| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING 00<br>B. WING | 02/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| SENIOR LIVING WINDERMERE, LLC | 9745 OLYMPIA DR<br>FISHERS, IN 46038 |

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| R 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00400160, IN00399683, IN00394029, IN00376205, and IN00374370.<br><br>Complaint IN00400160- Substantiated. State Residential Findings are cited at R349 and R357.<br>Complaint IN00399683 - Substantiated. State Residential Findings are cited at R121.<br>Complaint IN00394029 - Substantiated. State Residential Findings are cited at R349.<br>Complaint IN00376205 - Substantiated. State Residential Findings are cited at R240.<br>Complaint IN00374370 - Substantiated. State Residential Findings are cited at R240.<br><br>Survey Dates: February 2 and 3, 2023.<br><br>Facility Number: 002999<br><br>Residential: 79<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on February 7, 2023 | R 0000 | This Plan of Correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.<br>*Senior Living Windemere 002999*<br><br>**R 121 IN00399683** Personnel - Noncompliance<br>1. Immediate actions taken for employees identified.<br>a. List created of staff who are not in compliance and a TB clinic will be established for all new or current staff on or before 3/15/23.<br>b. LEA 5 on 1/16/23, CNA 6 on 1/12/23, and CNA 7 on 12/15/22. Restart TB Screening process.<br>2. Measures/systems put in place<br>a. Weekly Reporting from onboarding to monitor employee tracking (home office) ongoing | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Krystle Jacquin | RCA | 02/21/2023 |

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| | | | 3. How will the corrective action be monitored.<br>a. Testing will be arranged/coordinated by community designee Wellness Director & Property Administrator<br>4. Due Dates<br>3/1/23<br><br>**R 240 IN00374370, IN00376205**<br>Health Services<br>5. Immediate actions taken for those residents identified.<br>a. Chart/PCC audit with Senior Clinical Specialist Georgia Cruz 2/6 & 2/7 and ongoing weekly.<br>b. Chart/PCC audit/integration 2/6, 2/7, 2/8, 2/14, 2/15 and ongoing weekly.<br>c. 2/8 In-service with Paradigm Health to set expectations as far as documentation needed onsite, in clinical records, and communication binders. Paradigm Social worker onsite 2/13<br>d. Medication Administration Inservice 2/20 @2pm & QMA Scope of practice inservice 2/20 @2pm<br>e. Assignment sheet/CNA task sheets in-service 2/8<br><br>6. Measures/systems put in place<br>a. Assignment sheet/CNA task sheets in-service 2/8<br>b. Hired Charge LPN nurse to own and oversee delivery of | |

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| | | | care/medication management M-F 8-5pm. *Start date 2/15*<br>7. How will the corrective action be monitored<br>a. Hired Charge LPN nurse to own and oversee delivery of care/medication management M-F 8-5pm. *Start date 2/15*<br>a. PCC integration for electronic charting CNA, QMA, and LPN duties/accountability 3/20/23<br>8. Due Dates<br>2/15, 3/20/23<br><br>**R 349 IN00400160, IN00394029**<br>Clinical Records<br>1. Immediate actions taken for those residents identified.<br>a. Request documentation from all 3rd parties providers for residents identified<br>b. 2/8 Inservice with Paradigm Health to set expectations as far as documentation needed onsite, in clinical record, and communication binders. Paradigm Social worker onsite 2/13<br>c. 2/8 Inservice with Powerback Rehab, Select Home Health, and Paradigm team on documentation need in clinical records detailing admission/service dates<br>d. “Secure” Records room identified, shelving, and shred bins ordered for organization 3/20/23<br>2. How the facility identified other residents.<br>a. Chart/PCC audit with | |

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| | | | additional LPN onsite/6 & 2/7 and ongoing weekly.<br>b. Chart/PCC audit/integration with additional LPN onsite 2/6, 2/7, 2/8, 2/14, 2/15 and ongoing weekly<br>c.<br>3. Measures/systems put in place.<br>a. 2/23 CSIG PointClickCare Implementation Clinical Training Session Move In E002041<br>b. 3/2 CSIG PointClickCare Implementation Clinical Training Session Care Delivery E002041<br>c. 3/6 CSIG PointClickCare Implementation Clinical Training Session Incident/External Facilities/Security E002041<br>d. Requested new SOP for End of Life care from Compliance Office 3/1<br>e.<br>4. How will the corrective action be monitored.<br>a. Hired Charge LPN nurse to own and oversee delivery of care/medication management M-F 8-5pm. *Start date 2/15*<br>b.<br>5. Due Dates<br>a. 3/6/23 | |
| R 0121<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(f)(1-4)<br>Personnel - Noncompliance<br>(f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, | | | |

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| | PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:<br>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.<br>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.<br>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.<br>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. | | | |
| | Based on interview and record review, the facility failed to ensure second step TB (tuberculin) skin tests were completed timely for 3 of 3 employees reviewed for TB testing. (LEA-Life Enrichment | R 0121 | **R 121 IN00399683** Personnel - Noncompliance<br>1. Immediate actions taken for employees identified. | 03/01/2023 |

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| | Assistant 5, CNA-Certified Nursing Assistant 6, and CNA 7)<br><br>Findings include:<br><br>On 2/3/23 at 1:45 p.m., the ED (Executive Director) provided the following hire dates for the following employees: LEA 5 on 1/16/23, CNA 6 on 1/12/23, and CNA 7 on 12/15/22.<br><br>The Resident/Employee Mantoux Testing forms were reviewed for LEA 5, CNA 6, and CNA 7 on 2/3/23 at 1:00 p.m. LEA 5's form indicated she was given step one of a two step TB skin test on 1/2/23. The step two section of LEA 5's form was blank. CNA 6's form indicated she was given step one of a two step TB skin test on 1/2/23. The step two section of CNA 6's form was blank. CNA 7's form indicated she was given step one of a two step TB skin test on 12/5/22. The step two section of CNA 7's form was blank.<br><br>An interview was conducted with the Wellness Director on 2/3/23 at 1:08 p.m. She indicated she thought they were supposed to do the second step of a TB skin test 21 days after the first step and that there was a 2 week window for doing so. The Wellness Director reviewed their TB Infection Control Plan policy and indicated according to their policy, the second step of LEA 5's, CNA 6's, and CNA 7's TB skin tests should have been completed already and they had no verification of a previous tb skin test for the 3 employees in the previous 12 months.<br><br>The TB Infection Control Plan policy, last reviewed/updated on 11/11/22, was provided by the ED on 2/2/23 at 10:57 a.m. It read, "Testing is arranged by Onboarding or Community Designee.<br>a. Test method is either TST [Tuberculin Skin | | a. List created of staff who are not in compliance and a TB clinic will be established for all new or current staff on or before 3/15/23.<br>b. LEA 5 on 1/16/23, CNA 6 on 1/12/23, and CNA 7 on 12/15/22. Restart TB Screening process.<br>2. Measures/systems put in place<br>a. Weekly Reporting from onboarding to monitor employee tracking (home office) ongoing<br>3. How will the corrective action be monitored.<br>a. Testing will be arranged/coordinated by community designee Wellness Director & Property Administrator<br>4. Due Dates<br>3/1/23 | |

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| | Test] or BAMT [Blood Assay M. Tuberculosis]: i. Tuberculin skin test (TST), using the Mantoux method: 1. Two-step is required for new employees. The second step-test shall be initiated seven (7) to twenty-one (21) days after the first test. 2. The baseline (preplacement) TST shall count as the second-step TST if the employee provided medical documentation of a one-step TST interpreted as negative within one (1) year prior to initial testing at the time of initial employment/start."<br><br>This Residential Tag relates to Complaints IN00399683. | | | |
| R 0240<br><br>Bldg. 00 | 410 IAC 16.2-5-4(d)<br>Health Services - Deficiency<br>(d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.<br>Based on interview and record review, the facility failed to administer medications as ordered for 4 of 4 residents reviewed for medications, and to provide physical and occupational (PT/OT) services timely for 1 of 3 residents reviewed for falls. (Residents B, D, G, and P)<br><br>Findings include:<br><br>1. The clinical record for Resident B was reviewed on 2/2/23 at 1:30 p.m. The diagnosis for Resident B included, but was not limited to, multiple sclerosis. Resident B's admission date to the facility was on 3/10/22 and she discharged on 11/21/22.<br><br>A physician order dated 3/15/22 indicated Resident B was to receive 2 tablets of 20 milligrams of methylphenidate daily. | R 0240 | **R 240 IN00374370, IN00376205**<br>Health Services<br>1. Immediate actions taken for those residents identified.<br>a. Chart/PCC audit with Senior Clinical Specialist Georgia Cruz 2/6 & 2/7 and ongoing weekly.<br>b. Chart/PCC audit/integration 2/6, 2/7, 2/8, 2/14, 2/15 and ongoing weekly.<br>c. 2/8 In-service with Paradigm Health to set expectations as far as documentation needed onsite, in clinical records, and communication binders. Paradigm Social worker onsite 2/13<br>d. Medication Administration Inservice 2/20 @2pm & QMA | 03/20/2023 |

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| | A physician order dated 3/15/22 indicated Resident B was to receive 2 tablets of 5 milligrams of aminpyridine twice a day.<br><br>The May 2022 Medication Administration Record (MAR) indicated the following days Resident B had not received the 2 tablets of 20 milligrams of methylphenidate, because medication was not available: 5/13/22, 5/14/22, 5/15/22, 5/16/22, 5/17/22, and 5/18/22.<br><br>The June 2022 MAR indicated the following days Resident B had not received the 2 tablets of aminopyridine twice a day, because the medication was not available: 6/3/22 - a.m. dose, 6/4/22 a.m. and p.m. dose, 6/5/22 - a.m. and p.m. dose, 6/6/22 - p.m. dose. The MAR indicated the following days the 2 tablets of 20 milligrams of methylphenidate was not administered to the resident, because the medication was not available: 6/13/22 and 6/14/22.<br><br>2. The clinical record for Resident P was reviewed on 2/3/23 at 1:00 p.m. The diagnosis for Resident P included, but was not limited to, dementia.<br><br>A physician order dated 1/19/23 indicated Resident P was to receive 0.5 milligrams of lorazapam 3 times a day.<br><br>The January 2023 MAR indicated Resident P was to receive the 0.5 milligrams at midnight, 8:00 a.m., and 4:00 p.m. The following days the resident had not received her lorazapam 3 times a day:<br>1/20/23 - midnight, 8:00 a.m., 4:00 p.m.,<br>1/21/23 - midnight, 8:00 a.m., 4:00 p.m.,<br>1/22/23 - midnight, 8:00 a.m., 4:00 p.m.,<br>1//24/23 - midnight, 8:00 a.m., 4:00 p.m.,<br>1/25/23 - midnight, 8:00 a.m., 4:00 p.m.,<br>1/26/23 - midnight, 8:00 a.m., 4:00 p.m., and | | Scope of practice inservice 2/20 @2pm<br>e. Assignment sheet/CNA task sheets in-service 2/8<br><br>2. Measures/systems put in place<br>a. Assignment sheet/CNA task sheets in-service 2/8<br>b. Hired Charge LPN nurse to own and oversee delivery of care/medication management M-F 8-5pm. *Start date 2/15*<br>3. How will the corrective action be monitored<br>a. Hired Charge LPN nurse to own and oversee delivery of care/medication management M-F 8-5pm. *Start date 2/15*<br>a. PCC integration for electronic charting CNA, QMA, and LPN duties/accountability 3/20/23<br>4. Due Dates<br>2/15, 3/20/23 | |

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| | 1/27/23 - midnight dose.<br><br>3a. The clinical record for Resident D was reviewed on 2/2/23 at 1:00 p.m. The diagnosis for Resident D included, but was not limited to, Parkinson's Disease. Resident D's admission date to the facility was on 3/10/22, and he discharged on 11/21/22.<br><br>A physician order dated 11/29/21 indicated Resident D was to receive 100 milligrams of sertraline daily.<br><br>The November 2022 MAR indicated the following days Resident D did not receive his 100 milligrams of sertraline as ordered:<br><br>11/2/22 - documented as medication was not available,<br>11/3/22 - documented as medication was not available,<br>11/4//22 - documented as medication not available,<br>11/5/22 - documented as "med not in",<br>11/6/22 - no documentation as administered,<br>11/7/22 - documentation as medication was not available,<br>11/8/22 - documented as "refill"<br><br>An interview was conducted with the Wellness Director on 2/3/23 at 3:10 p.m. The facility just switched over to a new pharmacy. She was unable to determine why the medications were not available to administer for Resident B, D and P.<br><br>3b. A Nurse Practitioner note for Resident D dated 4/3/22 indicated "...PT [patient] was seen in his room for the visit today, PT was being seen for a f/u [follow up] on a fall with no significant injury, Pt has a small abrasion to his head, Pt is still waiting to start PT/OT due to waiting for PCP | | | |

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| | [Primary Care Physician] to send...Fall event...Pt would benefit from PT/OT, pending on PCP referral..."<br><br>A Medical Release dated 5/23/22 indicated Resident D would like to participate in rehab for strength and endurance.<br><br>A physician order dated 6/17/22 indicate Resident D was to start physical, occupational and speech therapy.<br><br>An interview was conducted with the Executive Director on 2/3/23 at 10:49 a.m. She indicated Resident D started therapy on 6/20/22. She could not provide any documentation on why there was a delay with Resident D receiving PT/OT services after falling. 4. The clinical record for Resident G was reviewed on 2/3/23 at 12:21 p.m. His diagnoses included, but were not limited to, type 2 diabetes mellitus and GERD (gastro esophageal reflux disease.)<br><br>The 9/16/22 Level of Care Evaluation indicated Resident G required the following assistance with medications: storage, administration, and ordering and coordination between family and/or health care providers.<br><br>The physician's orders indicated the following: one 10 mg tablet of loratadine to be administered once daily, starting 9/17/21 and stopping 1/24/22; 2.5 mg of glipizide to be administered daily starting 9/27/21 and stopping 1/24/22; one 20 mg tablet of omaprazole to be administered once daily starting 11/16/21 and stopping 2/1/22; and paroxetine starting 9/17/21 and stopping 1/24/23.<br><br>The September, 2021 through January, 2022 MARs (medication administration records) | | | |

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| | indicated the loratadine was not administered as ordered on the following dates due to it being unavailable: 10/10/22, 10/18/22, 10/19/22, 10/20/22, 10/21/22, 10/22/22, and 10/23/22. The glipizide was not administered on the following dates due to it being unavailable: 1/12/22, 1/14/22, 1/15/22, 1/17/22, 1/18/22, 1/19/22, 1/20/22, 1/22/22, and 1/23/22. The omaprazole was not administered on the following dates due to it being unavailable: 11/19/21, 11/20/21, 11/21/21, 11/22/21, 11/23/21, 11/24/21, 11/25/21, 11/29/21, and 12/28/21. The paroxetine was not administered on the following dates due to it being unavailable: 1/18/22, 1/19/22, 1/20/22, 1/21/22, 1/22/22, and 1/23/22.<br><br>An interview was conducted with the Wellness Director on 2/3/23 at 3:05 p.m. She indicated she was unsure why Resident G's medications were unavailable for administration.<br><br>This Residential Tag relates to Complaints IN00374370 and IN00376205. | | | |
| R 0349<br><br>Bldg. 00 | 410 IAC 16.2-5-8.1(a)(1-4)<br>Clinical Records - Noncompliance<br>(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows:<br>(1) Complete.<br>(2) Accurately documented.<br>(3) Readily accessible.<br>(4) Systematically organized.<br>Based on interview and record review, the facility failed to include an updated POST (Physician's Orders for Scope of Treatment) form in a resident's clinical record to provide a complete medical chart for 1 of 3 residents reviewed for discharge and 1 | R 0349 | **R 349 IN00400160, IN00394029**<br>Clinical Records<br>1. Immediate actions taken for those residents identified.<br>a. Request documentation | 03/20/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING 00<br>B. WING | 02/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| SENIOR LIVING WINDERMERE, LLC | 9745 OLYMPIA DR<br>FISHERS, IN 46038 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| | of 3 residents reviewed for death. (Residents B and K)<br><br>Findings include:<br><br>1. The clinical record for Resident K was reviewed on 2/2/23 at 11:20 a.m. His diagnoses included, but were not limited to, congestive heart failure, chronic kidney disease, and atrial fibrillation. He was readmitted to the facility from the hospital on 12/10/22 and died in the facility on 12/12/22.<br><br>The most recent POST form in Resident K's clinical record was dated 10/10/22 and indicated to attempt resuscitation/CPR (Cardio Pulmonary Resuscitation) if he had no pulse and was not breathing. It was signed by a physician on 10/11/22.<br><br>The 12/9/22, 8:45 p.m. change of condition note read, "RES [Resident] assessed at [name of local hospital.] RES has an increased level of care. RES on daily BP [blood pressure] monitoring, Needs X1 [times one] assistance with transfers from bed to W/C [wheel chair.] X1 assistance with toileting. X1 assistance with Bathing. Escort to and from activities/dining. X1 assistance with dressing/grooming. RES currently on [name of hospice company] palliative care. Family thinks hospice care would be more appropriate at this time. Triage contacted and received order for [name of hospice company] to eval [evaluate] and treat. Faxed to [phone number.] Contacted the on call Nurse at [name of hospice company] and they stated they will be out for an assessment today. Excepted [Sic] to discharge back to facility at 3:30. Family is transporting. Onsite Nurse notified. ED [Executive Director] made aware. RED flag call to be scheduled for Monday 12.12.22 and Care conference to be determined with family | | from all 3rd parties providers for residents identified<br>b. 2/8 Inservice with Paradigm Health to set expectations as far as documentation needed onsite, in clinical record, and communication binders. Paradigm Social worker onsite 2/13<br>c. 2/8 Inservice with Powerback Rehab, Select Home Health, and Paradigm team on documentation need in clinical records detailing admission/service dates<br>d. “Secure” Records room identified, shelving, and shred bins ordered for organization 3/20/23<br>2. How the facility identified other residents.<br>a. Chart/PCC audit with additional LPN onsite/6 & 2/7 and ongoing weekly.<br>b. Chart/PCC audit/integration with additional LPN onsite 2/6, 2/7, 2/8, 2/14, 2/15 and ongoing weekly with Licensed Chart order template<br>c.<br>3. Measures/systems put in place.<br>a. 2/23 CSIG PointClickCare Implementation Clinical Training Session Move In E002041<br>b. 3/2 CSIG PointClickCare Implementation Clinical Training Session Care Delivery E002041<br>c. 3/6 CSIG PointClickCare Implementation Clinical Training Session Incident/External Facilities/Security E002041 | |

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| | scheduled next week."<br><br>The 12/10/22, 4:34 p.m. progress note read, "Resident returned from [name of hospital,] transported by daughter. Came in wheelchair. Alert. Moist, productive cough, audible wheezing. No complaints of pain or discomfort voiced. T [Temperature]-97.5, P [Pulse] 92, R [Respirations] -18, B/p [Blood pressure] -114/69, O2 sat [Oxygen saturation] -99% on room air. Hospice to arrive at 5pm. Daughter will remain here to meet them. Still awaiting order from [name of medical provider.] Resident incontinent of bowel and bladder. Left AC space skin tear, Hospital unsure how it occurred. Resident has no complaints r/t [related to] to area. Discharge instructions left at nurses station to review with Hospice Nurse when they arrive. DNS [Director of Nursing Services/Wellness Director] aware of resident's return."<br><br>The 12/10/22, 6:48 p.m. nurse's note read, "Resident's daughter states Hospice will be in the morning. They fax papers and have her sign in the morning. Family will assist resident to bed, family encouraged to call if assistance needed."<br><br>The 12/11/22, 6:15 p.m. nurse's note read, "Resident admitted to [name of hospice company] this date with new orders for comfort medications. Resident has had no appetite and declined food when offered by family. Resident continues with moist non-productive cough and abnormal audible lungs sounds. No s/s [signs/symptoms] SOB [shortness of breath] or respiratory observed. Resident's has edema present in LUE [left upper extremity] and bilateral feet. Resident will be receiving a hospital bed and hoyer lift on Monday or Tuesday. Daughter present and aware of above information." | | d. Requested new SOP for End of Life care from Compliance Office 3/1<br>e.<br>4. How will the corrective action be monitored.<br>a. Hired Charge LPN nurse to own and oversee delivery of care/medication management M-F 8-5pm. *Start date 2/15*<br>b.<br>5. Due Dates<br>a. 3/6/23 | |

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| | The 12/11/22 hospice Initial Assessment summary, written by Hospice RN (Registered Nurse) 8, read, "Patient is currently a full code, DNR [Do Not Resuscitate] needs filled out and signed by physician."<br><br>The 12/12/22, 2:00 p.m. hospice note, written by Hospice RN 9, indicated the facility nurse was calling reporting that Resident K had RHC (respirations have ceased.) It read, "Patient is non-responsive and family member crying over him. Once family member was removed I listened for a full minute and there was no respiration or heart beat noted." The confirmed time of death was 1:13 p.m. on 12/12/22.<br><br>There was no information in the clinical record to indicate Resident K was provided CPR on 12/12/22.<br><br>The 12/12/22 Provisional Notification of Death - Burial Transit Permit indicated the facility released Resident K's body to a local funeral home.<br><br>An interview was conducted with Hospice RN 10, the immediate supervisor for Hospice RN 8 and Hospice RN 9, on 2/3/23 at 10:26 a.m. She indicated the most recent POST form their hospice company had on file was dated 3/22/22 and indicated he was a full code. They did not have a signed DNR POST form. She would need to verify with Hospice RN 9, but it didn't sound to her like hospice was present upon Resident K's death. She was uncertain if anyone at the facility performed CPR. Typically, hospice spoke with patients weekly about getting a DNR, but Hospice RN 9 only saw Resident K once and she didn't see where Hospice RN 8 had a DNR signed. Sometimes family wasn't present at the | | | |

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| | initial assessment to discuss it.<br><br>An interview was conducted with the Hospice Compliance Officer on 2/3/22 at 10:58 a.m. She indicated upon review of Resident K's death, the family was surrounding his body, grieving, and they did not want CPR performed.<br>Their documentation from 12/10/22 indicated Resident K's daughter informed them of his DNR status, but there was no paperwork available.<br>Their policy was if there was no copy of a DNR status, then they assumed the patient was full code. They did not get a copy of a new DNR POST form.<br><br>An interview was conducted with the Wellness Director on 2/3/23 at 10:06 a.m. She indicated she evaluated him at the hospital prior to his readmission to the facility and she saw a DNR form in Resident K's brother's hand, but did not have a copy. She was present, holding Resident K's hand when he passed, and CPR was not performed. She was on the phone with Resident K's daughter, his Power of Attorney and Health Care Representative, when he died.<br><br>A telephone interview was conducted with Resident K's daughter in the presence of the Wellness Director on 2/3/23 at 3:09 p.m. She indicated her brother, her sister, and she were all present at the facility with hospice. They and Resident K all agreed he would be a DNR on hospice. They didn't know he would pass quite that quickly. She thought the hospice nurse had her sign a new POST form while there, but she was unable to locate it and was unsure if she received a copy if she did sign one. They knew hospice meant a DNR status. She had no issues with the facility not performing CPR and was thankful the Wellness Director was present and | | | |

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| | called her when he passed.<br><br>The DNR policy was provided by the ED (Executive Director) on 2/2/23 at 8:30 a.m. It read, "1. Hospice will obtain current orders regarding resuscitation from patient's physician and proceed according to patient's wishes and applicable laws and regulations....6. Resuscitation details (verbal and written) will be made available to all caregivers. 7. Copies of DNR orders will be kept in the patient's medical record."2. The clinical record for Resident B was reviewed on 2/2/23 at 1:30 p.m. The diagnosis for Resident B included, but was not limited to, multiple sclerosis. Resident B's admission date to the facility was on 3/10/22, and she discharged on 11/21/22.<br><br>An interview was conducted with the Executive Director on 2/2/23 at 2:13 p.m. She indicated she was unable to locate Resident B's medical record.<br><br>An interview was conducted with the Wellness Director on 2/3/23 at 10:08 a.m. She indicated she had searched for Resident B's chart. She was able to provide the Medication and Treatment Records (MARS/TARS) due to the information was on the computer, but unable to provide the complete medical chart.<br><br>This State Tag relates to Complaint IN00394029 and IN00400160. | | | |
| R 0357<br><br>Bldg. 00 | 410 IAC 16.2-5-8.1(j)(1-3)<br>Clinical Records - Noncompliance<br>(j) If a death occurs, information concerning the resident ' s death shall include the following:<br>(1) Notification of the physician, family, responsible person, and legal representative.<br>(2) The disposition of the body, personal | | | |

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| | possessions, and medications.<br>(3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death.<br>Based on interview and record review, the facility failed to ensure a resident's medical record included information regarding the disposition of his personal possessions for 2 of 3 residents reviewed for death. (Residents F and K)<br><br>Findings include:<br><br>1. The clinical record for Resident K was reviewed on 2/2/23 at 11:20 a.m. His diagnoses included, but were not limited to, chronic kidney disease and atrial fibrillation. He was readmitted to the facility from the hospital on 12/10/22 and died in the facility on 12/12/22.<br><br>The 12/12/22, 2:00 p.m. hospice note indicated the confirmed time of death was 1:13 p.m. on 12/12/22.<br><br>The 12/12/22 Provisional Notification of Death - Burial Transit Permit indicated the facility released Resident K's body to a local funeral home.<br><br>There was no information in the clinical record to indicate disposition of Resident K's personal belongings.<br><br>An interview was conducted with the Wellness Director on 2/3/23 at 10:06 a.m. She indicated they did not document disposition of belongings or document a progress note as to when the family moved their belongings out of the facility. 2. The clinical record for Resident F was reviewed on 2/2/23 at 12:30 p.m. The diagnosis for Resident F included, but was not limited to, Alzheimer's Disease. On 9/27/22, Resident F had deceased. | R 0357 | **R 349 IN00400160, IN00394029**<br>Clinical Records<br>1. Immediate actions taken for those residents identified.<br>a. Request documentation from all 3rd parties providers for residents identified<br>b. 2/8 Inservice with Paradigm Health to set expectations as far as documentation needed onsite, in clinical record, and communication binders. Paradigm Social worker onsite 2/13<br>c. 2/8 Inservice with Powerback Rehab, Select Home Health, and Paradigm team on documentation need in clinical records detailing admission/service dates<br>d. “Secure” Records room identified, shelving, and shred bins ordered for organization 3/20/23<br>2. How the facility identified other residents.<br>a. Chart/PCC audit with additional LPN onsite/6 & 2/7 and ongoing weekly.<br>b. Chart/PCC audit/integration with additional LPN onsite 2/6, 2/7, 2/8, 2/14, 2/15 and ongoing weekly<br>c.<br>3. Measures/systems put in place.<br>a. 2/23 CSIG PointClickCare Implementation Clinical Training | 03/20/2023 |

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| | A nursing progress note dated 9/27/22 at 5:17 a.m., indicated "RHC [respirations has ceased], resident family at bedside, hospice notified, MD [Medical Doctor] notified, body was released to funeral home after family spent time together."<br><br>The resident's clinical record did not include documentation of the disposition of Resident F's belongings.<br><br>An interview was conducted with Executive Director on 2/3/23 at 3:00 p.m. She indicated she was unable to provide documentation of the disposition of residents' belongings after residents' have passed.<br><br>This State Tag relates to Complaint IN00400160. | | Session Move In E002041<br>b. 3/2 CSIG PointClickCare Implementation Clinical Training Session Care Delivery E002041<br>c. 3/6 CSIG PointClickCare Implementation Clinical Training Session Incident/External Facilities/Security E002041<br>d. Requested new SOP for End of Life care from Compliance Office 3/1<br>e.<br>4. How will the corrective action be monitored.<br>a. Hired Charge LPN nurse to own and oversee delivery of care/medication management M-F 8-5pm. *Start date 2/15*<br>b.<br>5. Due Dates<br>a. 3/6/23 | |