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	155736	A. BUILDING 00 B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILL POND HEALTH CAMPUS	1014 MILL POND LANE GREENCASTLE, IN 46135

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00431685 and IN00432056. Complaint IN00431685 - State deficiencies related to the allegations are cited at R0044, R0045, and R0048. Complaint IN00432056 - No deficiencies related to the allegations are cited. Survey date: April 19 and 22, 2024 Facility number: 004550 Residential Census: 27 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 2, 2024.	R 0000	The submission of this plan of correction does not indicate an admission by Mill Pond Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Mill Pond Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0044 Bldg. 00	410 IAC 16.2-5-1.2(r)(1-5) Residents' Right - Deficiency Based on record review and interview, the facility failed to allow a resident to remain in the facility for 1 of 3 residents reviewed for discharges (Resident C).	R 0044	1. Residents C did not return to the facility. 2. Discharged residents have the potential to be affected by the alleged deficient practice and	05/22/2024

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

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	Finding includes: An Indiana State Department of Health Survey System report, dated 3/25/24 at 4:35 p.m., submitted by the facility indicated Resident C was observed by staff seated on a shower chair in the shower with lacerations to both wrists and was not responsive but still breathing. Staff applied pressure to the lacerations, called 911/EMS (emergency medical services), first responders arrived and presumed care. The resident was transported via EMS to the hospital for treatment. The resident was currently stable. A follow-up statement was added on 4/2/24 and indicated the resident continued treatment in an in-patient hospital setting with psychiatric treatment. On 4/19/24 at 2:10 p.m., the Director of Nursing (DON) indicated Resident C was a danger to self and was not re-admitted to the facility for that reason. The resident had told the hospital to not to provide the documentation from the hospital stay to the facility. The resident's son had indicated to staff, on that day, that his father and him had discussed finances and the resident was almost out of funds or was running low, due to the facility fees, hospitalizations, doctor bills, and medications. On 4/19/24 at 2:57 p.m., the DON indicated the resident was not at the hospital for the 72-hour psychiatric hold, when the hospital started asking for the readmission to the AL (assisted living) facility. The facility did not feel confident that the resident was truly not a danger to self. Corporate policy, per corporate leadership, the AL did not provide enough supervision for the resident to be safe at the facility. The rationale for the financial stress was still present for the resident. The		through alterations in processes and in servicing the campus will ensure follow up with discharged residents are completed timely for potential return to campus. 3. An in-service has been completed with Interdisciplinary team to ensure discharged residents have follow up for return as warranted. As a measure of ongoing compliance, director of health services (DHS) or designee will audit 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months to ensure discharged residents have been reviewed for potential return to the campus. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	facility believed the financial situation was the rationale for the self-harm attempt. Psychological harm had to be considered for the other residents and staff if the resident was allowed to come back to the AL facility. The DON did not provide documentation nor an interview from Resident C to confirm the resident had financial concerns. On 4/19/24 at 3:50 p.m., Registered Nurse Consultant (RN) 3 indicated she was at the facility when Resident C had attempted suicide and observed the resident in his shower, seated on a shower bench, with the wounds on his wrists. There was paperwork, medical bills, and a handwritten note on a bedside table in the resident's room, which indicated, "Too much [s---], too much to handle ..." with more written on the note but the resident's son took the note from RN 3 and the son would not give the note back nor tell RN 3 what the remainder of the note stated. During a confidential interview, on 4/22/24 at 10:10 a.m., they indicated Resident C was transferred and resided on the hospital medical unit until he was discharged from the hospital. The facility had sent the resident an eviction notice on 4/8/24 and back dated to 3/25/24. The facility had been contacted by the hospital and indicated the facility would not be able to meet the resident's needs, then later, indicated the resident was a safety concern for staff and other residents. The facility indicated they needed to protect their staff and residents. The facility kept avoiding the phone calls when the hospital staff contacted the facility, and the resident never denied the facility to have access to his medical records. The facility kept coming up with excuses of why the resident could not be allowed to come back to the AL facility. The resident had always paid his bills/rent at the facility on time. It was hard to get into			

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	another facility since he had attempted to commit suicide. The resident was currently in the hospital medical floor and the hospital staff were working on his discharge from the hospital to an AL facility. The resident was safe and appropriate for admission into an AL facility at this time. On 4/22/24 at 10:55 a.m., the Business Office Manager (BOM) indicated she had heard in morning meeting from the Administrator (ADM) that the ADM had discussed with the corporate home office that Resident C was not allowed to come back to the AL facility. BOM indicated she sent out 30-day eviction notices to the residents, but she had never sent the resident any documentation. The resident had paid his bills timely, and she had not sent the resident any notices. A hospital psychiatrist had called the facility and had spoken to the DON about the resident. On 4/22/24 at 12:18 p.m., Resident C's family indicated the DON had called him and indicated the facility was not going to accept Resident C back to the facility and when would the family member come to gather the resident's belongings from the facility. The family member went to the facility the next weekend and retrieved all of Resident C's belongings. The resident had wanted to go back to the facility, but the DON had told him that they were not able to accept the resident back to the facility. The family member had not received any documentation or correspondence of the resident's bed hold nor a notice of transfer/discharge from the AL facility. During a telephone conversation, on 4/22/24 at 12:40 p.m., Resident C indicated the hospital staff were looking into another AL facility for the resident's discharge from the hospital. He would			

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	like to go back to the facility, but the facility would not let him back to the facility. The resident was unsure why they would not let him come back to the facility. He would like to come back to the facility, but with all that has gone on with the facility, he would rather go to another facility. He had not received any paperwork from the facility about the bed hold nor a notice of transfer or discharge. The hospital doctor had told the resident, on Friday 4/19/24, that he should know today what he was going to do and where the resident was going after the discharge from the hospital. The resident did not indicate he had concerns about being able to pay his bills. RN 3, on 4/22/24 at 2:20 p.m., indicated the required paperwork of the CCD (continuity of care document), code status, advanced directive, Notice of Transfer or Discharge form, and the Bed Hold policy should be given to a resident prior to discharge to the hospital and sent to the hospital, when a resident was sent to the hospital. The facility did not have a written policy and procedure for the transfer/discharge of an AL resident to the hospital, but the facility followed the State guidelines. Resident C's medical record was reviewed on 4/19/24 at 11:32 a.m. Diagnoses included, but was not limited to, depression, pain, acute and chronic respiratory failure with hypoxia, COPD (congestive obstructive pulmonary disease) (lung disease that block airflow and make it difficult to breathe), and CHF (congestive heart failure) (chronic condition in which the heart doesn't pump blood as well as it should). Resident C's semiannual service plan, dated 1/24/24, indicated the resident was cognitively intact, was independent with mobility and most			

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	activities of daily living with escort and/or supervision as needed. A nurse's progress note, dated 3/25/24 at 7:12 p.m., indicated Certified Resident Medication Aide (CRMA) 7 on AL (assisted living) had called the nurse and stated she needed help in Resident C's bathroom. Upon entering the resident's bathroom, she observed staff with Resident C bleeding from his wrists and a knife laying open with blood on it on the bar of soap. The nurse called the DON and asked her to call 911/EMS, got additional staff assistance, while CRMA 7 held pressure on both wrists. Staff moved the resident from the shower onto a blanket on the bathroom floor on his back where we continued to hold pressure and elevated above his heart until EMS arrived to take over. The resident was then transferred to the hospital. The medical record for Resident C lacked documentation of any behaviors, symptoms of depression, suicidal tendencies, or other events that would place Resident C or any other resident in the facility at risk. On 4/22/24 at 11:26 a.m., RN 3 provided a copy of the Notice of Transfer or Discharge document for Resident C, dated 4/1/24, and indicated she had spoken to the ADM and the Notice of Transfer or Discharge document was emailed, on 4/8/24, to the case manager at the hospital to give the resident a copy. The hospital had contacted the ADM about the transfer from the hospital back to the AL facility. The ADM had indicated to the hospital that the resident was a danger to self, other residents and staff, and the resident had 10 days to appeal the discharge, but the resident did not respond to the appeal within the 10 days. With the commotion at the time of the suicide attempt, on 3/25/24, staff had not provided the			

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	resident with documentation of the notice of transfer or discharge and had provided a copy for the case manager to give to him. The facility did not have a policy for the transfer or discharge of a resident but should have provided the Notice of Transfer or Discharge document and the Bed Hold document to the resident at the time of the transfer to the hospital. This citation relates to Complaint IN00431685.			
R 0045 Bldg. 00	410 IAC 16.2-5-1.2(r)(6-9) Residents' Rights - Deficiency Based on record review and interview, the facility failed to ensure bed hold documentation and notice of transfer or discharge policies were provided to the residents and/or responsible parties at the time of the hospital transfers for 3 of 3 residents reviewed for hospitalization (Residents C, B, and D). Findings include: 1. An Indiana State Department of Health Survey System report, dated 3/25/24 at 4:35 p.m., submitted by the facility indicated Resident C was observed by staff seated on a shower chair in the shower with lacerations to both wrists and was not responsive but still breathing. Staff applied pressure to the lacerations, called 911/EMS (emergency medical services), first responders arrived and presumed care. The resident was transported via EMS to the hospital for treatment. The resident was currently stable. A follow-up statement was added on 4/2/24 and indicated the resident continued treatment in an in-patient hospital setting with psychiatric treatment. On 4/22/24 at 12:18 p.m., Resident C's family	R 0045	1. Residents C, B, D suffered no ill effects from the alleged deficient practice. 2. Residents who have been discharged to the hospital have the potential to be affected by the alleged deficient practice. Like residents have been audited to ensure required paperwork is sent to the hospital with resident/family. 3 Nursing staff have been educated on sending required paperwork per policy, including the transfer/discharge/bed hold policy is sent with the residents upon going to the hospital. As a measure of ongoing compliance, the director of health services (DHS) or designee will audit 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months to ensure the transfer/discharge/bed hold policy is sent with the residents upon going to the	05/22/2024

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	indicated the Director of Nursing (DON) had called him and indicated the facility was not going to accept Resident C back to the facility and when would the family member come to gather the resident's belongings from the facility. The family member went to the facility the next weekend and retrieved all of Resident C's belongings. The resident had wanted to go back to the facility, but the DON had told him that they were not able to accept the resident back to the facility. The family member had not received any documentation or correspondence of the resident's bed hold nor a notice of transfer/discharge from the AL facility. During a telephone conversation, on 4/22/24 at 12:40 p.m., Resident C indicated the hospital staff were looking into another AL facility for the resident's discharge from the hospital. He would like to go back to the facility, but the facility would not let him back to the facility. The resident was unsure why they would not let him come back to the facility. He would like to come back to the facility, but with all that has gone on with the facility, he would rather go to another facility now. He had not received any paperwork from the facility about the bed hold nor a notice of transfer or discharge. Registered Nurse Consultant (RN) 3, on 4/22/24 at 2:20 p.m., indicated the required paperwork of the CCD (continuity of care document), code status, advanced directive, Notice of Transfer or Discharge form, and the Bed Hold policy should be given to a resident prior to discharge to the hospital and sent to the hospital, when a resident was sent to the hospital. The facility did not have a written policy and procedure for the transfer/discharge of an AL resident to the hospital, but the facility followed the State guidelines.		hospital. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	Resident C's medical record was reviewed on 4/19/24 at 11:32 a.m. Diagnoses included, but was not limited to, depression, pain, acute and chronic respiratory failure with hypoxia, COPD (congestive obstructive pulmonary disease) (lung disease that block airflow and make it difficult to breathe), and CHF (congestive heart failure) (chronic condition in which the heart doesn't pump blood as well as it should). Resident C's semiannual service plan, dated 1/24/24, indicated the resident was cognitively intact, was independent with mobility and most activities of daily living with escort and/or supervision as needed. A nurse's progress note, dated 3/25/24 at 7:12 p.m., indicated Certified Resident Medication Aide (CRMA) 7 on AL (assisted living) had called the nurse and stated she needed help in Resident C's bathroom. Upon entering the resident's bathroom, she observed staff with Resident C bleeding from his wrists and a knife laying open with blood on it on the bar of soap. The nurse called the DON and asked her to call 911/EMS, got additional staff assistance, while CRMA 7 held pressure on both wrists. Staff moved the resident from the shower onto a blanket on the bathroom floor on his back where we continued to hold pressure and elevated above his heart until EMS arrived to take over. The resident was then transferred to the hospital. The medical record lacked documentation the bed hold policy or other transfer or discharge documentation was provided to the resident at the time of the transfer to the hospital. On 4/22/24 at 11:26 a.m., RN 3 provided a copy of the Notice of Transfer or Discharge document for			

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	Resident C, dated 4/1/24, and indicated she had spoken to the ADM and the Notice of Transfer or Discharge document was emailed, on 4/8/24, to the case manager at the hospital to give the resident a copy. The hospital had contacted the ADM about the transfer from the hospital back to the AL facility. The ADM had indicated to the hospital that the resident was a danger to self, other residents and staff, and the resident had 10 days to appeal the discharge, but the resident did not respond to the appeal within the 10 days. With the commotion at the time of the suicide attempt, on 3/25/24, staff had not provided the resident with documentation of the notice of transfer or discharge and had provided a copy for the case manager to give to him. The facility did not have a policy for the transfer or discharge of a resident but should have provided the Notice of Transfer or Discharge document and the Bed Hold document to the resident at the time of the transfer to the hospital. During a confidential interview, on 4/22/24 at 10:10 a.m., they indicated Resident C was transferred and resided on the hospital medical unit until he was discharged from the hospital. The facility had sent the resident an eviction notice on 4/8/24 and back dated it to 3/25/24. The date on the form was 14 days before the date the notice was sent to the hospital. 2. An Indiana State Department of Health Survey System report, dated 4/7/24 at 6:23 p.m., submitted by the facility indicated, alert and oriented assisted living (AL) resident observed Resident B in the activity room becoming very pale and Resident B was then observed falling backward toward the floor. Nurse responded and noted large amount of bright red bloody emesis and a large hematoma to the back of the head. The nurse			

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	immediately responded to the fall. The responsible party and medical doctor notified. Emergency Medical Services (EMS) called and transported Resident C to the hospital for evaluation and treatment. Resident B's record was reviewed on 4/22/24 at 9:04 a.m. Diagnoses included, but were not limited to, essential (primary) hypertension (high blood pressure), edema, vascular dementia with anxiety. Resident B's semiannual service plan, dated 12/15/23, indicated the resident was cognitively severely impaired and was dependent on staff for assistance with activities of daily living. A nurse's progress note, dated 4/7/24 at 6:23 p.m., indicated Resident B was standing with her walker in the activity room with another resident, when per the other resident, Resident B got very pale and fell straight back onto the floor. Staff heard the fall and immediately came to the room. The nursing aide on unit notified the nurse. Upon the nurse's arrival to the room Resident B was agonal breathing and not responding to verbal or physical stimulation and pupils were not reactive. Do not resuscitate status verified at this time. Vital signs obtained with elevated blood pressure noted. Resident B began to vomit a large amount of bright red blood and was turned on to her side by staff. Resident B's emergency contact was notified and asked to send the resident to the hospital for evaluation. 911/EMS (emergency medical service) was called. Resident B vomited bright red blood 2 more times while waiting on the ambulance to arrive. Blood was also coming from the resident's nose and a large hematoma was noted to the back of the resident's head with an ice pack applied to the hematoma. Resident B did start to respond to some questions and stated she			

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	was scared. The ambulance crew arrived at 6:50 p.m. and placed a collar on the resident and lifted her onto the stretcher. Resident B left the building at this time for the hospital emergency department. A copy of the resident's CCD (continuity of care document) and DNR (do not resuscitate) was sent with the resident. The medical record lacked documentation the bed hold policy or other transfer or discharge documentation was provided to the resident at the time of the transfer to the hospital. On 4/22/24 at 2:55 p.m., Registered Nurse Consultant (RN) 3 indicated, the required paperwork of the CCD (continuity of care document), code status, advanced directive, Notice of Transfer or Discharge form, and the Bed Hold policy should be given to the resident prior to discharge to the hospital and sent to the hospital, when a resident was sent to the hospital. The facility did not have a written policy and procedure for the transfer/discharge of an AL resident to the hospital, but the facility followed the State guidelines. RN 3 indicated, she was unable to find the Notice of Transfer or Discharge and Bed Hold documentation for Resident B. 3. An Indiana State Department of Health Survey System report, dated 4/17/24 at 3:10 p.m., submitted by the facility indicated, assisted living (AL) Resident D stood up from the wheelchair, lost footing, and fell in the AL common area. After the fall, Resident D complained of pain to the right hip/leg. Resident D was sent to the hospital emergency room to x-ray for possible fracture. Verbal report of confirmed fracture provided to the AL facility on 4/17/24. The report from the hospital indicated Resident D was not a candidate for surgical intervention. The facility will address			

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	status upon return to the campus. Resident D's medical record was reviewed on 4/22/24 at 9:25 a.m. Diagnoses included, but were not limited to, edema, dementia, low back pain, hypertension (high blood pressure). Resident D's semiannual service plan, dated 2/29/24, indicated the resident was cognitively severely impaired, was dependent on staff for assistance with activities of daily living, and resided on a secured memory care unit in the assisted living (AL) facility. A nurse's progress note, dated 4/16/24 at 6:30 p.m., indicated the nurse was called to the secured memory care unit due to Resident D having a fall. Resident D was observed on the floor, sitting on her bottom, leaning against the desk on her right side. The resident was up walking around in the common area, lost her footing and fell. Initially stated she was fine. Slow to allow the nurse to do an assessment with no shortening of extremities or rotation noted. After assessment and the resident was assisted up and back into her wheelchair, she then complained of pain to right hip/leg. A call was placed to the resident's spouse to advise of the fall. Informed him that the resident was now complaining of pain and asked if spouse wanted resident to be sent to hospital emergency room (ER) for evaluation and x-rays. Resident D's spouse indicated, he preferred the x-rays be done in house with a mobile unit versus going to the ER. A call was placed to the medical doctor (MD) to advise of the incident and the family wishes. MD gave order to x-ray right hip/leg and pelvis. A call was placed to the x-ray team and ordered placed stat (urgent). A return call was received from the x-ray team approximately an hour later stating the earliest they could be at the facility			

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	would be in the morning. The family was given an update about x-rays. A nurse's progress note, dated 4/16/24 at 11:26 p.m., indicated the nurse was called to the secured memory unit, family wanted to speak to a nurse. Upon entering the unit, the staff advised the nurse of the resident's fall. The family voiced concerns of the resident's low blood pressure and low oxygen saturation. Resident D was very anxious at the present time with a pale pallor and complaints of extreme pain to the right lower extremity and right foot and noted swelling to right knee. Received orders to do an in-house right hip x-ray. The family was okay with sending the resident out to hospital emergency department (ED) due to the amount of pain the resident was experiencing and for complaints of chest pain. A nurse's progress note, dated 4/16/24 at 11:38 p.m., indicated 911/EMS (emergency medical services) was call for ambulance to transport Resident D to the ED. A nurse's progress note, dated 4/16/24 at 11:42 p.m., indicated Resident D observed exiting the facility on a stretcher via assistance by two EMT and a nurse to the hospital ED. A nurse's progress note, dated 4/17/24 at 2:28 a.m., indicated the nurse had received an update on Resident D from the hospital. Resident D would be admitted to the hospital with pneumonia, low oxygen saturation, and suspicious right knee fracture. The medical record lacked documentation the bed hold policy or other transfer or discharge documentation was provided to the resident at the time of the transfer to the hospital.			

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	On 4/22/24 at 2:56 p.m., Registered Nurse Consultant (RN) 3 indicated, the required paperwork of the CCD (continuity of care document), code status, advanced directive, Notice of Transfer or Discharge form, and the Bed Hold policy should be given to the resident prior to discharge to the hospital and sent to the hospital, when a resident was sent to the hospital. The facility did not have a written policy and procedure for the transfer/discharge of an AL resident to the hospital, but the facility followed the State guidelines. RN 3 indicated, she was unable to find the Notice of Transfer or Discharge and Bed Hold documentation for Resident D. This citation relates to Complaint IN00431685.			
R 0048 Bldg. 00	410 IAC 16.2-5-1.2(r)(18-24) Residents' Rights - Deficiency Based on record review and interview, the facility failed to ensure a relocation plan was prepared for the relocation and to provide continuity of care for a resident for 1 of 3 residents reviewed for discharges (Resident C). Finding includes: An Indiana State Department of Health Survey System report, dated 3/25/24 at 4:35 p.m., submitted by the facility indicated Resident C was observed by staff seated on a shower chair in the shower with lacerations to both wrists and was not responsive but still breathing. Staff applied pressure to the lacerations, called 911/EMS (emergency medical services), first responders arrived and presumed care. The resident was transported via EMS to the hospital for treatment. The resident was currently stable. A follow-up	R 0048	1. Residents C did not return to the facility. 2. Discharged residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in servicing the campus will ensure follow up with discharged residents are completed timely for potential return to campus. 3. An in-service has been completed with Interdisciplinary team to ensure discharged residents have follow up for return as warranted. As a measure of ongoing compliance, director of health services (DHS) or designee will audit 5 residents weekly for 4 weeks, then every other week for 2	05/22/2024

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	statement was added on 4/2/24 and indicated the resident continued treatment in in-patient hospital setting with psychiatric treatment. On 4/19/24 at 2:10 p.m., the Director of Nursing (DON) indicated, Resident C was a danger to self and was not re-admitted to the facility for that reason. The resident had told the hospital to not to provide the documentation from the hospital stay to the facility. The resident's son had indicated to staff, on that day, that his father and him had discussed finances and the resident was almost out of funds or was running low, due to the facility fees, hospitalizations, doctor bills, and medications. On 4/19/24 at 2:57 p.m., the DON indicated, the resident was not at the hospital for the 72-hour psychiatric hold, when the hospital started asking for the readmission to the AL (assisted living) facility. The facility did not feel confident that the resident was truly not a danger to self. Corporate policy, per corporate leadership, the AL did not provide enough supervision for the resident to be safe at the facility. The rationale for the financial stress was still present for the resident. The facility believed the financial situation was the rationale for the self-harm attempt. Psychological harm had to be considered for the other residents and staff if the resident was allowed to come back to the AL facility. On 4/19/24 at 3:50 p.m., Registered Nurse Consultant (RN) 3 indicated, she was at the facility when Resident C had attempted suicide and observed the resident in his shower, seated on a shower bench, with the wounds on his wrists. There was paperwork, medical bills, and a handwritten note on a bedside table in the resident's room, which indicated, "Too much [s--		months, and then monthly for 3 months to ensure discharged residents have been reviewed for potential return to the campus. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	-], too much to handle ..." with more written on the note but the resident's son took the note from RN 3 and the son would not give the note back nor tell RN 3 what the remainder of the note stated. During a confidential interview, on 4/22/24 at 10:10 a.m., they indicated, Resident C was transferred and resided on the hospital medical unit until he was discharged from the hospital. The facility had sent the resident an eviction notice on 4/8/24 and back dated to 3/25/24. The facility had been contacted by the hospital and indicated the facility would not be able to meet the resident's needs, then later, indicated the resident was a safety concern for staff and other residents. The facility indicated they needed to protect their staff and residents. The facility kept avoiding the phone calls when the hospital staff contacted the facility, and the resident never denied the facility to have access to his medical records. The facility kept coming up with excuses of why the resident could not be allowed to come back to the AL facility. The resident had always paid his bills/rent at the facility on time. It was hard to get into another facility since he had attempted to commit suicide. The resident was currently in the hospital medical floor and the hospital staff were working on his discharge from the hospital to an AL facility. The resident was safe and appropriate for admission into an AL facility at this time. On 4/22/24 at 10:55 a.m., the Business Office Manager (BOM) indicated, she had heard in morning meeting from the Administrator (ADM) that the ADM had discussed with the corporate home office that Resident C was not allowed to come back to the AL facility. BOM indicated she sent out 30-day eviction notices to the residents, but she had never sent the resident any documentation. The resident had paid his bills			

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	timely, and she had not sent the resident any notices. A hospital psychiatrist had called the facility and had spoken to the DON about the resident. On 4/22/24 at 12:18 p.m., Resident C's family indicated, the DON had called him and indicated the facility was not going to accept Resident C back to the facility and when would the family member come to gather the resident's belongings from the facility. The family member went to the facility the next weekend and retrieved all of Resident C's belongings. The resident had wanted to go back to the facility, but the DON had told him that they were not able to accept the resident back to the facility. The family member had not received any documentation or correspondence of the resident's bed hold nor a notice of transfer/discharge from the AL facility. The family member did not indicate the facility provided a discharge plan for continuity of care. During a telephone conversation, on 4/22/24 at 12:40 p.m., Resident C indicated, the hospital staff were looking into another AL facility for the resident's discharge from the hospital. He would like to go back to the facility, but the facility would not let him back to the facility. The resident was unsure why they would not let him come back to the facility. He would have liked to go back to the facility, but with all that has gone on with the facility, he would rather go to another facility now. The resident had not heard from the facility in regards to a discharge plan for continuity of care. He had not received any paperwork from the facility about the bed hold nor a notice of transfer or discharge. The hospital doctor had told the resident, on Friday 4/19/24, that he should know today what he was going to do and where the resident was going after the discharge from the			

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	hospital. Resident C's medical record was reviewed on 4/19/24 at 11:32 a.m. Diagnoses included, but was not limited to, depression, pain, acute and chronic respiratory failure with hypoxia, COPD (congestive obstructive pulmonary disease) (lung disease that block airflow and make it difficult to breathe), and CHF (congestive heart failure) (chronic condition in which the heart doesn't pump blood as well as it should). Resident C's semiannual service plan, dated 1/24/24, indicated the resident was cognitively intact, was independent with mobility and most activities of daily living with escort and/or supervision as needed. A nurse's progress note, dated 3/25/24 at 7:12 p.m., indicated Certified Resident Medication Aide (CRMA) 7 on AL (assisted living) had called the nurse and stated she needed help in Resident C's bathroom. Upon entering the resident's bathroom, she observed staff with Resident C bleeding from his wrists and a knife laying open with blood on it on the bar of soap. The nurse called the DON and asked her to call 911/EMS, got additional staff assistance, while CRMA 7 held pressure on both wrists. Staff moved the resident from the shower onto a blanket on the bathroom floor on his back where we continued to hold pressure and elevated above his heart until EMS arrived to take over. The resident was then transferred to the hospital. The medical record lacked documentation of a discharge or relocation plan for the resident. On 4/22/24 at 11:26 a.m., RN 3 provided a copy of the Notice of Transfer or Discharge document for Resident C, dated 4/1/24, and indicated she had			

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	spoken to the ADM and the Notice of Transfer or Discharge document was emailed, on 4/8/24, to the case manager at the hospital to give the resident a copy. The hospital had contacted the ADM about the transfer from the hospital back to the AL facility. The ADM had indicated to the hospital that the resident was a danger to self, other residents and staff, and the resident had 10 days to appeal the discharge, but the resident did not respond to the appeal within the 10 days. With the commotion at the time of the suicide attempt, on 3/25/24, staff had not provided the resident with documentation of the notice of transfer or discharge and had provided a copy for the case manager to give to him. The document lacked a discharge plan for continuity of care for the resident. This citation relates to Complaint IN00431685.			