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	155618	A. BUILDING 00 B. WING	12/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CARMEL	12999 N PENNSYLVANIA ST CARMEL, IN 46032

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00397504, IN00395453, and IN00397569. Complaint IN00397504 - Substantiated. State deficiencies related to the allegations are cited at R52, R242, and R382. Complaint IN00395453 - Substanitated. State deficiencies related to the allegations are cited at R214. Complaint IN00397569 - Substantiated. State deficiencies related to the allegations are cited at R241. Survey date: December 21, and 22, 2022 Facility number: 001149 Residential Census: 75 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 3, 2023.	R 0000	The Creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or of any violation of regulation. This provider respectfully requests the 2567 Plan of Correction be the letter of credible allegation and REQUESTS DESK REVIEW IN LIEU OF A POST SURVEY REVISIT on or after January 18, 2022.	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview, and record review, the facility failed to supervise a resident	R 0052	R052 Resident Rights – Offense Facility is requesting IDR as the	01/18/2023

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

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	with a history of suicidal ideation, and to implement their written policy of reporting, investigating, and ensuring protection of the resident, resulting in Resident B drowning in the facility retention pond for 1 of 3 residents reviewed for neglect. Findings include: An Indiana State Department of Health Survey Report System report, dated 12/20/22 at 9:01 a.m., indicated assisted living resident (Resident B) was found in the retention pond behind the facility. Police were immediately notified and on site. Upon investigation a suicide note was in the resident's apartment. Police were notified, the body was removed from retention pond per EMS (Emergency Medical Service), and the resident's death was confirmed. An anonymous person during the survey indicated Resident B had been missing since 12/19/22 when staff dropped off medications. Resident B was found deceased on 12/20/22 in the morning in the retention pond behind the facility. The anonymous person heard that the resident had drank most of a bottle of alcohol, pulled his wheelchair up to the railing, and was suspected of committing suicide by going off the railing into the retention pond. Police were called and it was suspected as suicide as there possibly had been a note left in his room. During an observation on 12/21/22 at 11:35 a.m., a dock jutted out over a retention pond behind the assisted living (AL) facility located approximately 100 feet from a secured back door. The dock was 20 or more feet long with 2 chairs on either end of the dock, and waist high railings on all 3 sides. The water in the pond was observed to have a		evidence presented does not amount to an offense as stated in 410 IAC 16.2-5-1.2(v)(1-6) Additionally facility intends to display that the surveyors intentionally ignored relevant information in reaching their conclusion. Furthermore the Settings Rule preempts application of the statute as applied. **1. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?** - Resident B no longer resides in the facility. - All Facility exits reviewed for safety and function. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** - All residents who require supervision to be outside have the potential to be affected by the alleged deficient practice. - All residents service plans reviewed and Care Plans updated as needed, with the audit focusing on safety when outside of the facility and identification of at risk residents. - Assisted Living Staff will be in-serviced on 410 IAC 16.2-5-1.2(v)(1-6) specifically	

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	thin layer of ice on top with a path of ice chipped from the shore around the right side and end of the dock. There were 2 cigarette butts floating in the water near the dock, scrapings of dried vomit in front of the far chair on the dock. The retention pond was accessible from Resident B's apartment through 2 doors and down 3 flights of stairs to the back exit door. During an observation on 12/22/22 at 11:37 a.m., Resident B's apartment was neat and tidy. The resident's apartment key attached to a scrunchy was lying on the couch. No alcoholic beverages were observed. A black TV stand was sitting within 10 feet of the apartment door in plain view with only a small candy jar on the right side of the TV nearest the doorway, and 2 thin note pads on the left of the TV. A bible on the bedside stand was open. The code to the back door exit was found taped to the front of the refrigerator door. During an observation on 12/22/22 at 11:42 a.m., the emergency exit nearest Resident B's apartment had an unarmed alarm. From Resident B's apartment the back exit door near the retention pond was accessed by going down 3 flights of stairs and by utilizing the code taped to Resident B's refrigerator. The dock was approximately 30 feet long by 8 feet wide with 1 chair placed on each end of the dock. A red ribbon was tied across the area preventing access to the dock. Water around the dock was observed to have a thin layer of ice, with a path of ice broken up and floating from a grassy area near the dock to side and around the front of the dock. There were no cameras observed outside the back exit door or toward the dock area. The Assisted Living (AL) Director of Nursing Services (DNS) indicated all residents had codes to the back door and there were no cameras on the back of the facility to		Residents have the rights to be free from: o (1) sexual abuse; o (2) physical abuse; o (3) mental abuse; o (4) corporal punishment; o (5) neglect; o (6) involuntary seclusion. - Assisted Living Staff will be in-serviced on Missing Resident Policy which outlines the resident policies and procedures regarding missing residents and initiation of search protocols and investigation. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** - All residents service plans reviewed and Care Plans updated as needed, with the audit focusing on safety when outside of the facility and identification of at risk residents. - Assisted Living Staff will be in-serviced on 410 IAC 16.2-5-1.2(v)(1-6) specifically Residents have the rights to be free from: o (1) sexual abuse; o (2) physical abuse; o (3) mental abuse; o (4) corporal punishment; o (5) neglect; o (6) involuntary seclusion. - Assisted Living Staff will be in-serviced on Missing Resident	

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	include the dock as it was assisted living. Resident B's record was reviewed on 12/22/22 at 9:50 a.m. Diagnosis on Resident B's profile included but were not limited to schizophrenia (hallucinations and delusions [disorganized thoughts and behaviors]), hypersomnia (excessive sleepiness or drowsiness), and nicotine dependence. A Physician's order, dated 9/1/22, indicated to give 1 tablet of Trazodone HCl Tablet (antidepressant) 150 milligrams (mg) by mouth at bedtime for insomnia. The medication had a black box warning to monitor for suicidal ideation. A Physician's order, dated 6/15/22, indicated to give 2 tablets of risperidone 4 mg by mouth one time a day for undifferentiated schizophrenia. A Physician's order, dated 6/3/22, indicated to give 2 tablets of Divalproex Sodium ER Tablet Extended Release 24 Hour (anticonvulsant) 250 mg by mouth one time a day for mood. The resident record lacked documentation Resident B was being monitored for mood, behaviors, or suicidal ideation. The resident record lacked documentation of nursing or interdisciplinary notes for Resident B, dated 11/1/22 to 12/20/22. A pre-admission clinical summary including a history and physical, and chest X-ray, dated 3/7/22, indicated the resident had a medical history to include, but not limited to schizophrenia, suicide attempt in 2008, alcohol problem (remote history with no current use), risk for falls, and a drive-by shooting victim.		Policy which outlines the resident policies and procedures regarding missing residents and initiation of search protocols and investigation. **4. How corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** - Audit Tool At Risk for Elopement will be completed by the Executive Director, Clinical Director and/or designee to monitor compliance. Audits will be completed daily X5days, weekly X4 weeks, monthly thereafter to ensure compliance. - Results of audit tool will be presented to the QAPI Committee Monthly to review for compliance and follow-up. Identified noncompliance may result in staff reeducation and/or disciplinary action. - If 100% threshold is not achieved an action plan will be developed to achieve desired threshold. Data will be submitted to the QAPI committee overseen by the ED for review and follow-up.	

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	On 12/21/22 at 11:45 a.m., the AL DNS indicated Resident B's record lacked documentation of separate pre-admission assessment, admission assessment, and a service plan. Due to being a Medicaid resident there was documentation on only one form titled, "A Level of Service Assessment/Evaluation-Full List of Items Assisted Living." This form was completed by the AL DNS when she knew a resident was coming, then upon admit she would review the questions for changes to include change of condition or change in cognition and revise it as needed. This assessment form was repeated every year. "A Level of Service Assessment/Evaluation - Full List of Items Assisted Living" form for Resident B, dated and signed by the AL DNS and Power of Attorney on 5/31/22, indicated Resident B usually understood information conveyed, but might miss part or the intent of the message. His ability to express himself was limited to making concrete requests regarding basic needs. Decisions were poor, requiring cueing and supervision in planning and/or organizing, and correcting daily routines. Resident had difficulty understanding needs that must be met but cooperated when given direction or explanation. Resident B could get around inside without assistance of another person inside with endurance limited to immediate vicinity of facility. Resident B required constant presence of staff for safety outside. On 12/22/22 at 10:09 a.m., the AL DNS indicated Resident B's medical record lacked documentation he had recently been seen by his primary care physician or for psychiatric services. She was sure he had been seen after recently being diagnosed with COVID-19 and taken by his family member to see both physicians. The facility did			

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	not consistently get or actively seek copies of physician documentation on residents that were not seen by facility physicians. A sign out log provided by the Administrator in Training (AIT), dated 12/8/22, 12/19/22, and 12/20/22, indicated 3 residents were documented as having left the facility, it did not include documentation for Resident B. The AIT (Administrator in Training) and AL DNS indicated although Resident B's whereabouts could not be determined on the evening and night of 12/19/22 or morning of 12/20/22, there was no missing persons search or elopement follow-up completed. They indicated there was "no such thing as elopement in AL" as the residents were free to come and go as they wanted. On 12/22/22 at 10:15 a.m., the AIT indicated the facility had not received the police, EMS, or coroner reports. She thought Resident Services had possibly written staff statements. The facility lacked documentation of any type to include elopement, missing persons, or resident suicide event had been followed up to include witness statements of staff involved, audit/review of residents with psychiatric diagnosis, or education provided to staff on abuse, elopement, or missing persons. On 12/22/22 at 1:28 p.m., the Regional Nurse provided documentation to include an undated typed timeline of follow up and 4 staff witness statements. The facility lacked documentation on-going education regarding elopement, missing persons, or suicide had been presented to the staff. Witness statements included, a. On 12/19/22 Environmental Services 8 indicated he was "advised by one of the aides that there			

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	was possibly drowning so I ran out the building I then observed that there was a person in the water, so I immediately called 911." b. On 12/19/22, an unidentified signature indicated, "Writer spoke with nurse on shift from Monday night and nurse stated that resident [Resident B] received his 6:00 p.m. meds. Resident did not seem out of character. Nurse stated patient was not in his room for 10:00 p.m. meds." c. On 12/19/22, an unidentified signature indicated, "Writer spoke with CNA from eve [evening] shift on 12/18/22 she stated that she did not see resident during her shift." During an interview on 12/20/22 at 9:05 a.m., the Skilled Nursing Facility (SNF) Director of Nursing (DON) indicated on 12/20/22 he had had been in the morning meeting when notified by Resident Services there was a body in the retention pond behind AL. At that point the management team all went outside to find 5 or 6 police officers down by the pond. It was his understanding a visiting hospice nurse in AL had looked out the window of an apartment and saw Resident B in the water. The police started taping off the scene, and the recovery dive team had to break through the ice to get to the resident. Resident B was then dragged to the shoreline where he was covered up. Resident B had been partially submerged under the ice, face down with his black coat floating, his body horizontal with some of his body under the water. The SNF DON indicated he had worked in the facility only 3 weeks on the skilled nursing facility (SNF) side and could not identify the resident. After being removed from the pond, the resident was identified when his identification was found in his wallet. The SNF DON observed an empty 750 milliliter (ml) bottle of alcohol brand unknown, a 2 liter (L) bottle of soda in a grocery bag, pens and pencils and pieces of paper like			

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	receipts, a zip lock bag with a few dozen cigarettes and loose tobacco, and dried vomit on the dock, all of these items were in front of a facility owned chair in the middle of the walkway about 2 feet from the rail at the end of the dock. There was no adaptive equipment such as a wheelchair, he had no personal knowledge of the resident, but was told the resident was ambulatory and could walk around independently. Two detectives arrived and spoke with the SNF DON, the AL DNS, and other staff, requested demographic information, and secured the resident's apartment, where detectives subsequently found a suicide note. The SNF DON was not sure if the coroner was on site or if an autopsy was being performed. The SNF DON immediately called for head count of residents in the AL and SNF units, although there was no documentation of this occurring. During an interview on 12/21/22 at 10:41 a.m., the AL DNS indicated Resident B had admitted from his parent's home the end of May 2022. The resident was pleasant, alert, and oriented, and his family member was his representative and emergency contact for health and financial. Resident B was ambulatory with no assistive devices and had no recent history of falls. The resident went on outings, came out of his apartment for meals, and would walk to the grocery store next door independently any time he wanted using the path behind the AL around the retention pond. To her the resident had not seemed sad and had no behaviors. He was seen by his primary physician and possibly psychiatric services. But she was not sure as his family member handled all appointments and just told staff what she wanted them to know and would provide after visit documentation. Resident B had been diagnosed with COVID-19 in the last month and was put in isolation, then recently released.			

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	He was very regimented and kept a set routine from home for meals, going out to smoke independently, and going to staff to get his medications by sitting beside the medication cart and waiting on them to administer his medications. To her knowledge Resident B did not drink alcohol but she was told there had been an unopened bottle of alcohol on the dock when he was found dead. At no time had the resident ever presented as sad, he was always mellow, she always called him cool, calm, and collected. She had asked evening shift if anything was different on 12/19/22, and they said no. The AL DNS indicated when she left the facility on 12/19/22 around 5:00 p.m., Resident B had been sitting downstairs, they told each other goodbye, and she left, there was nothing out of the ordinary. Resident B never presented as depressed or gave her reason to believe he would self-harm. The family member and parent visited at least weekly. Resident B had diagnosis of schizophrenia and took medications to include Depakote and Risperdal, but he had no diagnosis of depression. On 12/19/22 the resident did not come get his medications between 8:00 p.m. to 10:00 p.m., so Licensed Practical Nurse (LPN) 7 went to his room and he wasn't there. It was not normal for the resident to miss his medications or go out of the facility and not tell staff. But the nurse assumed he had gone out with family and had not told her. LPN 7 then told the night nurse LPN 11 Resident B was on leave of absence (LOA) with family, who did not pass this information on to the DNS in the morning report. On 12/20/22 at approximately 9:00 a.m., Home Health Aide 19 was in a resident apartment in AL, looked out the window and thought she saw a body in the pond, so she ran downstairs and told Receptionist 9 who called the police.			

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	Simultaneously the AL DNS who was in the morning meeting got a text there were a lot of police outside the facility, and Resident Services came into the meeting and reported there was a body in the pond. When she got outside, she observed divers go into pond and chipped ice away to get to the resident, then pulled him back to the dock. Police covered the resident's body and asked the AL DNS to identify him as a resident by his identification from his wallet. Once they had access to his apartment, police indicated they had found a suicide note in the apartment, staff were not allowed to read the note. A Coroner had been on site but had not indicated the cause of death at that time due to it being an on-going investigation. The AL DNS indicated she could not answer as to why staff assumed Resident B was LOA on 12/19/22 and did not check his apartment to assure he had not fallen or was unconscious on the floor due to a medical event or check outside to make sure he had not fallen and was hurt or in trouble due to weather. The DNS indicated she had received abuse training but was not sure she had received training for elopement or missing persons. She worked in AL and when residents could not be found it was not considered elopement or missing as it was an unlocked assisted living and residents could come and go as they pleased. During an interview on 12/21/22 at 12:30 p.m., Licensed Practical Nurse (LPN) 7 indicated on Monday 12/19/22 she worked her normal evening shift. She had seen Resident B at 6:00 p.m. when he had come to her to get his medications after going out to smoke. The resident would sometimes go to her to get medications but not all the time. Bedtime medications were scheduled for 8:00 p.m., and when Resident B did not go to her to get them, she went to his apartment to find he			

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	was not there. LPN 7 indicated she had opened the door and stepped inside the apartment and hollered his name a few times, but she did not go all the way inside. She figured he was outside smoking. LPN 7 finished passing meds and went back to Resident B's apartment but when she still did not find him she assumed he had gone LOA with his family member as he did that sometimes. LPN 7 did not call the family member to verify he was out. LPN 7 checked the sign out log and Resident B had not sign out, but sometimes the residents did not sign out. LPN 7 indicated Resident B did not make a habit of staying out all night and not telling staff he would be going out. Resident B or his family member usually informed staff if he was staying out all night and he would ask staff for his medications and take them with him. On 12/19/22 Resident B nor his family member had not informed staff he would be out, and they had not asked for his medications. LPN 7 indicated she had no idea how she would know a resident was missing as they did not always sign out, they would just come and go, there were a few residents that faithfully signed out but not many. Residents were not considered missing on AL as they could come and go. There was never a time she would consider a resident as having eloped or missing. On 12/19/22 she left work at 10:00 p.m., and just thought Resident B was with his family member. LPN 7 indicated on 12/20/22 she saw the news of a resident having drowned in the facility retention pond, then the DNS had called asking when the last time was, she had seen him, and she and she put "2 and 2 together" and figured out it was Resident B. LPN 7 indicated she could not answer as to why she did not go into Resident B's apartment or look outside when she could not confirm his location to assure he had not fallen or			

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	was unconscious due to a medical event. During an interview on 12/21/22 at 11:24 a.m., LPN 11 indicated during shift change on 12/19 at 10:00 p.m., LPN 7 had told her Resident B was LOA with his family. LPN 11 went to his apartment, opened the door, and saw it was dark and thought he was still out. LPN 11 indicated she did not go beyond the entrance walkway as it was dark how the resident usually left it when he was gone. Resident B would occasionally go out with the family for a couple of days. LPN 11 indicated from the entry she could see the resident was not in his bed, she could see the TV stand, bed and couch from his entryway. She did not check the sign out log as Resident B often he did not sign out, he would just meet his family member downstairs. LPN 11 indicated she would see Resident B on the night shift as he would occasionally go outside and smoke during the night. Resident B would talk and laugh with staff, he showed no signs or symptoms of being depressed, and gave no indication he would self-harm. When LPN 11 was asked how she knew the resident had not fallen or was unconscious inside or outside if she had not looked for him, she replied she did not check as the resident was pretty independent, had no falls, he would let them know if he needed anything. He had no symptoms of anything wrong and acted as he did every single day. During an interview on 12/21/22 at 11:30 a.m., the AL DNS indicated staff had been told residents no longer had to sign out in AL as it was their right not to. It was her understanding although residents did not have to sign out, there were sign out books on each floor on a table with a book and a pen for them to sign out. Resident B's family member would routinely call the DNS or communicate to the nurse that she was taking him			

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	out for several days. There were one or two occasions where the family member took Resident B to a doctor's appointment without telling staff and he came back late, maybe that was what LPN 7 had been thinking. The DNS was not sure if LPN 7 had called Resident B's family member to verify his location. There were no residents in the facility that were considered elopement risks, not even the residents with dementia were elopement risks. The facility was not a locked facility. The residents could come and go as they please. At no point did staff consider Resident B to be missing before he was found. The facility lacked service plans to address resident's ability to leave the facility. During a telephone interview on 12/21/22 at 12:00 p.m., the county Deputy Coroner indicated, she had been the responding coroner on 12/20/22. Resident B had already been removed from the retention pond by the boat team from the fire department when she arrived, but he still had ice on him. A ¾ empty bottle of gin alcohol had been found on the retention pond dock. The AL DNS had told the county Coroner that Resident B recently had an uptake of drinking, not extreme, but she was worried about interaction with his schizophrenia meds. AL staff told her the resident could come and go as he pleased, and he was not considered missing. Outings were usually pre-arranged although not on 12/19/22. The Deputy Coroner indicated she had found the suicide note inside Resident B's apartment addressed to his parent and family member, with his reason for committing suicide. The suicide note was sitting on the left side of the TV on a rectangle 10" piece of paper, that was in plain sight. Everything was organized, and a person needed to look, but the note was in plain sight. The Deputy Coroner had spoken that morning			

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	with the family member and was told she had no idea Resident B was suicidal. During an interview on 12/21/22 at 3:40 p.m., the AIT indicated there was no specific policy requiring residents in AL to sign and out when leaving. Residents were encouraged to sign in and out, but they were not required to as they could come and go as they pleased. Staff did not keep track of residents as they lived in their own apartments. Elopement was for SNF, not AL residents who were their own responsible party and could stay out 2 to 3 days as they wanted. Residents would be considered missing if they had not been seen or heard from at least 24 hrs. Staff would follow up with the contact person at 48 hours. Residents who were administered medications by staff could be tracked out of the facility if their medications had not been distributed or by missed meals for residents who self-administered meds. Family members usually notified staff if they were taking a resident out, or the resident would notify staff and get their medications if they were going to be out. Staff were electronically trained upon hire to include abuse, neglect, elopement, etc., and then were assigned monthly electronic training. During an interview on 12/22/22 at 1:00 p.m., the AL DNS indicated Resident B had no order and was not being monitored for suicidal ideation despite a past history of attempted suicide and the black box warnings to monitor for suicidal ideation on his psychotic medications as he was not in a skilled unit had no orders to monitor for side effects of medication. She had discussed with the Coroner Resident B's recent uptake of drinking alcohol, and she was concerned about interaction between alcohol and psychiatric medications, but there was no documentation of her concerns.			

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	On 12/22/22 at 12:18 p.m., the Regional Nurse indicated the facility had no policy on alcohol use. AL also had no service plans. The resident assessment was supposed to be on the Level of Care Assessment. On 12/21/22 at 4:03 p.m., the DNS provided an Abuse Prevention Program, last revised 3/2021, and indicated the policy was the one currently being used by the facility. The policy indicated, "Our facility is committed to protecting our residents from abuse by anyone ...Comprehensive policies and procedures have been developed to aid our facility in preventing abuse, neglect ...Assessing, care planning, and monitoring residents with needs and behaviors that may lead to conflict or neglect ...Neglect is the failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or mental illness ...A complete copy of the Incident Report and written statements from witnesses, if any, must be provided to the Administrator ..." Long-Term Care Abuse and Incident Reporting Policy, effective 12/8/22, indicated, " ...Elopement occurs when a resident without decision making capacity leaves the premises or a safe area without authorization [i.e.., an order for discharge or leave of absence] and/or any necessary supervision or do so OR a resident with decision making capacity leaves the premises or a safe area, without facility knowledge, and does not return as per the resident plan of care or service plan, related to leaving the facility." This State Residential finding relates to Complaint IN00397504.			

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R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.			
	The facility failed to evaluate residents for a change in condition and update the service plan for 1 of 3 residents reviewed for falls resulting in injury with physical limitation of an extremity, mobility, pain, and infection of a wound (Resident C). Findings include On 12/21/22 at 2:56 p.m., a comprehensive record review was completed for Resident C. Resident C had been a resident of the facility from 4/5/22 through 11/20/22. Resident C had the following diagnoses, but not limited to diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine), hypothyroidism (abnormally low activity of the thyroid gland, resulting in slowing of growth and development in children and metabolic changes in adults), and depression. She was ordered to take Eliquis (a medication use to prevent serious blood clots from forming due to a certain irregular heartbeat) for a diagnosis that was not listed in her electronic medical record. Resident C had 4 falls while residing at the facility. She had falls on the following dates: 10/18/22,	R 0214	R 214 Evaluation - Noncompliance **1. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?** - Resident C no longer resides in the facility. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** - All residents who have a change in condition requiring an update for the service plan due falls resulting in resulting in injury with physical limitation of an extremity, mobility, pain, and infection of a wound have the potential to be affected by the alleged deficient practices. - All residents with falls in the last six months have been re-evaluated to ensure that their service plans are up to date. Care plans modified and undated as needed.	01/18/2023

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	9/17/22, 7/31/22, and 6/20/22. An incident report provided by the Assisted Living (AL) Director of Nursing Services (DNS) on 12/22/22 at 11:36 a.m., indicated Resident C had a fall on 9/17/22 at 10:00 a.m., Resident C had a fall in her bathroom. She was observed to have a skin tear to her right forearm and left knee. The note indicated that pressure was applied to her lip as it was bleeding. Resident C was sent to the emergency room for evaluation and treatment related to the fall on 9/17/22. Resident C's nursing progress notes were provided by the AL DNS on 12/22/22 at 11:36 a.m. A progress note, dated 9/17/22 at 10:38 p.m., indicated Resident C returned from the hospital at approximately 11:00 p.m. via ambulance. The note indicated the resident complained of pain to her right arm and as needed medication was administered. A nursing progress note, dated 9/17/22 at 1:53 a.m., indicated Resident C was found on the bathroom floor. She was observed to have a skin tear to her right forearm and knee cap. She had a "split" lip. She had a "lump" on elbow area. The POA was notified and gave permission to send Resident C to the emergency room via ambulance. In this note the nurse indicated POA (Power of Attorney) informed nurse, Resident C had a break in her elbow and knee bone was chipped. Resident C had received sutures to her lip. The chart lacked documentation of what bones were fractured and the number of sutures received or location of sutures to Resident C's lip. A progress note, dated 9/18/22 at 5:21 p.m., indicated Resident C was medicated with as needed Tylenol for pain. Her right arm and right knee were bruised. Her right arm was elevated on		- Assisted Living Administrative staff will be in-serviced on 410 IAC 16.2-5-2(a) i.e. An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident's condition, or more often at the resident's of facility's request. A nurse shall evaluate the needs of the resident. - Assisted Living Staff will be in-serviced on Fall Prevention Program including but not limited to how "each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive care plan. Interventions will be monitored for effectiveness. The plan of care will be reviewed as needed. When any resident experiences a fall, the facility will: assess the resident, complete a post fall assessment, complete an incident report, notify the physician and family, review the residents care plan and update as indicated, document all assessments and actions, obtain witness statements in the event of an injury.."	

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	pillows and ice applied. A progress note, dated 9/21/22 at 1:39 p.m., indicated Resident C returned from an appointment with an order not to move her right upper extremity at all. She had a sling to her right upper extremity. After a short time, Resident was checked on and she had her sling off with her arm hanging down to her side. She was encouraged to leave sling on as the physician ordered. A progress note, dated 9/21/22 at 4:05 p.m., indicated Resident C was observed her sling hanging on the wheelchair and was encouraged to keep sling on. On 12/22/22 at 10:36 a.m., the AL DNS provided neurological assessments for 6/20/22, 7/31/22, and 10/18/22. The AL DNS did not provide neurological assessments for the fall from 9/17/22. The DNS provide an incident report on 12/22/22 at 10:36 a.m., for a fall that Resident C had on 1018/22 at 3:00 p.m. Resident C was unable to remember how she fell. Resident C indicated she got up on her own without assistance. A "small cut" was observed to the top of her left hand. The DNS provided nursing progress notes for Resident C on 12/22/22 at 10:36 a.m. A progress note dated 10/16/22 indicated Resident C had her call light on. She reported that she had fallen and got herself up. A "small cut" to the top of left hand was observed with no other injuries. Resident C's daughter was notified of the fall. Resident C was seen by the physician on 10/20/22. The physician assessed Resident C's hand from the fall on 10/16/22 and ordered Keflex (an antibiotic used to treat infections) to treat the wound to her hand. The order read 500mg by		**3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** - Assisted Living Administrative staff will be in-serviced on 410 IAC 16.2-5-2(a) i.e. An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually an upon a known substantial change in the resident's condition, or more often at the resident's of facility's request. A nurse shall evaluate the needs of the resident. - Assisted Living Staff will be in-serviced on Fall Prevention Program including but not limited to how "each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive care plan. Interventions will be monitored for effectiveness. The plan of care will be reviewed as needed. When any resident experiences a fall, the facility will: assess the resident, complete a post fall assessment, complete an incident report, notify the	

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	mouth three times daily for infection to hand until 11/1/22. Resident C's service plan was provided by the AL DNS on 12/22/22 at 10:36 a.m. The service plan, dated 7/1/22, was not updated after Resident C's falls to address functioning, mobility and pain. During an interview with the AL DNS on 12/22/22 at 1:36 p.m., she indicated Resident C was observed to have a sling when she returned from the emergency room. She indicated the facility did not receive any information from the emergency room regarding her visit. She was not aware that Resident C sustained fractures from the fall on 9/17/22. She knew that Resident C had a sling and did not follow up to inquire why she had the sling. The residents residing in assisted living do not have increased monitoring related to falls. The facility did not provide wound care to assisted living residents. They used a contracted provider for wound care. A policy titled, "Fall Prevention Program," with no date was provided by the Regional Nurse Consultant (RCS) on 12/22/22 at 1:27 p.m. The policy indicated, "Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive care plan. Interventions will be monitored for effectiveness. The plan of care will be reviewed as needed. When any resident experiences a fall, the facility will: assess the resident, complete a post-fall assessment, complete an incident report, notify the physician and family, review the resident's care plan and update as indicated, document all assessments		physician and family, review the residents care plan and update as indicated, document all assessments and actions, obtain witness statements in the event of an injury.." - Fall Prevention Checklist will be utilized for all fall events. **4. How corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** - Audit Tool Fall Prevention Checklist will be completed by the Executive Director, Clinical Director and/or designee to monitor compliance. Audit will be completed after every fall to ensure assessment of the resident, completion of a post fall assessment, completion of an incident report, notification of the physician and family, review of the residents care plan and update as indicated, documentation of all assessments and actions, and witness statements obtained in the event of an injury. Falls will be tracked and trended to monitor trends. - Results of audit tool will be presented to the QAPI Committee Monthly to review for compliance and follow-up. Identified noncompliance may result in staff reeducation and/or disciplinary action. - If 100% threshold is not	

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	and actions, obtain witness statements in the case of injury ...." This State Residential finding relates to Complaint IN00395453.		achieved an action plan will be developed to achieve desired threshold. Data will be submitted to the QAPI committee overseen by the ED for review and follow-up.	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview, and record review the facility failed to ensure all medications were administered by licensed nursing personnel or qualified medication aides, when a housekeeper applied a medication cream to a resident for a rash (Resident E) for 1of 7 residents reviewed for medication administration, and when a resident was self-administering medications without a physician order and an approved self-administration assessment for 2 of 7 residents reviewed for medication administration (Residents K and F). Findings include: 1. On 12/22/22 at 10:44 a.m., during an interview, Resident E indicated a couple weeks ago the Assisted Living (AL) Director of Nursing Services (DNS) had come into her apartment, checked her blood sugar, and gave her evening medications. The resident had asked about the cream for the infection on her neck and arm. The DNS indicated she would bring it back since she did not have it with her.	R 0241	R 241 Health Services - Offense **1. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?** - 1. Resident E no longer resides in the facility. o Facility Investigation completed. o AL DNS educated on medication administration and subject to AL disciplinary procedures. o Resident H evaluated for effectiveness of sertraline and /or side effects including but not limited to clinical worsening and Suicidal ideations. o Housekeeper 14 was educated regarding scope of practice and subjected to Community Disciplinary Procedures. - 2. Resident K:	01/18/2023

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	Resident E indicated someone came to her apartment and told her they had her cream for her rash. She did not recognize the voice of the person and asked, "are you the nurse?" The person indicated "no." The resident then asked her if she was a "Q" (Qualified Medication Aide). The employee responded "No." The resident asked, "Who are you then?" The employee then told her she was the AL DNS' daughter, she worked in housekeeping and was helping her mother out so they could "get out of here." Resident E indicated Housekeeper 14 applied the cream to her rash and left her apartment. On 12/22/22 at 11:00 a.m., Resident E's medical record was reviewed. The diagnoses included, but were not limited to, loss of vision and diabetes. A physician's order, dated 11/11/22, indicated apply clotrimazole (antifungal medication) cream 1% to affected areas topically (rub on skin) two (2) times a day for rash for 31 days. On 12/22/22 at 11:57 a.m., during an interview, Housekeeper 14 indicated she worked at the facility, through a contract company, as a housekeeper. Her job description was cleaning rooms, and "such like that." Her mother was the AL DNS. When asked if she had ever helped her mother with nursing tasks, she indicated she had. Her mother was busy with another resident and asked her to take some cream to Resident E. She took it to the apartment. The resident asked who she was, and she told her. The resident then showed her where to apply the cream and she did. On 12/22/22 at 12:50 p.m., during an interview, the AL DNS indicated Housekeeper 14 was her daughter. A resident was having blood sugar problems, she had been on her way to take a		o Medications in Room of Resident K were removed. o Resident K Medication orders were reviewed with Resident and Family as well as facility standards regarding storage and self-administration of medication. o Resident K assessed for self-administration of medications to determine what medications might be safely stored and administered by the resident. - 3. Resident F: o Medications and Medical supplies in Room of Resident F were removed upon discovery. o Resident F Medication orders were reviewed with Resident and Family as well as facility standards regarding storage and self-administration of medication. o Resident F assessed for self-administration of medications to determine what medications might be safely stored and administered by the resident. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** - All residents who have the potential to be affected by the alleged deficient practice. - Audit of all residents to determine what residents have medication stored in their rooms	

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	treatment to Resident E, when she got interrupted. She had made a bad decision by telling her daughter to take the cream to Resident E. On 12/22/22 at 12:20 the Regional Nurse (RNC) provided a current, undated policy, titled "Medication Administration." This policy indicated " ...Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection ...." 2. On 12/22/22 at 8:30 a.m., during a random medication pass observation, Resident K was observed in her room. Licensed Practical Nurse (LPN) 18 administered medications to her. A clear plastic shoe box was observed on a bookcase shelf adjacent to the resident's bed. The box appeared to contain multiple bottles of prescription medications. LPN 18 retrieved the box and a tube of lotrimen cream (an antifungal), which was laying on the resident's dresser. The LPN explained to the resident the medications all had to be locked in the medication room and all medications had to be administered by the facility's nursing staff. Resident K indicated she needed those medications, and she had pain at bedtime. She often had to take Tylenol to be able to sleep. LPN 18 reassured her she could get her ordered medications when she needed them and to ask for Tylenol when needed. On 12/22/22 at 8:40 a.m., during an interview, LPN 18 indicated Resident K did not have an order to self-administer medications. To self-administer the		completed. Residents requesting to continue to store and self administer medications reviewed by IDT and service plan and care plan updated. - Assisted Living staff will be in- serviced on Medication Administration Policy, including but not limited to scope of practice and who may assist with the administration of medications. - Assisted Living Residents and representatives provided notice of the rules regarding storage and administration of medications, including but not limited to the requirement that in order for a resident to store and administer medications the medication in question must evaluated by the facility IDT to determine what medications may be self-administered safely and that the self-administration must be part of the resident care plan. - Assisted Living staff will be in-serviced on 410 IAC 16.2-5-4(e) (1) specifically the requirement that (e) The administration of medications and the provision of residential nursing care shall be ordered by a resident’s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aids Unless the resident has been assessed and has orders in place for	

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	resident had to be evaluated and the physician would then write an order if the resident was able to self-administer her own medications. On 12/22/22 at 11:15 a.m., the medical record for resident K was reviewed. The diagnoses included, but was not limited to, anxiety and depression. On 12/22/22 at 12:20 p.m., the Regional Nurse (RNC) provided a copy of Resident K's medication self-administration assessment, dated 9/12/22. This evaluation indicated Resident K had "dementia diagnosis and/or significant memory loss combined with behaviors, including but not limited to, wandering, requiring directions or reminding, and continuous cuing ...caregiver administration and/or observation requiring judgement for necessity, dosage and/or effect ...." The total score of the evaluation was 85 (over 61), which indicated the resident could not self-administer. A list of the medication in the plastic shoe box, from the resident's apartment, was provided by the RNC, and a copy of Resident K's Medication Administration Record (MAR) with current physician orders. The medications (in the shoe box) were a stimulant laxative, Vitamin B-6, clindamycin (antibiotic), indapamide (water pill, diuretic), niacin (nutritional supplement), colace (stool softener, prevents constipation), vitamin E (supplement), prevagen (supplement for healthy brain function), zinc (supplement) and acetaminophen (Tylenol). Resident K did have an as needed (PRN) order for Tylenol every 6 hours but did not have physician orders for any of the other medications from the shoe box, or the lotrimen cream. The resident did not have an order to self-administer medications		self-administration. - Assisted Living staff will be in-serviced on “Resident Self Administration of Medication” Policy specifically that it is the policy of this facility to support each residents right to self-administer medication. A resident may only self-administer medication after the facility IDT has determined which medications may be self-administered safely. All nurses and aides are required to report to the charge nurse on duty any medications found at bedside not authorized for bedside storage. Unauthorized medications are given to the charge nurse for return to the family or responsible party. Families or responsible parties are remined of the policy and procedures regarding the resident self-administration when necessary. The Care Plan must reflect resident self-administration and storage arrangements for such medications. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** - Assisted Living staff will be in- serviced on Medication Administration Policy, including but not limited to scope of practice and who may assist with the administration of medications. - Assisted Living Residents	

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	or keep them at bedside. On 12/22/22 at 12:20 the RNC provided a current, undated policy, titled "Resident Self-Administration of Medications." This policy indicated " ...A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely ...All nurses and aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage ...." On 12/22/22 at 12:20 the RNC provided a current, undated policy, titled "Medication Storage." This policy indicated "It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and or medication rooms according to manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security." 3. During an observation on 12/21/22 at 10:20 a.m., medications were observed in Resident F's apartment. There were 3 boxes of albuterol nebulizer (a medication used to treat lung conditions that is inhaled through the mouth) on his refrigerator, a Ventolin inhaler, and a bottle of AREDS (vitamin for eye health). He had Azelastine spray (a medication used to treat stuffy or runny nose), mag citrate (a medication used to treat constipation), and MiraLAX (a medication used to treat constipation) on his closet floor. He had a bottle of nitroglycerin (a medication used to treat chest pain) sitting on his end table. He had a nebulizer machine on his end table with a mouthpiece attached and uncovered. During an interview with Resident F on 12/21/22 at 10:20 a.m., he indicated he did not administer his		and representatives provided notice of the rules regarding storage and administration of medications, including but not limited to the requirement that in order for a resident to store and administer medications the medication in question must evaluated by the facility IDT to determine what medications may be self-administered safely and that the self administration must be part of the resident care plan. - Assisted Living staff will be in-serviced on 410 IAC 16.2-5-4(e) (1) specifically the requirement that (e) The administration of medications and the provision of residential nursing care shall be ordered by a resident's physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aids Unless the resident has been assessed and has orders in place for self-administration. - Assisted Living staff will be in-serviced on "Resident Self Administration of Medication" Policy specifically that it is the policy of this facility to support each residents right to self-administer medication. A resident may only self-administer medication after the facility IDT has determined which medications may be self-administered safely.	

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	medications. Nursing administered his medications. On 12/21/22 at 2:15 p.m., a comprehensive record was completed for Resident F. He had the following diagnoses, but not limited to hyperlipidemia (an abnormally high concentration of fats or lipids in the blood), unspecified depression, anxiety disorder, age-related macular degeneration (a degenerative condition affecting the central part of the retina (macula) and resulting in distortion or loss of central vision), essential hypertension, atherosclerotic heart disease (a disease of the arteries characterized by the deposit of plaques of fatty material on the inner walls), supraventricular tachycardia (an irregularly fast or erratic heartbeat the affects the heart's upper chambers), Chronic Obstructive Pulmonary Disease (COPD) (a condition involving constriction of the airways and difficulty or discomfort in breathing), Gastro-esophageal reflux disease (GERD) (a condition that occurs when stomach acid repeatedly flows back into the tube connecting you mouth and stomach) and Benign Prostatic Hypertrophy (BPH) (a condition in which overgrowth of prostate tissue pushes against the urethra and bladder, blocking the flow or urine). Resident F service plan, dated 11/3/22, indicated he needed staff to administer or supervise self-administration of medications. In the comment section of his service plan, a note was written. It indicated resident will be on medication services and the facility was to store and administer medications. During an interview with the AL DNS on 12/22/22 at 11:46 p.m., she indicated he was not supposed to have medications in his apartment. She		All nurses and aides are required to report to the charge nurse on duty any medications found at bedside not authorized for bedside storage. Unauthorized medications are given to the charge nurse for return to the family or responsible party. Families or responsible parties are remined of the policy and procedures regarding the resident self-administration when necessary. The Care Plan must reflect resident self-administration and storage arrangements for such medications. - Labeling system for Medications the facility IDT has determined may be stored in resident room and self-administered safely implemented. - Assisted Living staff will be in- serviced on Labeling system for Medications the facility IDT has determined may be stored in resident room and self-administered safely implemented. - Residents and Family and / or responsible party notified of Labeling system for Medications the facility IDT has determined may be stored in resident room and self-administered safely implemented. **4. How corrective actions will be monitored to ensure the**	

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	indicated that she removed medications from Resident F apartment. His daughter brought in medications and left them in his apartment. A policy titled, "Resident Self-Administration of Medication," with no date indicated, provided by the Regional Nurse Consultant (RNS) on 12/22/22 at 12:20 p.m. The policy indicated, "It is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determine which medications may be self-administered safely. All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage. Unauthorized medications are given to the charge nurse for return to the family or responsible party. Families or responsible parties are reminded of policy and procedures regarding resident self-administration when necessary. The care plan must reflect resident self-administration and storage arrangement for such medications." This State Residential finding is related to Complaint IN00397569.		**deficient practice will not recur i.e., what quality assurance program will be put into place?** - Audit Tool Medication Storage and Administration will be completed by the Executive Director, Clinical Director and/or designee to monitor compliance. Audits will be completed daily X5days, weekly X4 weeks, monthly thereafter to ensure compliance. - New residents to the facility will be educated regarding the Resident Self Administration of Medication prior to and upon admission. - Results of audit tool will be presented to the QAPI Committee Monthly to review for compliance and follow-up. Identified noncompliance may result in staff reeducation and/or disciplinary action. - If 100% threshold is not achieved an action plan will be developed to achieve desired threshold. Data will be submitted to the QAPI committee overseen by the ED for review and follow-up.	
R 0242 Bldg. 00	410 IAC 16.2-5-4(e)(2) Health Services - Offense (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record.			

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	Based on interview and record review, the facility failed ensure residents were monitored for the effectiveness and side effect of medications to include but were not limited to antipsychotic and antidepressant medications. This deficient practice had the potential to effect 2 of 3 residents reviewed for Major Mental Illness (Resident B and H). Findings include: 1. On 12/22/22 at 9:15 a.m., Resident B's medical record was reviewed. He had diagnoses which included, but were not limited to, undifferentiated schizophrenia (a type of schizophrenia that is diagnosed when a person meets the criteria for diagnosis for schizophrenia but cannot be classified into any of the subtypes). Resident B had a physician's order for trazadone, (an antidepressant medication) with instructions to take 150 mg at bedtime for insomnia which included the following black-box warning: "Suicidal thoughts and behaviors: Antidepressants increase the risk of suicidal thoughts and behaviors in pediatric and young adult patients in short-term studies. Closely monitor all antidepressant-treated patients for clinical worsening and for emergence of suicidal thoughts and behaviors ...." The electronic and hard chart medical record lacked documentation of medication monitoring for effectiveness and/or side effects. 2. On 12/22/22 at 10:00 a.m., Resident H's medical record was reviewed. She was a newly admitted Assisted Living Resident with a current diagnosis which included, but was not limited to, bipolar disorder, current episode severe with psychotic	R 0242	Facility is requesting IDR as the evidence presented does not amount to an offense as stated in 410 IAC 16.2-5-4(e)(2). The Citation as presented fails to present an citation under the statute. R 242 Health Services - Offense **1. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?** - Resident B no longer resides in the facility. - Resident H evaluated for effectiveness of sertraline and /or side effects including but not limited to clinical worsening and Suicidal ideations. No negative side effects noted. - Facility contacted physician to review order for sertraline and ensure review process was in place including but not limited to monitoring the effectiveness and side effects of sertraline i.e. clinical worsening and / or for emergence of suicidal thoughts and behaviors. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** - All residents have the potential to be affected by the	01/18/2023

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	features, (bipolar disorder is a mental health condition that causes extreme mood swings that include emotional highs and lows). She had a physician's order for sertraline (an antidepressant medication) with instructions to take two, 100 mg tablets daily for depression which included the following black-box warning: "Suicidal thoughts and behaviors: Antidepressants increase the risk of suicidal thoughts and behaviors in pediatric and young adult patients in short-term studies. Closely monitor all antidepressant-treated patients for clinical worsening and for emergence of suicidal thoughts and behaviors ...." The electronic and hard chart medical record lacked documentation of medication monitoring for effectiveness and/or side effects. During an interview on 12/22/22 at 12:55 p.m., when asked if the nursing staff were monitoring the effectiveness or for side effects of medications which included, but were not limited to, antipsychotics, antidepressants, and/or opioids, the Assisted Living (AL) Director of Nursing Services (DNS) indicated nursing staff were not monitoring residents psychotropic medications because it was up to the psychiatric prescribing doctor to follow up with and to her knowledge, because it was an Assisted Living Facility, they did not need to monitor medications. A policy and/or procedure for medication monitoring of psychotropic medications was requested but was not provided by the survey exit date. This State Residential finding relates to Complaint IN00397504.		alleged deficient practice. - All Resident medications reviewed for potential side effects. - All Residents observed for potential side effects. - Assisted Living management staff will be in-serviced on 410 IAC 16.2-5-4(e) (2) specifically the requirement that each resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The Physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record. - Assisted Living staff will be in-serviced regarding requirements for observation of side effects and documentation and notification of physician if undesirable effects occur. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** - Assisted Living management staff will be in-serviced on 410 IAC 16.2-5-4(e) (2) specifically the requirement that each resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The Physician shall be notified	

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			immediately if undesirable effects occur, and such notification shall be documented in the clinical record. - Assisted Living management staff will be in-serviced regarding the requirements for observation of side effects and documentation and notification of physician if undesirable effects occur. - Assisted Living Nursing staff will complete Medication Review Tool for all new admissions to look for potential side effects. - Assisted Living Nursing staff will review all new medication orders for potential side effects to ensure that orders for monitoring are in place where necessary. **4. How corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** - Audit Tool MMI Side Effects Monitoring Tracking Tool will be completed by the Executive Director, Clinical Director and/or designee to monitor compliance. Audits will be completed daily X5days, weekly X4 weeks, monthly thereafter to ensure compliance. - Residents on Antipsychotic and Antidepressant Medications will be reviewed Monthly and upon order changes for Antipsychotic and Antidepressant medications. - Results of audit tool will be	

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			presented to the QAPI Committee Monthly to review for compliance and follow-up. Identified noncompliance may result in staff reeducation and/or disciplinary action. - If 100% threshold is not achieved an action plan will be developed to achieve desired threshold. Data will be submitted to the QAPI committee overseen by the ED for review and follow-up.	
R 0382 Bldg. 00	410 IAC 16.2-5-11.1(f) Mental Health Screening - Noncompliance (f) Each resident with a major mental illness must have a comprehensive care plan that is developed within thirty (30) days after admission to the residential care facility. Based on observation, interview, and record review, the facility failed to ensure a system was in place to create and implement comprehensive care plans, in cooperation with a psychiatric physician, for Residents who received Medicaid benefits and had chronic major mental illness (MMI) diagnoses for 3 of 22 residents residing in the Assisted Living facility with MMI diagnoses (Residents B, H, and J). Findings include: 1. On 12/22/22 at 9:15 a.m., Resident B's medical record was reviewed. He had diagnoses which included, but were not limited to, undifferentiated schizophrenia (a type of schizophrenia that is diagnosed when a person meets the criteria for diagnosis for schizophrenia but cannot be classified into any of the subtypes). A pre-admission history and physical assessment	R 0382	R 382 Mental Health Screening - Noncompliance **1. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?** - Resident B no longer resides in the facility. - The facility collaborated with psychiatric physician for Resident H to create, implement comprehensive Care plan to address the diagnosed mental illness. - The facility collaborated with psychiatric physician for Resident J to create, implement comprehensive Care plan to address the diagnosed mental illness.	01/18/2023

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	was dated 3/7/22 and indicated Resident B was planning to look for a new Assisted Living Facility and had not talked much about his feeling about having to leave the last facility. He had a therapist but had not talked much about it, but admitted he still had some anger about leaving the last facility. His undifferentiated schizophrenia diagnosis was listed, "high," while the remainder of his diagnoses were listed, "medium." In review of his past medical history the following was included, but were not limited to: "Alcohol Problem drinking, remote history, no current use ... alcohol withdrawal symptoms ... depression ... Insomnia ... opiate use, remote history no current use ... schizophrenia hallucinations and delusions disorganized thoughts and behaviors ... Suicide attempt, once in 2008 ... Traumatic Brain Injury (TBI), multiple head injuries including hit his head with bat in his 20' or 30's; also motorcycle wreck at 36 ...." Resident B was seen by his primary physician on 9/1/22 and 12/2/22. Neither corresponding After Visit Summary's indicated Resident B's MMI (schizophrenia) had been reviewed for ongoing medical management and/or the presence of new or worsening symptoms. Resident B had physician's order for Risperdal (an antipsychotic medication) with instructions to take 10 mg (milligrams) every evening for his MMI and Trazadone, (an antidepressant medication) with instructions to take 150 mg at bedtime for insomnia. The electronic and hard chart record lacked documentation of any psychiatric assessments. The record lacked documentation of any comprehensive care plan related to his MMI		**2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** - All residents who have MMI have the potential to be affected by the alleged deficient practices. - All residents reviewed for MMI and Care Plans updated and referrals made to psychiatric physician as needed. - Assisted Living management staff will be in-serviced on 410 IAC 16.2-5.11.1(f) specifically the requirement that each resident with a major mental illness must have a care plan that is developed within (30) days after admission to the residential care facility. - Assisted Living management staff will be in-serviced on MMI Care Plans which outlines the system of creating and implementing comprehensive care plans, in cooperation with a psychiatric physician for those resident chronic major mental illness (MMI) diagnosis. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** - Assisted Living management staff will be	

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	diagnosis. The record lacked documentation of any behavior and/or symptom monitoring related to his MMI diagnosis. On 12/20/22, Resident B was found downed in a retention pond on the facility's property. His cause of death had not officially been determined by the survey exit date, however in subsequent interviews with the coroner, it was revealed that a suicide note had been found in his apartment. During an interview on 12/22/22 at 11:15 a.m., Licensed Practical Nurse (LPN) 18 indicated, she had known Resident B. He had good days and bad days, maybe some increased depression, like seasonal depression. He would drink a few beers here and there, but she did not know if he had a past history of drug/alcohol abuse or any previous suicide attempts. During an interview on 12/22/22 at 12:05 p.m., the Social Service Director (SSD) from the Skilled Nursing Facility indicated, she did not work directly with the Assisted Living Residents, unless it was part of the discharge process from Skilled Care to Assisted Living. There was no SSD for the Assisted Living side of the facility. During an interview on 12/22/22 at 12:27 p.m., Vice President of Senior Living (VP) if there was not an active issue related to a resident's MMI, then a care plan would not have been created. For residents on a Medicaid waiver, they were assessed upon admission and every 6 months, but care planning was not a part of that process unless there were active issues. During an interview on 12/22/22 at 12:30 p.m., the		in-serviced on 410 IAC 16.2-5.11.1(f) specifically the requirement that each resident with a major mental illness must have a care plan that is developed within (30) days after admission to the residential care facility. - Assisted Living management staff will be in-serviced on MMI Care Plans which outlines the system of creating and implementing comprehensive care plans, in cooperation with a psychiatric physician for those resident chronic major mental illness (MMI) diagnosis. - Assisted Living Nursing staff will complete MMI Review Tool for all new admissions. - Assisted Living Nursing staff will track all residents with MMI , and collaborate with a psychiatric physician for those residents with chronic major mental illness (MMI) diagnosis to ensure care plans are accurate and up to date. **4. How corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** - Audit Tool MMI Tracking Tool will be completed by the Executive Director, Clinical Director and/or designee to monitor compliance. Audits will be completed daily X5days, weekly X4 weeks, monthly thereafter to address all new	

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	155618	A. BUILDING 00 B. WING	12/22/2022

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	Assisted Living (AL) Director of Nursing Services (DNS) indicated Resident B's psychiatric notes were not on file and she had requested them to be faxed. She indicated she was supposed to oversee the Resident Assessments which should include the Care Planning process, but until that time, she had been unaware care plans were required, because "it's Assisted Living (AL)." If they do see a psychiatric provider, it up to the resident and the family to arrange and oversee those appointments, Psychiatric providers managed the prescription medications and the facility followed what they said. As long as she had been working at the facility, no one had been care-planning in coordination with psychiatric services and she was unaware care plans were required since it was AL. The AL DNS indicated she and other staff were completely shocked about what happened to Resident B because to their knowledge nothing had seemed off. 2. On 12/22/22 at 10:00 a.m., Resident H's medical record was reviewed. She was a newly admitted Assisted Living Resident with a current diagnosis which included, but was not limited to, bipolar disorder, current episode severe with psychotic features, (bipolar disorder is a mental health condition that causes extreme mood swings that include emotional highs and lows). She had physician's order for asenapine (an atypical antipsychotic medication used to treat schizophrenia and acute mania associated with bipolar disorder), with instructions to take one 5 mg tablet sublingually (under the tongue) every morning and 2 5 mg tablets sublingually every evening for her bipolar disorder. She had a physician's order for olanzapine, (an atypical antipsychotic primarily used to treat		admissions and changes in condition. - Results of audit tool will be presented to the QAPI Committee Monthly to review for compliance and follow-up. Identified noncompliance may result in staff reeducation and/or disciplinary action. - If 100% threshold is not achieved an action plan will be developed to achieve desired threshold. Data will be submitted to the QAPI committee overseen by the ED for review and follow-up.	

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	schizophrenia and bipolar disorder), with instructions to take a 5 mg tablet once before bedtime. She had a physician's order for sertraline (an antidepressant medication) with instructions to take two, 100 mg tablets daily for depression. The electronic and hard chart record lacked documentation of any psychiatric assessments. The record lacked documentation of any comprehensive care plan related to his MMI diagnosis. A nursing progress note, dated 12/6/22 at 4:30 p.m., indicated Resident H became upset and agitated during her insulin medication administration. She screamed at the nursing staff, cursed and waved her arms as if to hit the staff. She thew her phone and keys into the hallway. Nursing progress notes from 12/9/22 revealed the following: At 10:57 a.m., Resident H began yelling and screaming at staff to go to the hospital and called 911, but then refused to go to the hospital. Staff called a psychiatric provider. At 2:01 p.m., Resident H called a facility desk phone to ask for medication and was informed she would need to contact her psychiatric doctor. Resident H refused, so the writer called the psychiatric provider and left a message. By 3:39 p.m., Resident H still experienced behaviors but her psychiatric provider did not give any new orders, so the facility Nurse Practitioner (NP) was called, and a new order was			

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	received for Haldol (an antipsychotic medication) 5 mg intramuscular (IM) injection to be given at that time and another 5 mg dose in 30 minutes if no improvements in behaviors and could repeat that order for 24 hours over the next 3 days for aggressive behaviors. A STAT (immediately) order was sent to the pharmacy for delivery. At 3:58 p.m., the Haldol order was discussed with Resident H who began to yell and stated she would not take Haldol. At 8:12 p.m., an order administration note indicated, Resident H was given a Haldol injection for aggressive behaviors. On 12/22/22 at 11:05 a.m., Resident H was observed. Resident H had been lying in bed, but independently got up and walked to seat herself in her apartment living room for a conversation. She was wearing a t-shirt but no pants, so that her brief was exposed. She made no attempt to cover herself. Resident H indicated she was a new resident in the AL, she had come here after rehab in the nursing home where she had been treated for lithium toxicity. Resident H indicated everything was going ok for the most part, but she wanted an appointment with her doctor or NP that managed her psychiatric care. She indicated she had depression and bipolar and was anxious about her medication adjustments, so she wanted to talk to her doctor about it. So far that had not happened, and it was beginning to make her frustrated. Resident H indicated no one had talked to her about her medications or plan of care besides just bringing her medications in a cup and telling her what they were. No one had asked her about other things besides medicine that might help her calm down when she had episodes. Resident H indicated things that helped her were			

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	to be left alone for quiet time, going outside if the weather was nice, playing cards, and talking to her doctors about her feelings. Resident H indicated it would make her feel a lot better to see a psychiatric doctor to talk about her medications. During an interview on 12/22/22 at 11:45 a.m., the SSD from the Skilled Nursing Facility indicated she had worked with Resident H while she was in rehab in the nursing home. Typically, after a resident discharged from the skilled facility into AL, the SSD's role ended, however, Resident H did have some ongoing anxieties about her move to AL, so the SSD had helped her move into her new apartment and referred her to a psychiatrist that worked with the AL. The SSD did not know if this was the same provider she had seen before or not. When she was seen on the skilled side we did identify a lot of mental health concerns and she was followed closely by psychiatric provider while in rehab, as far as in AL, the SSD was unsure, but indicated nursing staff were responsible for admission process and planning. During an interview on 12/22/22 at 12:30 p.m., the AL DNS indicated she was supposed to oversee the Resident Assessments which should include the Care Planning process, but until that time, she had been unaware care plans were required, because "it's Assisted Living (AL)." If they do see a psychiatric provider, it up to the resident and the family to arrange and oversee those appointments, Psych managed the prescription medications and the facility followed what they said. As long as she had been working at the facility, no one had been care-planning in coordination with psychiatric services and she was unaware care plans were required since it was AL.			

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	3. On 12/22/22 at 10:50 a.m., Resident J's medical record was reviewed. He was an Assisted Living resident who had been living at the facility for less than a year. He had diagnoses which included, but were not limited to, schizoaffective disorder, bipolar type, mood disorder and recurrent major depressive disorder. He had physician's orders for risperidone (an antipsychotic medications) with instructions to take one 2 mg tablet every day for his MMI. The record lacked documentation of any comprehensive care plan related to his MMI diagnosis. Facilities policies/procedures related to comprehensive care plans for Medicaid recipients with a MMI diagnoses were requested but could not be provided by the survey exit date. This State Residential finding relates to Complaint IN00397504.			