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| | | A. BUILDING 00<br>B. WING | 10/04/2024 |

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| R 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00444050, IN00435195, IN00435202 and IN00435204.<br><br>Complaint IN00444050 - State deficiency related to the allegations is cited at R0051<br><br>Complaint IN00435195- State deficiencies related to the allegations are cited at R0052 and R0090<br><br>Complaint IN00435202 - State deficiency related to the allegations is cited at R0240.<br><br>Complaint IN00435204 - State deficiency related to the allegations is cited at R0240.<br><br>Survey dates: October 1, 2, 3 and 4, 2024<br><br>Facility number: 012229<br><br>Residential Census: 118<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality Review completed on 10/10/2024 | R 0000 | 11/5/24 – To Whom It May Concern: On October 1st to October 4th, 2024, a complaint survey was conducted at StoryPoint Granger. Attached is the revised plan of correction for tags R051, R052, R090 and R240, the creation and submission of this 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.<br>Due to the relative low scope and severity of this survey, the community respectfully requests a desk review in lieu of a post-survey revisit.<br>Thank you for your time and consideration,<br>Martin Lebbin<br>Executive Director<br>StoryPoint Granger | |
| R 0051<br><br>Bldg. 00 | 410 IAC 16.2-5-1.2(u)<br>Residents' Rights - Offense<br><br>Based on interview and record review, the facility failed to ensure residents were free from chemical restraints related to the use of antipsychotic medications for Resident B without a supporting diagnosis and a physicina's order, for its use, for 1 of 3 residents reviewed for antipsychotic medication usage. (Resident B) | R 0051 | **R051 – Residents' Rights - Offense**<br>It is the practice of this provider to assure residents have the right to be free from any physical or chemical restraints imposed for the purposes of discipline or | 11/01/2024 |

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

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| | Finding includes:<br><br>On 10/3/24 at 11:22 A.M., a review of the clinical record for Resident B was conducted. The record indicated the resident was admitted on 6/27/24. The resident's diagnoses included, but were not limited to: "...unspecified dementia, unspecified severity, without behavior disturbance, psychotic disturbance, mood disturbance and anxiety and osteoarthritis of hip...."<br><br>A Nursing Progress Note, dated 7/9/24 at 6:13 P.M., indicated there was a new order to start ABH (Ativan 1mg/Benadryl 25 mg/Haldol 1 mg) gel topically at night every evening ,between 7:00 & 8:00 P.M., for anxiety.<br><br>A Behavior Expression Note, dated 9/11/24 at 3:20 P.M., indicated Resident B had been continuously redirected and reassured , had been yelling out and was negatively agitated by any distractions and interactions with staff. Staff had attempted to offer fluids and snacks but the interventions had been unsuccessful.<br><br>A Physician order, dated 9/11/24, indicated to increased the dose of ABH gel and apply the gel, 1 milliliter (ml) to the resident's inner wrist twice a day and once a day PRN (as needed).<br><br>A Behavior Expression Note, dated 9/12/24 at 3:01 P.M., indicated Resident B was yelling out and staff had attempted to hydrate the resident to help keep him calm was the intervention was unsuccessful. The PRN anxiety medication used had been approved for administration.<br><br>A Medication Administration Note, dated 9/13/24 at 1:29 P.M., indicated the resident was | | convenience and not required to treat the resident's medical symptoms.<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>Resident B was missing a supporting diagnosis and physician's order.<br>The residents did not experience any negative outcomes related to the deficient concern.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**<br>All residents have the potential to be affected.<br>Resident B was missing a supporting diagnosis and physician's order.<br>Residents did not experience any negative outcomes related to the deficient concern.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>Nursing will review charts and meet with medical providers to assure supporting diagnosis and physician's orders are up to date for all in-house residents. The DNS/Designee will re-educate (Appendix A) the nursing staff on the need to have supporting | |

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| | administered a PRN dose of the ABH gel due to yelling out. The medication was ineffective.<br><br>A Medication Administration Note, dated 9/14/24 at 3:11 P.M., indicated the resident was again administered a PRN dose of the ABH gel, for yelling out and the medication was ineffective.<br><br>A Communication Note from the facility to the physician, dated 9/16/24 at 12:42 P.M., indicated staff had reported Resident B had increased agitation and aggression towards staff during dinner the previous evening. A new order was received for Ativan (an anti-anxiety medication) 0.5 mg (milligrams) every 8 hours.<br><br>A Behavior Expression Note, dated 9/17/24 at 3:20 P.M., indicated Resident B was yelling out and staff had attempted to distract the resident, but he continued to yell out.<br><br>A new Physician's Order was received, on 9/17/24, for Zyprexa (an anti-psychotic medication) 5 mg two (2) times a day for "antipsychotic".<br><br>A Communication Note from the facility to the physician, dated 9/20/24 at 1:17 P.M., indicated the resident had experienced increased weakness, was dropping food from his mouth and his tongue had become deviated to the right side. The daughter had been contacted but refused to allow the resident to be sent to a local ER. Staff were advised to have the resident lie down and continue to monitor the resident. However, when the staff transferred the resident, to bed, he became unresponsive. The note indicated the resident was talking with his eyes closed and the daughter then agreed for the resident to be transferred to a local ER. | | diagnosis and physician orders upon admission.<br>The physician/psych provider will see the residents on antipsychotic medications monthly and review their effectiveness. Any new residents prescribed antipsychotic medications will be monitored for 7-14 days with supporting documentation for any adverse reactions including notifying the provider if needed. The physician/psych provider will reevaluate the resident in two weeks and then monthly. This will be ongoing. The DNS/Designee will retrieve weekly reports for any resident receiving antipsychotic medications to ensure documentation is complete. This will be ongoing.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**<br>The physician/psych provider will see the residents on antipsychotic medications monthly and review their effectiveness. Any new residents prescribed antipsychotic medications will be monitored for 7-14 days with supporting documentation for any adverse reactions including notifying the provider if needed. The physician/psych provider will reevaluate the resident in two weeks and then monthly. This will | |

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| | The Emergency Department Note, dated 9/20/24 at 1:15 P.M., indicated Resident B presented to the ER with decreased mental status. It had been reported to the ER that the resident had recently became more agitated at nighttime and was started on Ativan, as well as Zyprexa. The resident received a CT (Computed Tomography) scan, blood work and a chest x-ray which were all normal. The Note indicated the ER physician spoke to the resident's internist and he agreed he would take the resident off of the sedating medications (Ativan & Zyprexa) and "ramp" them up more slowly if the resident became more agitated. The Note indicated the resident was released back to the facility. The ER Clinical Impression, dated 9/20/24 at 6:48 P.M., indicated the resident had been diangosed with: "Adverse effect of drug" and resident was discharged back to the facility.<br><br>The Medication Administration indicated the resident was administered Zyprexa 5 mg at 8:00 P.M. on 9/20/2024.<br><br>A Communication Note from the facility to the physician, dated 9/20/24 at 10:32 P.M., indicated the resident had returned from the ER, with orders from the ER physician to administer the ABH gel but to discontinue the Zyprexa and Ativan.<br><br>A Communication Note from the facility to the physician, dated 9/23/24 at 3:00 P.M., indicated the resident had a new order to start Seroquel (an antipsychotic) 12.5 mg twice a day for agitation and anxiety because staff had reported the resident had been calling out since 2:00 P.M.<br><br>A Communication Note from the facility to the physician,, dated 9/24/24 at 12:50 P.M., indicated the resident appeared to be adjusting to the | | be ongoing.<br>The DNS/Designee will be responsible for the review and completion of resident records. Reviewing to make sure they contain updated supporting diagnosis and physician orders. This is ongoing. If a threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Executive Director for review and follow-up.<br>**By what date the systemic chances will be completed:**<br>Compliance date: 11/15/24 | |

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| | Seroquel with no adverse side effects noted. The resident had not yelled out.<br><br>An Physician's Order/Medication Note, dated 9/24/24 at 3:26 P.M., indicated a new physician order was received. The resident's current dose of Seroquel was discontinued and a new order for Seroquel 12.5 mg at bedtime was received for sleep<br><br>On 9/30/24 at 4:19 P.M., an Admit/Discharge Note indicated the resident had moved from the facility.<br><br>During an interview, on 10/3/24 at 3:03 P.M., the Assistant Director of Nursing (ADON) confirmed the resident should not have received another dose of the Zypreza medication after his return from the hospital as it had been discontinued.<br><br>During an interview, on 10/4/24 at 2:15 P.M., the ADON indicated the resident had not had a psychotropic medication review completed.<br><br>On 10/4/24 at 2:15 P.M., the ADON provided a policy titled, "Psychotropic Medication Review", dated 5/12/24, and indicated the policy was the one currently used by the facility. The policy indicated "...The purpose of the Psychotropic Medication Review policy is to ensure psychotropic medications are used to prescriber's guidelines at the lowest effective dose for the purpose of resident safety...Psychotropic medications may be used in the treatment of a variety of psychotic and anxiety disorders. In the older adult, non-pharmacological alternatives are preferred. When a psychotropic medication is prescribed, a Psychotropic Medication Review form should be completed...The review is to be completed by the Wellness Director...." | | | |

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| R 0052<br>Bldg. 00 | This State Residential finding relates to Complaint IN00444050.<br><br>410 IAC 16.2-5-1.2(v)(1-6)<br>Residents' Rights - Offense<br><br>Based on interview and record review, the facility neglected to provide nursing assessments, after an unwitnessed fall,, for 1 of 4 residents reviewed for falls. This deficient practice the resident becoming nonresponsive prior to being sent to the emergency room with diagnoses of a brain hemorrhage (active bleeding), a massive brain hematoma (clotted blood). The resident did expire from his injuries. (Resident D)<br><br>Finding includes:<br><br>On 10/1/24 at 1:05 P.M., a review of the clinical record for Resident D was conducted. The record indicated the resident was admitted on 4/18/24 The resident's diagnoses included, but were not limited to: aphasia (inability to speak well), cerebral infarction, delusions, history of brain hemorrhage and seizures.<br><br>A Morse Fall Assessment for Resident D, completed on 4/18/24, indicated the resident scored a 50. The Fall Assessment indicated a score of 45 or higher indicated the resident was at high risk for a falls.<br><br>A Nursing Progress Note, dated 4/18/24 1:42 P.M., indicated Resident D was alert and oriented to person. place and time. The resident was verbal but had aphasia and delayed speech response times He was ambulatory with a steady and slow gait and used a walker at times<br><br>There were no other Progress Notes until the date | R 0052 | **R052 – Residents' Rights - Offense**<br>It is the practice of this provider to assure residents have the right to be free from sexual abuse, physical abuse, mental abuse, corporal punishment, neglect, and involuntary seclusion.<br>***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:***<br>The Wellness staff were re-educated by the DNS/Designee regarding the protocol (Appendix B) for assessing a resident with an unwitnessed fall after normal business hours.<br>It is unclear if the resident experienced any negative outcomes related to the deficient concern.<br>***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:***<br>All residents have the potential to be affected.<br>The Wellness staff were re-educated by the DNS/Designee regarding the protocol (Appendix B) for assessing a resident with an | 10/31/2024 |

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| | of his fall on 5/2/2024.<br><br>A Nursing Progress Note, dated 5/2/24 at 4:35 A.M., created on 5/2/24 by Triage Agency Nurse 6 indicated the following "QMA 2 stated resident was found during rounds lying on his right side outside his bathroom near the bathroom doorway. Resident could not state what he was doing or how he fell. Resident does not use a walker or wheelchair. No injuries noted to head or body. Resident denied any pain. Resident was assisted off the ground and was able to ambulate back to bed without difficulty. Vital signs obtained...."<br><br>A form titled "Fall", dated 5/2/24 at 4:35 A.M., indicated the following "QMA 2 ...stated resident was found during rounds lying on his right side outside his bathroom near the bathroom doorway. Resident could not state what he was doing or how he fell. Resident does not use a walker or wheelchair. No injuries noted to head or body. Resident denied any pain. Resident was assisted off the ground and was able to ambulate back to bed without difficulty...." The resident's temperature was 97.7, Pulse 75, Respirations 17, blood pressure 173/87 and oxygen saturation was 91%. The resident was alert and oriented to person and place. The form indicated Resident D was not taken to the hospital and the daughter was notified, the MD (Medical Doctor) was faxed and the Director of Nursing was emailed regarding the fall.<br><br>There were no other documented assessments, on 5/2/24 between 4:35 A.M. and 8:33 A.M.<br><br>A Nursing Progress Note, dated 5/2/24 at 8:34 A.M., indicted LPN 3 had documented Resident D was transported to a local Emergency Room (ER) due to a head injury with a change in the | | unwitnessed fall after normal business hours.<br>Residents did not experience any negative outcomes related to the deficient concern.<br>***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:***<br>StoryPoint utilizes an in-house on-call nurse who is available for visual triage after hours. Any after-hour triage calls are handled by the on-call nurse and the DNS/Designee is notified to make sure all assessments are completed appropriately. If concerns are noted, the DNS/Designee follow-up to make sure the assessment was completed. This will be on-going. The DNS/Designee will review the “Pertinent Q Shift Charting” report (Appendix C) each weekday. The report will be reviewed for any after-hour falls and documentation will be reviewed. Any wellness staff not following the protocol will be identified.<br><br>***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:***<br>StoryPoint utilizes an in-house on-call nurse who is available for visual triage after hours. Any after-hour triage calls are handled | |

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| | resident's condition and a decline in his mobility.<br><br>An Emergency Room (ER) Note, dated 5/2/24 at 8:47 A.M., indicated the following: "Resident D arrived to the ER unresponsive. According to the facility staff, the patient had been found on the ground outside of his bed, at approximately 4:00 A.M. and placed back in his bed. Later, facility staff found the patient to be minimally responsive, nursing concerned with possible right facial droop and had not appeared to be moving his extremities. He was taken directly to CT (Computerized Tomography) by EMS (Emergency Medical Services) where he was evaluated. CT demonstrated a catastrophic large left intracranial hemorrhage. "<br><br>A CT report, dated 5/2/24 at 8:59 A.M., indicated "...New massive left hemispheric parenchymal [functional tissue in the brain] hematoma measuring at least 9 cm [centimeters]...."<br><br>A Nursing Progress Note, dated 5/2/24 at 1:04 P.M., indicated Resident D "... is admitted to [name of hospital] for massive brain bleed per ER nurse, dtr [daughter] is planning to take resident home...on hospice...."<br><br>A review of Timecard Report indicated there was no Registered Nurses (RN) or Licensed Practical Nurses (LPN) working at the facility during the night shift on 5/2/24.<br><br>A Nursing Progress Note dated 5/7/24 at 12:43 P.M., indicated the resident's daughter "...notified facility that resident passed away on Saturday, May 4th...."<br><br>A hand written statement by LPN 3, dated 5/17/24 indicated on 5/2/24 night shift reported a fall with | | by the on-call nurse and the DNS/Designee is notified to make sure all assessments are completed appropriately. If concerns are noted, the DNS/Designee follow-up to make sure the assessment was completed. This will be on-going. To ensure ongoing compliance with this corrective action, nursing will review the “Pertinent Q Shift Charting” report (Appendix C) each weekday. The report will be reviewed for any after-hour falls and documentation will be reviewed. Any wellness staff not following the protocol will be identified. If a threshold of 100% is not met, an action plan for the employee will be developed. This will be ongoing. Findings will be submitted to the Executive Director for review and follow-up.<br>**By what date the systemic changes will be completed:**<br>Compliance date: 11/5/24 | |

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| | no injuries in Resident D's room. LPN had directed staff, on 1st shift (6:00 A.M. was the day shift start time), to check on the resident . " ...It was noted a laceration was present to back of his head. Resident was then sent to ER [emergency room] ...."<br><br>A hand written statement by QMA 2, dated 5/21/24, indicated, on 5/2/24 at approximately 4:00 A.M., CNA 4 had called on a walkie talkie to QMA 2 to report to Resident D's room as he had fallen. When QMA 2 arrived to the room, she observed the resident on the floor of his bedroom, lying on his right side. CNA 4 obtained vitals as QMA 2 called a Triage Agency. QMA 2's statement indicated she had asked the resident if he was in pain " ...he mumbled but no clear answer ...." QMA 2 explained everything CNA 4 had told QMA 2 to the Triage Agency nurse and theTriage nurse asked if there were any visible injuries, which QMA 2 had told the nurse there were none. QMA 2 was instructed, by the Triage nurse, to "get him off the floor and she would complete her report". QMA 2's statement indicated as she was coming downstairs she saw LPN 3 (day shift nurse) and explained everything that had happened, then proceeded to the North unit to get CNA 5 to assist CNA 4 to lift Resident D up off of the floor.<br><br>During an interview, on 10/1/24 at 2:24 P.M., the Director of Nursing (DON) indicated when QMAs and CNAs worked the night shift and there was no RN or LPN in the facility, the QMA's had been instructed to contact a Triage Service if there was a need for a nurse and RN 6 worked for the Triage service.. The Triage Service was contacted for required incident/fall reports and as needed for medication approval. The DON indicated a QMA can not assess a resident after a fall. The DON | | | |

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| | indicated LPN 3 and QMA 2 no longer worked for the facility and were unable to be contacted for an interview. QMA 3 had been terminated due to falsifying documentation.<br><br>During a telephone interview, on 10/1/24 at 3:13 P.M., RN 6 indicated she worked for a Triage Service located in Mississippi. She indicated she had been contacted by QMA 2, on 5/2/24, regarding Resident D's fall and would be referring to her notes during the conversation. RN 6 indicated she had received a call from a QMA 2 ,who indicated she had found the resident on the floor during her rounds, lying on his side, near the bathroom. RN 6 indicated she heard the automated vital sign machine working in the background and the QMA had relayed the vitals signs to her. RN 6 indicated she was told the resident had no injuries. She could not see the resident and she directed them to place the resident in bed. She had not provided any further directions to QMA 2 and had written the Progress note with the information provided by QMA 2.<br><br>During an interview, on 10/2/24 at 10:00 A.M., CNA 4 indicated she had found the Resident D, in his room, on the floor. CNA 4 indicated QMA 2 did not find him. CNA 4 had called for help on a "walkie" stating Resident D was on the floor and required immediate assistance. CNA 4 indicated the resident was incoherent and moaning. No one answered her call for help for approximately 10 minutes, so she told the resident she needed to go get help and left him to go to the first floor and grabbed a vitals machine (takes the resident's b/p, temperature, and pulse). QMA 2 came in Resident D's room and called the Triage Nurse as she was taking the resident's vital signs . QMA 2 instructed her to lift the resident to his bed but would not assist CNA 4, as QMA 2 said she had | | | |

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| | a bad shoulder. So QMA 2 left the resident's room and obtained another CNA. CNA 4 and CNA 5 then lifted the resident to his bed, about 30 minutes after CNA 4 had found him on the floor. CNA 4 indicated the resident did not assist with the transfer and was "dead weight". CNA 4 indicated this was not normal for the resident as he had walked independently in his room and could bear his own weight. CNA 4 indicated she had checked on the resident earlier in the night and he had been walking around, in his room, searching for something.<br><br>On 10/1/24 at 3:12 P.M., the DON provided a policy titled, " Resident Falls", dated 3/22/23, and indicated the policy was the one currently used by the facility. The policy indicated "...The purpose of the Residents Falls policy is to provide guidelines for evaluating a resident after a fall...a. Caregivers provide appropriate care and frequent resident checks. Any change in status is reported to the Wellness Leader [Director of Nursing]. The staff, with the Healthcare provider's guidance, will follow up on any fall with associated injury until resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out of [sic] resolved...."<br><br>This State Residential finding relates to Complaint IN00435195. | | | |
| R 0090<br><br>Bldg. 00 | 410 IAC 16.2-5-1.3(g)(1-6)<br>Administration and Management - Deficiency<br><br>Based on interview and record review, the facility failed to inform the Indiana Department of Health (IDOH) of a incident, in which a resident had an unwitnessed fall, which resulted in hospitalization and death. (Resident D) | R 0090 | **R090 – Administration and Management - Deficiency**<br>It is the practice of this provider to immediately report any unusual occurrence that directly threatens the welfare, safety, or health of a | 10/31/2024 |

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| | Finding includes:<br><br>On 10/1/24 at 1:05 P.M., a review of the clinical record for Resident D was conducted. The record indicated the resident was admitted on 4/18/24 The resident's diagnoses included, but were not limited to: aphasia (inability to speak well), cerebral infarction, delusions, history of brain hemorrhage and seizures.<br><br>A Nursing Progress Note, dated 5/2/24 at 4:35 A.M., created on 5/2/24 by Triage Agency Nurse 6 indicated the following: "QMA 2 ..stated resident was found during rounds lying on his right side outside his bathroom near the bathroom doorway. Resident could not state what he was doing or how he fell. Resident does not use a walker or wheelchair. No injuries noted to head or body. Resident denied any pain. Resident was assisted off the ground and was able to ambulate back to bed without difficulty. Vital signs obtained...."<br><br>A form titled "Fall", dated 5/2/24 at 4:35 A.M., indicated the following: "QMA 2 ...stated resident was found during rounds lying on his right side outside his bathroom near the bathroom doorway. Resident could not state what he was doing or how he fell. Resident does not use a walker or wheelchair. No injuries noted to head or body. Resident denied any pain. Resident was assisted off the ground and was able to ambulate back to bed without difficulty...." The resident's vital signs were documented as follows: temperature was 97.7, Pulse 75, Respirations 17, blood pressure 173/87 and oxygen saturation was 91%. The resident noted to be alert and oriented to person and place. The form indicated Resident D was not taken to the hospital , the resident's daughter was notified, the MD (Medical Doctor) | | resident.<br>***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:***<br>The policy on “Resident Incident/Accident Reporting” was reviewed regarding the reporting of any unusual occurrence that directly threatens the welfare, safety, or health of a resident. (Appendix D) Staff were re-educated, by the DNS/ED, regarding the need to report any unusual occurrence (Appendix E) that directly threatens the welfare, safety, or health of a resident within 24 hours to the state.<br>The resident did not experience any unexpected outcome related to the deficient concern.<br>***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:***<br>All residents have the potential to be affected.<br>The policy on “Resident Incident/Accident Reporting” (Appendix D) was reviewed regarding the reporting of any unusual occurrence that directly threatens the welfare, safety, or health of a resident. Staff were re-educated (Appendix E), by the DNS/ED, regarding the need to report any unusual occurrence that directly threatens the welfare, | |

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| | was faxed and the Director of Nursing was emailed regarding the fall.<br><br>A Nursing Progress Note, dated 5/2/24 at 8:34 A.M., indicated LPN 3 had documented Resident D was transported to a local Emergency Room (ER) due to a head injury with a change in the resident's condition, with a decline in his mobility.<br><br>An Emergency Room (ER) Note, dated 5/2/24 at 8:47 A.M., indicated the following: "Resident D arrived to the ER unresponsive. According to the facility staff, the patient had been found on the ground outside of his bed, at approximately 4:00 A.M. and placed back in his bed. Later, facility staff found the patient to be minimally responsive, nursing concerned with possible right facial droop and had not appeared to be moving his extremities. He was taken directly to CT (Computerized Tomography) by EMS (Emergency Medical Services) where he was evaluated. CT demonstrated a catastrophic large left intracranial hemorrhage. "<br><br>A Nursing Progress Note, dated 5/2/24 at 1:04 P.M., indicated Resident D "... is admitted to [name of hospital] for massive brain bleed per ER nurse, dtr [daughter] is planning to take resident home...on hospice...."<br><br>A Nurse Progress Note dated 5/7/24 at 12:43 P.M., indicated the following "...notified facility that resident passed away on Saturday, May 4th...." Resident D's daughter had notified the facility of the resident's passing.<br><br>During an interview on 10/2/24 at 12:25 P.M., the Administrator indicated there was no self-reported incident reported to IDOH regarding the fall with injury for Resident D. | | safety, or health of a resident within 24 hours to the state. Residents did not experience any negative outcomes related to the deficient concern.<br>***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:***<br>The policy on "Resident Incident/Accident Reporting" (Appendix D) was reviewed regarding the reporting of any unusual occurrence that directly threatens the welfare, safety, or health of a resident. Staff were re-educated (Appendix E), by the DNS/ED, regarding the need to report any unusual occurrence that directly threatens the welfare, safety, or health of a resident within 24 hours to the state. If concerns are noted, the ED/DNS/Designee will be notified immediately for corrective action. To ensure timely reporting, the DNS/ED/Designee will immediately be notified of any resident incidents. The DNS/ED will follow up and submit any reportables to the state. The DNS/ED/Designee will review the 24-hour report and or incident reports to ensure that all resident incidents have been completed and reported. Per the policy on "Resident Incident/Accident Reporting" (Appendix D). This will be ongoing. | |

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| | On 10/1/24 at 3:12 P.M., the DON provided a policy titled, "Resident Incident/Accident Reporting", dated 1/20/23, and indicated the policy was the one currently used by the facility. The policy indicated "...Reportable Incidents...The Administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be mad by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:<br>(A) epidemic outbreaks;<br>(B) poisonings;<br>(C) fires; or<br>(D) major accidents...<br>Types of incidents reportable under state rules...2. Death of a resident that is unusual, violent, suspicious, or resulted from an accident...."<br><br>This State Residential finding relates to Complaint IN00435195. | | ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:***<br>The policy on "Resident Incident/Accident Reporting" (Appendix D) was reviewed regarding the reporting of any unusual occurrence that directly threatens the welfare, safety, or health of a resident. The ED will monitor the reporting of any allegations of abuse and report to the state within 24 hours. If concerns are noted, the ED/DNS/Designee will be notified immediately for corrective action. In order to ensure timely reporting, the DNS/ED/Designee will immediately be notified of any resident incidents. The DNS/ED will follow up and submit any reportables to the state. The DNS/ED/Designee will review the 24-hour report and or incident reports to ensure that all resident incidents have been completed and reported. Per the policy on "Resident Incident/Accident Reporting" (Appendix D). This will be ongoing.<br><br>**By what date the systemic changes will be completed:**<br>Compliance date: 11/5/24 | |
| R 0240<br><br>Bldg. 00 | 410 IAC 16.2-5-4(d)<br>Health Services - Deficiency | | | |

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| | Based on observation, interview and record review, the facility failed to provide, physician ordered, colostomy/ileostomy care and assistance for 1 of 1 residents reviewed who had an iloeostomy (an opening in the abdominal wall in which stool comes out of the body). (Resident C)<br><br>Finding includes:<br><br>On 10/1/24 at 2:22 P.M., the Director of Nursing provided a Qualified Medication Aide (QMA) Scope of Practice, which indicated a QMA could empty and change a colostomy bag.<br><br>On 10/2/24 at 12:54 P.M., a review of the clinical record for Resident C was conducted. The resident's diagnoses included, but were not limited to: intestinal obstruction with ileostomy and edema<br><br>A Physician Order, dated 1/27/24 indicated "... Assist resident with replacement of ostomy system, remove old wafer and paste, cleanse with soap and water, air dry with blow dryer on low heat, apply skin prep, apply clear protectant film, apply stoma powder to stoma, apply paste to wafer system, apply to stoma and secure with kinetic tape, blow dry area on low heat for 1 min and press firmly to secure, apply ostomy belt one time a day every 3 day(s) for ileostomy...." There was also an order to provide ostomy assistance as needed.<br><br>A Wellness Evaluation/Service Plan dated 9/23/24, indicated Resident C required atypical service due to physical limitations including, but not limited to: assistance with ostomy care and toileting management. | R 0240 | **R240 – Health Services - Noncompliance**<br>It is the practice of this provider to provide personal care, and assistance with activities of daily living, based upon the individual needs and preferences.<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>Nursing staff followed up with resident 1's physician to update colostomy/ileostomy care orders. The residents did not experience any negative outcomes related to the deficient concern.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**<br>All residents have the potential to be affected.<br>Nursing staff followed up with resident 1's physician to update colostomy/ileostomy care orders. Any new residents admitted with colostomy/ileostomy care orders will be reviewed by the DNS/Designee to make sure the proper care is being administered. Residents did not experience any negative outcomes related to the deficient concern.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient** | 10/31/2024 |

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| | During an interview, on 10/2/24 2:11 P.M., Resident C indicated she had an ostomy and pointed to her upper abdomen. She indicated there were staff that had refused to mess with it and it made her feel insecure. She indicated if those who did not want to mess with it were working and something went wrong, they might not deal with it. The resident indicated she was required to pay extra on her rent due to needing staff assistance, with her ostomy, due to her arthritic hands. She indicated her ostomy care usually was completed on her shower days (Monday and Thursday) but she might have to wait until there was someone at the facility who was willing to help her.<br><br>A Review of the MAR (Medication Administration Record) for September indicated there was no documentation indicating the ostomy assistance was provided on the following days: 9/2, 9/8, 9/17, 9/20, 9/23, 9/26 and 9/29/24.<br><br>During an interview, on 10/2/24 at 2:57 P.M., the Assistant Director of Nursing (ADON) indicated the colostomy process was being provided and thought the staff had just failed to document its completion. She some indicated some QMAs (Qualified Medication Aide) had refused to assist the resident with her ostomy care and the resident had to wait until another staff member provided the assistance.<br><br>On 10/2/24 at 2:59 P.M., the ADON provided a policy titled, "Medication Administration", dated 4/11/24, and indicated the policy was the one currently used by the facility. The policy indicated the individual who administers medication and/or treatments on the resident's MAR "...records the administration...." | | **practice does not recur:**<br>Nursing has been re-educated by the DNS/Designee on the requirements for colostomy/ileostomy care (Appendix F & G). Any new residents admitted with colostomy/ileostomy care orders will be reviewed by the DNS/Designee to make sure the proper care is being administered. All existing and new nursing staff will be in-serviced using colostomy/ileostomy care check off with return demonstration to make sure they are comfortable with providing colostomy/ileostomy care.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**<br>To ensure ongoing compliance with this corrective action, all existing and new nursing staff will be in serviced using colostomy/ileostomy care check off with return demonstration to make sure they are comfortable with providing colostomy/ileostomy care. The DNS/ADNS will meet with any resident needing colostomy/ileostomy care weekly for 4 weeks. Monthly for 4 months and then quarterly. Nursing staff will be in-serviced yearly.<br>The DNS/Designee will be | |

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| | During an interview, on 10/4/24 at 12:18 P.M., the Administrator indicated there was no facility policy regarding ostomy care or procedure.<br><br>This State Residential finding relates to Complaints IN00435202 and IN00435204. | | responsible for reviewing the orders of any new residents admitted or with a new diagnosis requiring colostomy/ileostomy care. The DNS/Designee to make sure the proper care is being administered by reviewing the "Pertinent Q Shift Charting" report (Appendix C) regarding any concerns regarding colostomy/ileostomy care. If a threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the ED for review and follow-up.<br>**By what date the systemic chances will be completed:**<br>Compliance date: 11/15/24 | |