name of Facility] (the "Facility") will submit notification to the following that the Facility will close 60 days from the date of this notice (July 1, 2021), or later if all residents have not been relocated as of the 60th day ("Closure Notification")...Discharge planning for each resident will begin immediately upon delivery of the Closure Notification to the resident and will...schedule meetings with each resident and/or resident's legal representative or other responsible parties to discuss the most appropriate and convenient relocation options. The IDT [Interdisciplinary Team] will consider each resident's individual needs, choices, and best interests in the selection of the relocation facility...The IDT will make every reasonable effort to accommodate each resident's goals, preference, and relocation needs...The IDT will prepare discharge summary information for the receiving provider...recapitulation of resident's stay...post discharge plan of care...This Closure Plan will serve as the policy and procedure for the closure plan...."

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EAGLE CREEK HEALTHCARE CENTER	4102 SHORE DR INDIANAPOLIS, IN 46254

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A current policy, titled, "Eagle Creek Healthcare Center Closure Plan," with no date, indicated, " ... The IDT (Inter-Disciplinary Team) will consider each resident's individual needs, choices, and best interests in the selection of the relocation facility...The IDT will provide the resident...with pertinent information regarding nursing facilities in the resident's geographic area of choice, including facility consumer reports and publicly available standardized quality information...The IDT will make every reasonable effort to accommodate each resident's goals preference, and relocation needs, including but not limited to: Assistance with arranging transportation for any resident who wishes to visit a prospective relocation facility ...This Closure Plan will serve as the policy and procedure for the closure phase ...."

1. Notification before transfer and Ombudsman information:
The facility failed to ensure residents were provided notices as required before their transfer and discharge from a facility during a facility-initiated closure for 74 of 76 residents residing in the building (Residents B, C, D, E, X, Y, Z, AA, K, F, L, M, N, P, Q, R, and S).

During an interview, on 5/12/21 at 6:08 p.m., the State Long-Term Ombudsman indicated she visited the facility on 5/10/21 to inform the facility resident of their rights, had packets ready for the residents and was prepared to assist as needed with enforcing their rights. When she got to the facility, she found only 8 of 76 residents still residing in the building. They had been told they were also to be transferred to a sister facility. The residents were not informed of their rights to

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	155664	A. BUILDING _____ B. WING _____	C 05/14/2021

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choose from other facilities. There were no 30-day notices given to the residents. The Ombudsman's office did not receive any notices of transfer discharge for the resident's before they were moved and did not receive weekly updates. The residents were unaware they could contact the Ombudsman about the transfers. Staff indicated to the local Ombudsman that corporate wanted all residents out by the end of the month, which was not in accordance with the letter received regarding their closure. The ombudsman indicated the residents were not given their due process. The Closure letter was received by the State Ombudsman office's, but there was no Closure Plan included with the letter.

On 5/13/21 at 12:10 p.m., the Administrator provided a document she indicated was provided to the residents by the Ombudsman during her visit on 5/10/21. The Ombudsman document, provided by the Administrator was titled, "Know our Rights During Your Nursing Home Closure," with no date. A review of this document indicated, "You have the right to written notice of the closure at least 60 days in advance that also includes the facility's closure plan and where they will be transferring you. Assurances that you will be transferred to the most appropriate facility of your choice or a setting with comparable quality, services, and location. Your needs and choices honored...Contact information for the Long-Term Care Ombudsman Program, any concerns or questions information shared with the receiving provider, such as care plan goals discharge summary, special instruction, etc. Make sure you have the following: Items when you move: all medication, complete medical record, including comprehensive care plan, personal funds with full

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accounting and any identification, family or legal representative contact information, legal papers, such as power of attorneys and advance directives, personal property with inventory list, identification ...." There were only 8 of 76 residents left in the building on 5/10/21. Sixty-eight residents had been moved out of the building prior to the Ombudsman's arrival.

Cross reference F623.

2. Orientation for transfer or discharge:
The facility failed to ensure residents were sufficiently oriented prior to leaving their current facility due to a facility-initiated closure for 20 of 27 residents moved within 30 minutes notice, and for 11 of 11 residents interviewed for discharge from facility (Residents BB, CC, Q, DD, GG, EE, B, FF, C, K, F, L, M, P, Q, R, S and V).

An email from the Ombudsman, during the survey, indicated she had several concerns with the facility-initiated transfer and discharge of residents. She interviewed 20 of 27 residents transferred to (name of company) sister facility (nursing home owned by the same company). Of the 20 residents questioned all of them stated they were given 30 minutes to prepare their belongings because they were moving. No one was given choices outside the sister facilities. After she interviewed the residents, she indicated some of her other concerns were as follows:
a. Resident BB was still waiting on his personal property.
b. Resident CC was missing personal pillows.
c. Resident Q wanted to move to the east side of Indianapolis but was sent to the sister facility not on the east side.
d. Resident DD was missing clothes.

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e. Resident GG was missing clothes and paperwork needed for a social security hearing.
f. Resident EE was missing a lamp.
g. Resident B was missing clothes and her bariatric (extra-large) wheelchair.
h. Resident FF was missing medication. She was 22 years old and placed in a room with a resident who had dementia.

On 5/12/21 at 10:40 a.m., during an interview, Resident V's family member indicated on April 30, 2020 the facility had sent out a letter, they were closing. She had received it in the mail on May 1st, 2 Fridays ago. Last Thursday, May 6th, she had received a phone call saying they were closing this Friday, May 14th. On the day she received the letter in the mail there was a care plan meeting. During the care plan meeting she told the facility she wanted to make arrangements to bring her mother home. She contacted (Name of Agency) to help with arrangements. They (agency) were working with her. It would take a couple weeks to get everything in place. Then, the facility told her they were closing this Friday, May14, and resident had to be out. They were transferring only to other (Corporate Name) buildings and they chose where she was going. They chose (Sister Facility Name). Resident V had been discharged from the facility to another (sister) facility with the same company, on 5/10/21. The facility where the resident had gone (Sister Facility) told her they received no paperwork when the resident arrived, and her g-tube (gastric feeding tube) was clogged.

During the survey, interviews and record reviews indicated Residents C, K, F, L, M, P, Q, R, and S were not provided sufficient information or time to transfer or discharge from the facility to ensure

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F 845	Continued From page 68 their new facility would be able to meet their preferences, interests, and needs. Cross reference F624. This Federal tag relates to Complaints IN00353549 and IN00351267. 3.1-12(a)(20) 3.1-12(a)(21) 3.1-12(a)(22)	F 845		