STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155807	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RURAL HEALTH CARE CENTER	1747 N RURAL ST INDIANAPOLIS, IN 46218

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00403448. Complaint IN0040344- deficiencies are cited at F0661 and F0740 Survey date: April 28, 2023 Facility number: 000388 Provider number: 155807 AIM number: 100454140 Census Bed Type: SNF/NF: 41 Total: 41 Census Payor Type: Medicaid: 39 Other: 2 Total: 41 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 8, 2023	F 0000		
F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Olivia Winston	Administrator	05/25/2023

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

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	results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.			
	Based on interview and record review, the facility failed to prepare a discharge summary that included a recapitulation of the resident's stay, a final summary of the resident's status, a reconciliation of all pre and post discharge medications, and a discharge plan of care for 1 of 3 residents reviewed for discharge. (Resident F) Findings include: The clinical record for Resident F was reviewed on 4/28/23 at 11:00 a.m. Her diagnoses included, but were not limited to, bipolar disorder, major depressive disorder, anxiety, and insomnia. She was readmitted to the facility from a psychiatric facility on 1/11/23; and discharged to another skilled nursing facility on 1/19/23.	F 0661	Based on interview and record review, the facility failed to prepare a discharge summary that included a recapitulation of the resident's stay, a final summary of the resident's status, a reconciliation of all pre and post discharge medications, and a discharge plan of care for 1 of 3 residents reviewed for discharge. (Resident F) · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident F no longer resides at the facility	05/25/2023

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	The 3/10/22 care plan indicted the focus was that she had a long history of mental illness. She had 9 psychiatric admissions to a hospital. She utilized antianxiety medication antipsychotic medications, and antidepressant medications. Symptoms of her diagnoses included anxiety, panic, wanting 911 called, and wanting to go to the hospital, suicidal ideation, and 1 suicidal attempt, running into traffic, insomnia, reports of feeling down, depressed, and hopeless. She had a history of PTSD (post traumatic stress disorder,) a history of homelessness, and a history of not taking her medications. The goal was for her to remain safe in the environment with no attempts of self-harm; would have 2 or less episodes a week of depressed mood and anxious mood; would sleep 6-8 hours a nigh; and for mood distress to be calmed upon staff interventions. Interventions included to respect her privacy; encourage her to spend time out of her room; ensure her room was dark and quit to promote sleep; to provide reassurance and express care; to redirect her by offering a snack or something to drink; to redirect her by tuning in soothing music peer her preference; to remind her to get grounded by taking slow deep breaths and acknowledging that she was safe; and to use a calm approach. This care plan did not reference an intervention to consult with her psychiatrist, clinical social worker, or psychologist for for further evaluation. The 1/12/23 Notice of Transfer or Discharge indicated she was being transferred to another nursing facility for 2 reasons. The first reason was because the transfer or discharge was necessary to meet the resident's welfare and the resident's needs could not be met in the facility. The second reason was the health of the individuals in the facility would otherwise be endangered.		Nursing staff in-serviced on 5-22-23 on the facility discharge summary policy that includes a recapitulation of the resident's stay, a final summary of the resident's status, a reconciliation of all pre and post discharge medications, and a discharge plan of care. · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; A discharge summary audit on the previous 3 months was completed, no deficiencies found. · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON or designee will audit use of new discharge summary for completion of all components daily as permanent discharges occur Monday-Friday x 6months. · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and DON or designee will bring the findings of the audits to QAPI monthly for 6 months. After 6	

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	An interview was conducted with the ED (Executive Director) on 4/28/23 at 10:25 a.m. She indicated Resident F was admitted to their facility from a psychiatric hospital. When she first arrived, "she cried and cried," and was very unhappy. She ended up "getting married" to Resident B in August, 2022. She stated, "I was kind of against it, but staff were insistent," saying it would be good for her, make her happy. All of the other residents dressed up for the wedding. After marrying Resident B, "it was a nightmare." Resident F would tell staff not to look at her husband, and tell her husband not to take the medications attempting to be administered by staff, and say to staff, "Why are you looking at him?" She would transfer him out of bed on her own. Staff educated her about these things "for months," but she went "out of control." They ended up giving her a 30 day discharge notice. Resident F had a guardian, Guardian 4, who was court appointed. At first, Guardian 4 did not want her transferred to the facility to which she ended up discharging, so they gave the 30 day notice and continued to look for other locations. Eventually, Guardian 4 decided that facility was okay. The other facility came to pick her up, and they had to call the police to be involved with getting her to leave the facility, which took 2 hours. She sat in a chair in the dining room, and staff had to persuade her to leave, convince her that she could visit. She ended up standing up and walking to the door. Resident F and Resident B hugged goodbye and she left. In the meantime, Resident F had contacted lawyers, the media, and the ombudsman, who was involved, but didn't know what to do. Resident F's "husband," Resident B, was still residing in the facility. Resident B would say things about Resident F like she needed help, but then get on the phone with her and say he was going to her new facility.		months, the committee will decide the new for further monitoring and/or frequency of. - · by what date the systemic changes for each deficiency will be completed. - May 25th, 2023	

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	Resident F continued to call the facility "nonstop, all day, like 50 times a day." They hadn't spoken with the new facility about the situation since she discharged there. There was not currently a plan for visits. Resident F also wanted to cancel her guardianship with Guardian 4. The Ombudsman was the only one trying to bridge the gap. An interview was conducted with Resident F by telephone at her new facility on 4/28/23 at 12:58 p.m. She indicated her husband was at her previous facility and she'd like to return there. She hadn't adjusted to her new facility "at all." She cried all the time and really missed her husband. She couldn't kiss him. He couldn't comfort her. She could only talk on the phone. They'd been married for 8 months, but the ED at her previous facility kept saying they weren't really married. She stated, "I have a ring. We had a ceremony, a picture, my wedding dress, everything to prove it. We need to live together." She couldn't get into activities like bingo at her new facility, because she wasn't interested without Resident B there. She'd lost sleep and would cry herself to sleep, then wake up crying, because she'd realize Resident B was not there with her. There was no discharge summary in Resident F's electronic health record or hard chart. An interview was conducted with the DON (Director of Nursing) on 4/28/23 at 1:35 p.m. She indicated their process was to complete discharge summaries by paper and then scan them into the electronic health record. She would look for Resident F's paper discharge summary in case it hadn't been filed and scanned into the computer yet. An interview was conducted with the DON on			

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	4/28/23 at 2:10 p.m. She indicated she was unable to locate a discharge summary for Resident F's 1/19/23 discharge to another facility. The Transfer or Discharge Documentation policy was provided by the ED on 4/28/23 at 10:59 a.m. It read, "Should a resident be transferred or discharged for any reason, the following information will be communicated to the receiving facility or provider: ...a. The basis for the transfer or discharge; (1) If the resident is being transferred or discharged because his or her needs cannot be met at the facility, documentation will include: (a) the specific resident needs that cannot be met; (b) this facility's attempt to meet those needs; and (c) the receiving facility's service(s) that re available to meet those needs. b. Contact information of the practitioner responsible for the care of the resident; c. Resident representative information including contact information; d. Advance Directive information; e. All special instructions or precautions for ongoing care, as appropriate; f. Comprehensive care plan goals; and g. All other necessary information, including a copy of the residents discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care." This Federal Tag relates to Complaints IN00403448. 3.1-36(a)(1) 3.1-36(a)(2) 3.1-36(a)(3) 3.1-36(a)(3)(b)			
F 0740 SS=G Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services.			

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	Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on observation, interview, and record review, the facility failed to coordinate care with residents' mental health provider regarding a major life event resulting in increased repetitive behaviors, agitation, crying, refusal of medications, and loss of interest in activities for 2 of 3 residents reviewed for discharge. (Resident B and F) Findings include: 1. The clinical record for Resident F was reviewed on 4/28/23 at 11:00 a.m. Her diagnoses included, but were not limited to, bipolar disorder, major depressive disorder, anxiety, and insomnia. She was admitted to the facility on 2/18/22; discharged to a psychiatric facility on 1/3/23; readmitted to the facility on 1/11/23; and discharged to another skilled nursing facility on 1/19/23. The 1/12/23 Notice of Transfer or Discharge indicated Resident F was being transferred to another nursing facility for 2 reasons. The first reason was because the transfer or discharge was necessary to meet the resident's welfare and the resident's needs could not be met in the facility. The second reason was the health of the	F 0740	Based on observation, interview, and record review, the facility failed to coordinate care with residents' mental health provider regarding a major life event resulting in increased repetitive behaviors, agitation, crying, refusal of medications, and loss of interest in activities for 2 of 3 residents reviewed for discharge. (Resident B and F) · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident F no longer resides at the facility. Resident B's mental health provider is now consulted for any potential and/or actual major life events. IDT Team in-serviced on 5/22/23 on coordination of care with all Residents mental health provider regarding major life events.	05/25/2023

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	individuals in the facility would otherwise be endangered. An interview was conducted with the ED (Executive Director) on 4/28/23 at 10:25 a.m. She indicated Resident F was admitted to their facility from a psychiatric hospital. When she first arrived, "she cried and cried," and was very unhappy. She ended up "getting married" to Resident B in August, 2022. She stated, "I was kind of against it, but staff were insistent," saying it would be good for her, make her happy. All of the other residents dressed up for the wedding. After marrying Resident B, "it was a nightmare." Resident F would tell staff not to look at her husband, and tell her husband not to take the medications attempting to be administered by staff, and say to staff, "Why are you looking at him?" She would transfer him out of bed on her own. Staff educated her about these things "for months," but she went "out of control." They ended up giving her a 30 day discharge notice. Resident F had a guardian, Guardian 4, who was court appointed. At first, Guardian 4 did not want her transferred to the facility to which she ended up discharging, so they gave the 30 day notice and continued to look for other locations. Eventually, Guardian 4 decided that facility was okay. The other facility came to pick her up, and they had to call the police to be involved with getting her to leave the facility, which took 2 hours. She sat in a chair in the dining room, and staff had to persuade her to leave, convince her that she could visit. She ended up standing up and walking to the door. Resident F and Resident B hugged goodbye and she left. In the meantime, Resident F had contacted lawyers, the media, and the ombudsman, who was involved, but didn't know what to do. Resident F's "husband," Resident B, was still residing in the facility.		· how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; An audit of all Resident major life events occurring within the last 3 months with mental health notification was completed on 5/22, no new deficiencies found. · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Administrator or designee will audit mental health notifications of all new major life event occurrences of all Residents Monday-Friday x 6months. · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Administrator or designee will bring the findings of the audits to QAPI monthly for 6 months. After 6 months, the committee will decide the new for further monitoring and/or frequency of. · by what date the systemic changes for each deficiency will be completed.	

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	Resident B would say things about Resident F like she needed help, but then get on the phone with her and say he was going to her new facility. Resident F continued to call the facility "nonstop, all day, like 50 times a day." They hadn't spoken with the new facility about the situation since she discharged there. There was not currently a plan for visits. Resident F also wanted to cancel her guardianship with Guardian 4. When Resident F left, they washed their hands of her. The Ombudsman was the only one trying to bridge the gap. Resident B did not currently speak about Resident F and didn't always take her phone calls and would say to tell her he was asleep, when he would be present in activities. Resident B was transferred out to a psychiatric hospital a couple of weeks ago due to his behaviors, getting aggressive physically and verbally with the DON (Director of Nursing.) Resident B hit the DON with a Bible. The ED did not think the increased behaviors had anything to do with Resident F. Resident B was at the psychiatric hospital for 2 weeks and was also refusing medications before he left, which led to the increased behaviors. Resident B and Resident F were both seen by Psychologist 2 for psychological services regularly in the facility. The SSD (Social Services Director) was heavily involved and in close contact with Guardian 4. The 3/10/22 care plan for Resident F indicted the focus was her long history of mental illness. She had 9 psychiatric admissions to a hospital. She utilized antianxiety medication, antipsychotic medications, and antidepressant medications. Symptoms of her diagnoses included anxiety, panic, wanting 911 called, wanting to go to the hospital, suicidal ideation, 1 suicidal attempt, running into traffic, insomnia, and reports of feeling down, depressed, and hopeless. She had a		- May 25th, 2023	

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	history of PTSD (post traumatic stress disorder,) a history of homelessness, and a history of not taking her medications. The goals were for her to remain safe in the environment with no attempts of self-harm; would have 2 or less episodes a week of depressed mood and anxious mood; would sleep 6-8 hours a night; and for mood distress to be calmed upon staff interventions. Interventions included to respect her privacy; encourage her to spend time out of her room; ensure her room was dark and quiet to promote sleep; to provide reassurance and express care; to redirect her by offering a snack or something to drink; to redirect her by tuning in soothing music per her preference; to remind her to get grounded by taking slow deep breaths and acknowledging that she was safe; and to use a calm approach. This care plan did not reference an intervention to consult with her psychiatrist, clinical social worker, or psychologist for further evaluation. The 11/26/22, 1:32 p.m. behavior note read, "Her roommate [Resident B] attempted to go outside to smoke and because she could not go outside with him she said that he won't be smoking anymore. She was told she cannot say whether or not he can smoke." The 12/5/22, 9:26 a.m. social services note read, "Resident and significant other [Resident B] where separated into separate rooms today per IDT [interdisciplinary team] and guardians' decision due to resident trying to provide care for him. Social Services will monitor for psychosocial distress." The 12/5/22, 11:00 a.m. progress note read, "Pt. [Patient] is tearful and upset due to recent separation from roommate [pt. considers this pt. her husband] pt. has been calling legal services			

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	and reporting the room change as she has stated that they said that they have the legal right to be in the same room. However pt. and her old roommate are not legally married to each other. Pt. states that she wants her and the other pt. to go to another facility where they can have a room together. The other pt. states that she has been calling his daughter multiple times this morning and is worried that she will cause more problems. Pt. said that he cares about the other individual but is okay being in another room and just wants things to calm down. He has been telling pt. that she needs to calm down and that her behavior is not helping the situation." The 12/6/22, 9:58 p.m. progress note read, "Resident cont [continues] to go in room [number of room] with [name of Resident B] cont to cuss staff out will not come out of room tried to redirect several times resident refused, stating she has the right to be with her husband." The 12/8/22, 12:33 p.m. IDT note read, "DON, SSD, Admin [Administrator] spoke with Resident and her male partner regarding their ongoing continued concerns regarding their new room change. Residents notified that both of their guardians prefer them to not go back into a room together due to safety concerns. Everyone in the meeting agreed to a schedule of 2 nights a week that the Residents spend the night together. Residents agreed and are in agreeance. No new concerns. MD and guardians notified." The 12/8/22, 8:19 p.m. progress note read, "Resident cont to be noncompliant with arrangement, resident [name of Resident B] was in bed and cont trying to go in room while he is sleep, cont to cuss staff out, going in other residents room refusing to come out trying to talk			

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	to other men about her problems, DON was notified of behavior, cont to mont [monitor] resident to stay out of residents room." The 12/24/22, 10:57 a.m. behavior note read, "The resident's man attempted to run me over in her doorway and it got her worked up. To deescalate the situation I asked her to go lay down in her room so I can get him away from the door to calm him and her down. Instead resident tried pushing me out the way and I had to move her hands down so she would stop trying to push me. I then closed to [sic] the door to once again try to deescalate the situation but she kept opening it. Finally I was able to get the man to his room and it helped calm down both of the parties. The DON was made aware, will continue to monitor resident." The 12/27/22, 12:20 p.m. Social Services Note read, "Late Entry: Note Text: Resident had an incident with a staff member. MD, Guardian made aware." The 1/1/23, 10:18 p.m. progress note read, "Resident in room [room number] in bed with resident [number assigned to Resident B] instruction was given that it was inappropriate to be in the room when another male resident is in there she stated 'I have permission from DON." The 1/2/23, 1:51 p.m. progress note read, "resident was [sic] hallway yelling at staff about not been able to go into significant other room r/t [related to] staff providing patient care." The 1/3/23, 6:07 progress note read, "Resident was picked up per ambulance to go to [name of psychiatric hospital] for eval [evaluation] and tx [treatment] no problems noted."			

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	The 1/12/23, 9:30 a.m. progress note read, "Resident given a 30 day notice due to continued behaviors of obsessiveness of male partner. MD, guardian, and Resident notified. Social services witness. Resident states she's not leaving without her husband." An interview was conducted with the SSD on 4/28/23 at 12:23 p.m. She indicated she worked in the facility for 2 years. Resident F and Resident B came to them one day and informed them they wanted to get married. Resident B did not want to legally marry Resident F due to financial reasons. The SSD and Activity Director spoke with both residents about it and thought it was a good idea at the time, because Resident F was previously crying from morning to night, but after meeting Resident B, she "flipped" and would do activities, set the table, watch movies, get snacks, and was very pleasant. Right after the wedding, within a week, Resident F became possessive and would make Resident B refuse his medications, because she thought they were making him tired. Resident F was jealous if young CNAs (Certified Nursing Assistants) took care of him. Resident B would buy snacks for other residents from the vending machine, and Resident F would get "pissed" about it. Resident B would stand his ground, but Resident F was mad about it. They did not discuss the wedding with Psychologist 2 before planning their wedding. The SSD had never done a wedding before at the facility, but the Activity Director had. The SSD discussed the wedding with Guardian 4, who brought Resident F her dress, jewelry, and shoes. Resident B's guardian brought the ring and tuxedo. Both of their guardians came to the wedding. Resident F referred to herself as Resident B's wife. Resident F and Resident B began sharing a room after the wedding. After that, care and medications started			

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	being refused. Resident B informed the SSD that he wanted a separate room because of Resident F's crying and attempts to sit on the bed with him while he was asleep. The facility spoke with both residents and their guardians about this, and it was decided they would move into separate rooms. After the separation, Resident F would often stand outside of Resident B's door, so staff came up with specific visiting times, but Resident F wouldn't follow the schedule. She wanted to stay every night. Resident B's guardian, his daughter, was very involved and concerned about her father. Resident F was discharged to a psychiatric hospital due to the obsessive crying, which worked up Resident B, "causing a big problem." When Resident F returned to the facility from the psychiatric hospital, "I don't think she was better." Resident F would sit in a chair in her doorway and make Resident B sit next to her and eat lunch. Resident F being around Resident B was making the situation worse. The SSD stated, "I don't think we should have done the wedding." They thought they were doing a good deed, but as soon as it happened, they regretted it. Resident F still called the facility phone 100 times a day. Resident B's guardian had to block Resident F from calling her phone. Resident B had a cell phone, but refused to give Resident F his phone number. Resident B would speak to Resident F on the facility phone sometimes, but talking to her got him "excited and upset." When he didn't speak with Resident F, he was fine. Resident B's guardian informed the SSD if Resident F continued to call, she wanted to cut all ties. Resident B's guardian currently did not want visits between Resident B and Resident F. The SSD last spoke with Resident B's guardian maybe a few weeks ago and was informed even though Resident B's guardian had Resident F's number blocked, she still received the voicemails. The			

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	SSD stated, "This was my first and probably last wedding." Guardian 4 had to block Resident F from calling too. The SSD stated, "We all regret it." Psychologist 2 didn't think the wedding ever should have happened. The 1/19/23 Discharge MDS (Minimum Data Set) assessment indicated Resident F had a BIMS (brief interview for mental status) score of 15, indicating she was cognitively intact. An interview was conducted with Resident F by telephone at her new facility on 4/28/23 at 12:58 p.m. She indicated her husband was at her previous facility and she'd like to return there. Her previous facility said she wasn't letting her husband receive care, but it wasn't true. She hadn't adjusted to her new facility "at all." She cried all the time and really missed her husband. She couldn't kiss him. He couldn't comfort her. She could only talk on the phone. They'd been married for 8 months, but the ED at her previous facility kept saying they weren't really married. She stated, "I have a ring. We had a ceremony, a picture, my wedding dress, everything to prove it. We need to live together." She couldn't get into activities like bingo at her new facility, because she wasn't interested without Resident B there. She'd lost sleep and would cry herself to sleep, then wake up crying, because she'd realize Resident B was not there with her. An interview was conducted with Guardian 4 on 4/28/23 at 2:35 p.m. She indicated she was still Resident F's guardian. She tried to help Resident F understand how she was interfering in Resident B's care at the facility. Resident F couldn't really process the marriage was not legal. She felt it was best for Resident F to discharge for continuity of care. Resident F had been "on a vengeance"			

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	against the facility since she was discharged. Resident F had called "every attorney in town." Guardian 4 and her attorney saw Resident F last week and explained everything to her, but Resident F did not seem ready to process what was going on. Resident F was "hyperfocused on her relationship" with Resident B. Guardian 4 also had conversations with Resident B's guardian. Resident F was putting Resident B in unsafe situations by being in bed with him, laying across him, and exploiting him financially. Resident F wanted to appeal her discharge from the facility, but after Guardian 4 spoke with her legal director, they withdrew the request for appeal. Resident F was not happy about that, but they had no grounds to stand on because Resident F was "absolutely impeding his care." Guardian 4 discussed the wedding with the facility beforehand, supplied Resident F's dress and some other things. Guardian 4 spoke with Psychologist 2, who informed her neither she nor Physician 3, Resident F's primary care physician, agreed with the wedding nor were they consulted prior. Psychologist 2 reached out to Guardian 4 to inform her she was leaving the facility along with Physician 3. Guardian 4 informed her it was due to the facility not consulting with her while both Resident F and Resident B were under her care. Psychologist 2 was very upset about it all. Guardian 4 indicated it was her first experience with a wedding, "definitely a learning lesson." Guardian 4 was unaware Resident F had such traumatic relationships in the past or that Resident F's sister was recently released from prison for murdering her own husband. Resident F grew up in a violent household. An interview was conducted with Psychologist 2 on 5/1/23 at 11:08 a.m. She indicated Resident F was still her patient while residing in her new			

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	skilled nursing facility. No one consulted with her on the wedding. She was not consulted on anything psychiatric related at the facility. She would find out after an event and would be like, "Oh my God. I can't believe you did this." The horse was already out of the barn by the time she would find out. When she learned about the wedding afterwards, she informed the SSD it was "problematic to lie to residents with impairments." There was some question as to the possibility of whether Resident F was borderline developmentally disabled, as there was some suggestion in the paperwork. Both Resident F and Resident B had significant psychiatric issues. The facility went ahead with the wedding and then "of course" there were complications afterwards, like sharing a room. Psychologist 2 was not consulted on those things. Her recommendations were ignored. The ED questioned Psychologist 2 how she would know certain things, and Psychologist 2 informed her she would know through her years of experience and education. This was part of the reason she was no longer providing services at the facility. The health and safety of her patients was her top priority. Keeping facilities out of trouble was secondary. Psychologist 2 tended to be vocal when she thought things weren't handled appropriately at the facility. Resident B understood they weren't really married, but was complicit with the wedding. Resident B didn't want a real marriage due to financial concerns. Resident F didn't understand this early on. Psychologist 2 spoke with Resident F and explained they weren't married. Psychologist 2 was not happy "that they lied to her in first place." Guardian 4 explained it to Resident F too. Psychologist 2 thought part of Resident F not understanding was that she didn't want to believe the marriage wasn't real. This was still a part of Resident F's issues. "This is why you don't lie to			

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	patients." There was no way to predict how they would react. It generally didn't end well with residents with serious mental issues. There was going to be ongoing behavioral issues no matter where Resident F ended up. "[Name of facility] created the problem in the first place." It wasn't too long after the wedding that Psychologist 2 found out about it. There were a lot of concerns about managing them as a couple afterwards. Psychologist 2 wasn't consulted in advance of planning the wedding, but perhaps was made aware a day or 2 before it happened. Psychologist 2 probably didn't find out about sharing a room until after they were already living together. Since the current ED began working at the facility, Psychologist 2 hadn't been consulted on a lot of things. At first, Psychologist 2 was consulted, then when she started to disagree with the ED, she began not being consulted. "I would volunteer my advice." There was a situation where they had been sharing a room and Resident F was becoming verbally aggressive with staff when they would provide care to Resident B. Resident B was flirtatious and inappropriate with staff. Had someone asked Psychologist 2 in advance, she'd have said they shouldn't get married and shouldn't share a room. It's okay to be a couple in the facility. Once they shared a room and had the door shut, no one knew what was being discussed or happening. Psychologist 2 "worked my tail off to get both of them stable." Then 2 chronically ill people who were prone to wanting to stop their medications, began telling each other just that. It became an issue with both of them. Then after not taking their medications, Resident F became more jealous, and Resident B became more flirtatious with staff, which was why they shouldn't have been in the same room in the first place. The facility separated them into separate rooms, but still tried to accommodate			

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	them spending time being alone together, but that didn't work out, which all stemmed from the initial lie of being married. Resident F was going to get a roommate, and "I was like, this is insane. These 2 can't have sex in front of the roommate." This was when the ED questioned how Psychologist 2 knew this was going to be a problem. "It was all so ridiculous." Once in separate rooms, Resident F began to continue her anger and cycle. She blew up and ultimately was sent to a psychiatric hospital and discharged. "None of this would have happened if they didn't do the marriage in the first place." Psychologist 2 spoke with Physician 3 about it and they decided they just needed to get Resident F out of the facility. "They were going to the psyche hospital over ridiculous situations manufactured by the building." Psychologist 2 stopped providing services to the facility the same time Physician 3 stopped. March, 2023 was Psychologist 2's last month providing services to the facility. The wedding has had an effect on Resident F "absolutely." The majority of Resident F's time at her current facility was spent on the phone either calling her previous facility, the psychiatric hospital while Resident B was there, the ombudsman, the Indiana Department of Health, or her guardian. "She's perseverative on these topics." Every time Psychologist 2 visited Resident F's new facility, she wanted to discuss this. "She's distraught." Resident F would tell everyone she was being kept from her husband, with them not knowing she's not legally married, all stemming from this lie that she and Resident B were married. It was hard to pan out how much was cognitive versus psychiatric, but most was due to psychiatric illness, and "we knew this." All Psychologist 2 knew was she had 2 patients who were looking the best they'd ever looked, since she began providing care to them since their admissions. It was hard to get them stable. "After			

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	the wedding, I had 2 unstable patients." Resident F was someone who used to spend time socializing with other residents, and this type of perseverative behavior was not a part of her every day functioning prior. "The wedding was a significant contributor to psychiatric decline for both residents," regarding making poor choices in medication compliance, which contributed to their overall health and well-being. "This is a progressive journey of effect." The ED did not have the education and training to understand psychiatric patients were complex and their underlying character structure that sets the base for how they perceive and interact with the world. It was part of their behavioral reactions to things. Psychologist 2 did not need to know everything about someone's prior history, if she'd observed them, to know that if you lie to them about a major thing, it's going to snowball and there was going to be repercussions, and that's "what we're seeing now." As far as Resident B, anytime you had a chronically mentally ill patient who went off their medications, it took higher doses of medications to stabilize them. Physician 2 was uncertain at the moment, exactly what medication Resident B was currently taking, but he was on a decent amount of medication before. There was greater risk for side effects on higher doses. Psychologist 2 informed the facility they were making decisions that contributed to residents not taking their medications. Then they would get sent out, come back, and they'd have to start over. She hoped Resident B was doing better and stable, but that was the risk, a risk that didn't need to be taken. "They were perfectly content boyfriend and girlfriend." She was unsure where the idea for the wedding came from, but "it probably was [name of Resident F's] idea." Residents with significant psychiatric illness "have all kinds of ideas we don't need to implement. What problem were we			

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	solving by having them get married? We did nothing but create problems." If the facility had consulted with her prior to planning the wedding, "I would have said no. Let's not do that." There's no point in putting them at risk for further psychiatric problems. Even if it was Resident F's idea, they could have managed her by speaking with her about the complications of marriage in general without creating all the problems that resulted. It would have been easier to manage without introducing the concept of a legal marriage. "It's messy all around." There was no reason to do it. They could have had a party for everyone, a summer fling, just because it was August and the weather was nice. "That would have been my advice. I've always maintained my first priority is the patient. Secondary is the facility out of trouble, but that involves the facility listening to me. This was a huge thing, and I was unhappy with how it all happened." 2. The clinical record for Resident B was reviewed on 4/28/23 at 10:50 a.m. The Resident's diagnosis included, but was not limited to, schizophrenia and hypertension. A PASRR (Preadmission Screening and Resident Review) Level I Screen, dated 8/31/21, indicated Resident B had a neurocognitive disorder which was so severe that he could not live in the community. He had a history of serious difficulty interacting with others, required assistance thinking through or completing tasks which he should be capable of completing. He had a history of needing metal health crisis services. A care plan, dated 10/21/21, indicated he required the use of psychoactive medications related to paranoid schizophrenia. He received a mood stabilizer, antipsychotic and antidepressant			

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	medication. The goal was for him to be maintained on the lowest therapeutic dose of medications and to engage in counseling/ behavioral programing to facilitate maximum functioning and wellbeing and be free of adverse effects of medications. The interventions, initiated 10/12/21, included, but were not limited to, monitor for changes in cognition, mood, and/or delusions, conduct the medication management regimen as prescribed, report any changes or complications to physician, and to offer behavioral counseling and interventions to help him cope with mood and behavioral distress or dysfunction. A care plan, dated 11/1/21, indicated he had repetitive questions and verbalizations. The goal was for him to experience fewer episodes of repetitive questions and anxious verbalizations. The interventions, dated 11/1/21, were to allow him to express his feelings, establish a caring relationship with him, relay accurate information to him and to try to determine reason for reoccupation with questions and verbalizations. A care plan, dated 11/1/21, indicated he had inappropriate sexual behaviors toward staff and peers. The goal was for him to accept redirection form staff. The interventions included, but were not limited to, praise all efforts to comply, dated 11/1/21 and explain to him that behavior is inappropriate and allow him to vent, when necessary, dated 4/25/23. A progress note, dated 8/23/22 at 2:59 a.m., indicated he was acclimating well to room and married life. He smiled often and was jovial during conversations. A Care Conference Note, dated 10/18/22 at 1:18 p.m., indicated Resident B had attended his care			

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	plan meeting with the IDT (Interdisciplinary Team). He was stable at that time. He required total care with some ADLs (Acts of Daily Living). He was incontinent of bowel and bladder and was taking psychotropic medications. A progress note, dated 11/9/22 at 7:26 p.m., indicated Resident B spit his medication out of his mouth while using profanity. A progress note, dated 11/10/22 at 7:28 p.m., indicated he had refused his meds. The DON (Director of Nursing), physician and his relative had been notified. A progress note, dated 11/11/22 at 8:19 p.m., indicated he had refused his night medications because the medications give him a bad stomachache. A progress note, dated 11/15/22 at 6:50 p.m., indicated the DON, physician and daughter had been informed of Resident B's medication refusals due to hit hurting his stomach and not thinking he was getting the right dose of medications. A Psychotherapy/ Behavior Therapy Progress Note, dated 11/18/22, indicated Resident B was refusing his Zyprexa (anti-psychotic medication) and Depakote (mood stabilizing medication) which he had been taking for two to three months. He was refusing due to believing the Depakote makes him depressed and the Zyprexa "makes my head explode: His affect was agitated and expressive. His speech was rapid and pressured. His Zyprexa was decreased to 7.5 mg (milligram) each am, and the pm dose was discontinued. The Depakote was decreased to 500 mg every evening. Resident B was in agreement with the changes.			

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	A progress note, dated 11/21/22 at 10:53 a.m., indicated he refused his medications due to stating they gave him a bad stomach and pains. A Social services note, dated 12/5/22 at 9:31 a.m., indicated Resident B and significant other (Resident F) were separated into separate rooms today per IDT and Guardians decision due to significant other trying to provide care for him. An IDT note, dated 12/5/22, indicated Resident B had come into the Administrators office upset that he was moved out of the room with his female roommate. Resident B was very upset. An IDT note, dated 12/8/22, indicated the DON, SSD (Social Services Director), and ED (Executive Director) met with Resident B and significant other regarding their ongoing continued concerns about their new room change. Residents were notified that both of their guardians preferred then to not go back into a room together due to safety concerns. A Behavior Note, dated 12/10/22 at 10:21 p.m., indicated that Resident B and his significant other were found in Resident B's room together. His significant other had been told it was okay for her say goodnight to Resident B. Resident B became upset and threatened to have someone kill the writer. Resident B also became rude with his significant other. A Health Status Note, dated 12/13/22 at 7:44 a.m., indicated he refused his morning medications. A Behavior Note, dated 12/24/22 at 10:40 a.m., indicated Resident B had been asked to take his medication and began cursing and went in the other directions. he was again asked to take his			

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	155807	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RURAL HEALTH CARE CENTER	1747 N RURAL ST INDIANAPOLIS, IN 46218

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	medications because of his blood pressure issues and because there was Tylenol in his medications, which he had asked for, He continued to refuse his medications. He was asked to put on a mask, and he began going in the direction of his significant others room and cursing. The nurse was in between Resident B and his significant others doorway attempting to redirect Resident B when he continued forward in his electric wheelchair and ran into the nurse with the wheelchair. His significant other came to the door and attempted to push the nurse out of the way and was angry and yelling. The nurse attempted to de-escalate the situation and shut the door. Resident B continued to curse and attempted to throw his Bible at the nurse. He was redirected back to his room and laid down so that he could calm down. An eMAR (electronic Medication Administration Record) note, dated 12/29/22 10:23 a.m., indicated he had refused his medications and his family had been made aware.A Health Status Note, dated 12/31/22 at 4:46 p.m., indicated he had refused his medications, as he did daily, and that all appropriated persons had been informed.A Health Status Note, dated 1/4/23 at 9:32 a.m., indicated he was being inappropriate and sexual toward the staff.A Quarterly MDS (Minimum Data Set) Assessment, completed 1/7/23, indicated he was cognitively intact and had no behaviors. He needed extensive assistance on 1 staff member for bed mobility and toileting, extensive assistance of 2 staff members to			

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	transfer, and total assistance of 1 staff member for bathing.A Psychotherapy/ Behavior Therapy Progress Note dated 1/13/23 indicated he had signs and symptoms of mania and psychosis. Staff was reporting intermittent poor compliance in the mornings. Resident B denied need for medications. His speech was pressured, thoughts were tangential and delusional. His Zyprexa was adjusted to 10 mg every morning ad 10 mg every evening.A Health Status Note, dated 1/17/23 at 1:52 p.m., indicated the IDT team and Resident B attended a meeting. Resident B had no concerns or complaints. He rambles on and on about nothing in particular. He attends activities of choice and needs assist with all ADL care due to his limited mobility.A Psychotherapy/ Behavior Therapy Progress Note, dated 1/20/23, indicated Resident B was being seen for signs and symptoms of mania and psychosis. He had continued to make inappropriate comments to female staff. His speech was pressured and thoughts tangential. His Depakote was increased to 1000mg each evening. An eMAR progress note, dated 2/8/23 at 9:09 a.m., indicated Resident B refused him medications and when redirection was attempted, he knocked the medication over. An eMAR progress note, dated 2/14/23 at 10:03 a.m., indicated Resident B had stated			

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	he did not need his medications and would not take them. A Health Status Note, dated 2/17/23 at 9:03 a.m., indicated Resident B had been attempting to hit another resident all morning and had threw his phone at the other resident. He was being argumentative and non-articulate. Resident B was discharged to an inpatient psychiatric hospital on 2/17/23 and remained in the psychiatric hospital until 3/9/23.A Health Status Note, dated 3/9/23 at 4:17 p.m., indicated Resident B was readmitted to facility. A Psychiatric Progress Note, dated 4/10/23, indicated Resident B was seen for a routine follow up visit for management of his psychiatric disorder. He had good eye contact during the examination and appeared calm and cooperative. His mood was anxious, and he had moderate impairment of judgement and insight. His speech was rapid and talkative. On 4/29/23 at 11:45 a.m., Resident B was observed in the entry way of the facility talking on the public phone. During an interview on 4/29/23 at 1:01 p.m., Resident B indicated he had gotten married to Resident F at the facility. Resident F had been moved to another facility. Resident B had spoken to Resident F before lunch. Resident B reported his daughter had gotten Guardianship over him illegally and that the facility did not know how to treat Christians and that he was a Christian. The ED was			

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	satanical and addressed problems in an evil way. His speech was garbled and hard to understand.During an interview on 4/28/23 at 1:35 p.m., the SSD indicated Resident B had experienced a substantial change mentally. The change had started around the time he went to the inpatient psychiatric hospital. He continued to speak to Resident F on the phone and after they talk Resident B would get "worked up" about his guardianship and that he stays upset for a while. The SSD believed that Resident F was trying to make Resident B believe his daughter was fraudulent in obtaining guardianship. During an interview on 4/28/23 at 3:54 p.m., GD (Guardian) 5 indicated she was Resident B's Court Appointed Guardian. Resident F had come to the facility in 2022 and had started to like Resident B. GD 5 felt that the relationship started because Resident B was trying to help Resident F by trying to cheer her up after she came to the facility. Resident B would buy Resident F things from the vending machine and order food for her. Resident B had a history of being taken advantage of by other women in his life. Resident B and Resident F had started to talk about marriage, but Resident B and Guardian 5 had not wanted them to get "legally" married. The facility had suggested a "pretend" wedding. GD 5 had agreed to			

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	the pretend wedding because she thought it would make Resident B happy. After the "pretend" wedding Resident F began to interfere with Resident B's care and to tell him what to do. Resident F would try to get the staff of the facility in trouble when they cared for Resident B. Resident F had begun mentioning that she and Resident B could move out to an apartment or assisted living. GD 5 felt that Resident B needed to remain in long term care for his physical and mental needs to be met. Resident B and Resident F had shared a room after the "pretend" wedding, but Resident F began trying to take care of Resident B. Resident F had tried to change Resident B and had gotten BM (Bowel Movement) all over Resident B, it was at that point that the facility wanted to place them in separate rooms. GD 5 believed that Resident F added stress to Resident B, because she wouldn't leave him alone. GD 5 could not visit without Resident F being present. GD 5 felt that Resident F agitated Resident B in some ways because Resident B was trying to meet Resident F's expectations. When Resident F was moved to a different facility it had upset Resident B. Resident B talked with Resident F often on the phone and had asked to visit Resident F, but had not asked in a while. Resident B had expressed that there was something "not quite right" about Resident F, but seemed to			

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	enjoy the attention he received from Resident F.The Behavior Management policy was provided by the SSD on 4/28/23 at 1:34 p.m. It read, "Residents in long term care facilities may exhibit puzzling and troublesome behaviors. The behaviors may become difficult to handle for staff and may involve other residents. Sometimes, a resident becomes dangerous to himself or abusive to others and may keep others from enjoying a quiet and peaceful place. The staff should assess the behaviors and document in a quantitative manner, to assist in determining whether the behaviors can be addressed in the facility or whether outside assistance may be needed...Handling Difficult Behaviors Internally...Reorient to time, place and person when receptive. Confusion may manifest in the form of aggression or other behaviors at times."This Federal Tag relates to Complaints IN00403448.3.1-37(a)			