STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155815	A. BUILDING 00 B. WING	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLEARVISTA LAKE HEALTH CAMPUS	8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00433407, IN00429359, IN00425779 and Residential Complaint IN00424020. Complaint IN00433407 - No deficiencies related to the allegations are cited. Complaint IN00429359 - Federal/state deficiencies related to the allegations are cited at F684. Complaint IN00425779 - No deficiencies related to the allegations are cited. Complaint IN00424020 - Residential- State deficiencies related to the allegations are cited at R27 and R117. Survey date: May 3, 2024 Facility number: 013019 Provider number: 155815 AIM number: 201251520 Census Bed Type: SNF/NF: 20 SNF: 9 Residential: 36 Total: 65 Census Payor Type: Medicare: 9 Medicaid: 20 Total: 29 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	The submission of this plan of correction does not indicate an admission by Clearvista Lake that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, and living environment provided to the residents of Clearvista. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandie Briggs	RN, Clinical Support	05/16/2024

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

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	Quality review completed on May 8, 2024			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure a resident was provided timely care and/or services in accordance with professional standards of practice for a resident who experienced an unwitnessed fall within the facility for 1 of 3 residents reviewed for falls. (Resident M) Findings include: The clinical record for Resident G was reviewed on 5/3/24 at 2:39 p.m. Resident M's diagnoses included, but not limited to, cerebrovascular accident (CVA, stroke), fibromyalgia (widespread body pain), hypertension (high blood pressure) and dementia. A nursing note dated 3/20/24 at 8:25 a.m. indicated, Resident M had an unwitnessed fall and was found on the floor between her bed and the bedside table by a staff member. No injuries were noted at the time and the resident had no complaints of pain per the nursing note. A physician's note dated 3/21/24 at 9:16 a.m. and recorded as a late entry on 3/26/24 at 9:16 a.m.	F 0684	1 Resident M was affected. Resident is without adverse effect. 2 All residents whom have orders for neurological checks have the potential to be affected. All nursing staff have been educated on the neurological check policy. All residents whom had orders for neurological assessments post fall were audits for completion. 3 As a measure of ongoing compliance, DHS or designee to complete random audits of neurological assessments for residents post fall. Audits to be completed on 3 residents weekly x4 weeks; then 3 residents biweekly x8 weeks, then 3 residents monthly x3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred	05/20/2024

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	indicated, "Resident experienced an unwitnessed fall [sic, and] was found on the floor in her room. No signs or symptoms of obvious injury. Mentation at baseline. Continue post fall neuro [sic, neurological] checks and fall precautions per facility standard." A review of Resident M's March 2024 orders indicated, a nursing intervention for post fall neurological assessments were to be completed as follows: Every 30 minutes for 4 times; Every hour for 4 hours; and every 4 hours for 5 times. Neurological assessments were to begin immediately post fall and included to monitor for level of consciousness; ability to perform certain facial movements; strength of hand grasps and bilateral lower extremity movements; pupil reactions; quality of speech; and signs and/or symptoms of dizziness, headache, nausea/vomiting or seizure activity. Resident M's March 2024 MAR (medication administration record) received on 5/3/24 at 3:08 p.m. from CS (Clinical Support) indicated, the every 30 minute neurological assessments began at 8:30 a.m. and ended at 10 a.m. on 3/20/24. The hourly neurological assessments should have begun at 11 a.m. and ended at 2 p.m. However, Resident M's March 2024 MAR did not indicate the 11 a.m. neurological assessment had been completed. The every four hour neuro assessments should have started at 6 p.m. on 3/20/24 and ended at 6 a.m. on 3/21/24. However, Resident M's March 2024 MAR indicated the following: On 3/20/24, the first of the every 4 hour neuro assessments was completed on 3/20/24 at 11 p.m. which was late as it should have been done at 6 p.m. then again at 10 p.m., 2 a.m. on 3/21/24 and finally at 6 a.m. on 3/21/24. Additionally, on 3/21/24 the only neuro		percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	assessment completed was at 3 a.m. The 7 a.m. assessment only documented the vitals but did not indicate the neurological assessment had been completed. An interview with CS conducted on 5/3/24 at 4:19 p.m. indicated, when a resident has an unwitnessed fall, neurological assessments should have been completed to minimize and/or prevent injury. A Falls Management Program Guidelines policy received on 5/3/24 at 10:42 a.m. from ED (Executive Director) 3 indicated, the purpose of the policy was to maintain a hazard free environment, mitigate fall risk factors and implement preventive measures however, not all falls are prevented and at those times "intensive efforts will be directed toward minimizing or preventing injury." This tag relates to Complaint IN00429359. 3.1-37(a)			
R 0000 Bldg. 00	This visit was for the Investigation of Residential Complaint IN00424020 and Nursing Home Complaints IN00433407, IN00429359, IN00425779 Complaint IN00424020 - Residential-State deficiencies related to the allegations are cited at R27 and R117. Complaint IN00433407 - No deficiencies related to the allegations are cited. Complaint IN00429359 - Federal/state deficiencies related to the allegations are cited at F684.	R 0000	The submission of this plan of correction does not indicate an admission by Clearvista Lake that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, and living environment provided to the residents of Clearvista. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient	

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	Complaint IN00425779 - No deficiencies related to the allegations are cited. Survey date: May 3, 2024 Facility number: 013019 Residential Census: 36 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 8, 2024		manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0027 Bldg. 00	410 IAC 16.2-5-1.2(b) Residents' Rights - Deficiency (b) Residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Residents have the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States. Based on interview and record review, the facility failed to ensure a dignified existence regarding a staff member not appropriately addressing a resident experiencing a behavior for 1 of 3 reportable incidents reviewed. (Residents B and C) Findings include: 1. The clinical record for Resident B was reviewed on 5/3/24 at 11:00 a.m. The diagnoses for Resident B included, but were not limited to, dementia, Alzheimer's disease, psychotic disturbance and agitation. The resident was admitted to the facility on 11/1/23.	R 0027	1 Resident B was affected. Resident was without adverse effect. 2 All residents with behavioral expressions have the potential to be affected. All nursing staff have been educated on behavioral expressions and approach, ADL's and dignity. 3 As a measure of ongoing compliance, DHS or designee to complete random audits of interactions of nursing staff with residents with behavioral expressions. Audits to be	05/20/2024

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	A service plan for Resident B dated 11/1/23 indicated "...Mobility Performance: requires physical assistance - requires a person to push wheelchair, use gait belt to steady during ambulation or some type of physical assistance...Mobility Service: encourage safety precautions, provide assistance of two as needed...Transfer Performance: physical assistance - requires physical assistance of one person to transfer. Transfer Service Plan: provide assistance of two (describe) - sundown (a mental state of confusion which can cause behaviors such as anxiety, aggression, wandering)...Hygiene/Dressing Performance: Requires physical assistance - physical assistance to get dressed by the staff...Mood and Behavior: No mood or behavior concerns - resident does not exhibit any mood or behavior concerns...BIMS [Brief Interview for Mental Status] Summary: severe impairment..." 2. The clinical record for Resident C was reviewed on 5/3/24 at 11:15 a.m. The diagnoses for Resident C included, but were not limited to, dementia with behavior disturbances and anxiety. The resident resides on the memory care unit. A service plan dated 9/22/23 indicated "...Mobility Performance: Total dependence on staff to move about - unable to move from one place to another without staff assistance. Mobility Service Plan: provide escort and/or supervision as needed, Encourage safety precautions, provide assistive device (describe) - wheelchair, provide assistance (describe) - x 1, provide assistance of two as needed...Transfers: total assist to transfer to/from bed or chair - totally dependent on staff to transfer from bed to chair...Tolieting and Continence Care: incontinent, with assistance of		completed on 5 residents weeklyx4 weeks; then 5 residents biweekly x8 weeks, then 5 residents monthly x3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	one..Mood and Behaviors: no mood or behavior concerns - resident does not exhibit any mood or behavior concerns...BIMS...severe impairment..." A skin event dated 12/1/23 indicated Resident B had obtained a skin tear to his right hand. The skin tear was caused by an "accident". A nursing progress note for Resident C dated 12/01/2023 at 5:29 p.m., indicated "Writer summoned to legacy unit [memory care unit] by staff, observed resident lying on right side in front of w/c, resident alert to self only as has late stage dementia with all needs anticipated and provided per staff. Resident assisted to w/c per staff...Resident has 1.5 cm [centimeters] x 0.5 cm laceration to rt [right] eyebrow, cleansed with normal saline and closed with 3 steri strips and covered with foam dressing for oozing of wound, tolerated procedure. Appropriate staff notified of episode and resident will continue to be observed per staff..." A reportable incident to the Indiana Department of Health dated 12/5/23 indicated an incident had occurred on 12/1/23 at 4:09 p.m. An allegation was reported Resident B had pushed Resident C out of her wheelchair resulting in a fall in the memory care unit. The investigation of the reportable incident between Resident B and Resident C was provided by the Clinical Support on 5/3/24 at 3:42 p.m. It included the following: A timeline of events document indicated at 12/1/23 at 3:25 p.m., Resident C "was found on floor in front of wheelchair in common area." 12/1/23 at 4:15 p.m., "Staff member [Certified Resident Care Assistant (CRCA) 5] notified ED			

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	[Executive Director] 8 that she thought that resident [B] pushed resident [C] out of her wheelchair. [Registered Nurse 6] assessed resident [C] post fall. Residents immediately separated. There was no staff witnesses to the fall. 12/1/23 at 4:45 p.m., "ED reviewed video footage had fallen secondary to [Resident B] standing up and bracing himself on the arm rest of [Resident C]'s wheelchair..." A statement by ED 8 on 12/1/24 indicated "...Upon investigation and review of camera footage, it appears that resident [B] was attempting to stand from a seated position in his wheelchair by placing his left hand on top of the right handle of resident [C]'s wheelchair. As [Resident B] attempted to stand, the wheelchair tipped forward and rested on top of [Resident C] with her bottom near the front edge of the seat. [Resident B] picked the wheelchair up and returned it to all wheels on the floor. It appeared that [Resident B] was attempting to stand again when CRCA [5] came out from [another resident room] and intervened. CRCA [5] moved [Resident B] in his wheelchair away from resident [Resident C] who was on the floor, then sought help from the nurse on the rehab unit adjacent to Legacy's secured doors. Upon nurse assessments, [Resident B] appeared to have a skin tear on the inside of his right hand near his thumb, possibly from picking up the wheelchair. [Resident C] had a laceration to her right brow and abrasions to her right cheek bone. There were no witnesses to the event..." A written statement by CRCA 5 on 12/1/23 indicated "res [resident] [C] found on floor. I came out of a res room. Res [F] was pushing res [B] out of her room. Res [B] grabbed res [HH]'s cane and started swinging the cane. I stood between the res so no one would be hurt. I pushed res [B] in his			

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	wheelchair to the outside of the living room. I returned to [resident room] to finish her shower. When I came out I saw res [C] on the floor out of her wheelchair and res [B] standing with his left hand on the right handle of res [C]'s wheelchair. I went to get nurse for assistance." A reportable incident to the Indiana Department of Health dated 12/5/23 indicated "...Brief of Description...During an investigation of an unwitnessed fall, it was determined that the employee [CRCA 5] may have provided rough care with a resident. Employee immediately suspended and investigation initiated....Type of Injury...No injuries or skin impairment noted....Follow up added: --12/8/23 Allegation has been substantiated for failure to meet company standards and inappropriate resident handling." The investigation of the reportable incident between Resident B and CRCA 5 was provided by the Clinical Support on 5/3/24 at 3:42 p.m. It included the following: An incident document dated 12/5/23 indicated "...All Residents with a BIMS of 8 or higher were interviewed to assess for any care concerns/abuse allegations. All interviews completed and no care concerns/abuse allegations noted. A statement by CRCA 5 dated 12/5/23 indicated "...I had [Resident F] in the shower, and I left her room door open. I could see [Resident C] and [Resident G] sitting there. I just happened to come out and the ladies [Resident H and Resident J] told me that 'he pushed her out of the chair.' I tried to sit [Resident B] back down in the chair, and scoot him back. My first thought was to get [Resident B] up off the floor, but I know not to			

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	touch them after a fall so I went to get help. I didn't physically see [Resident B] push her, out the chair. When you got done with the shower, how did you care for [Resident B]? I tried to get him situated into his wheelchair. Can you show me how you intervened?...Demonstration... [Resident B] was kind of standing up in semi-position, so I was trying to get him away from [Resident C]'s body. It was nothing too abrasive. Did you make any physical contact with [Resident B]? No. Nothing flat handed or back of the hand? No. When you were touching his shirt, how would you describe it? I kind of grabbed him, but not aggressively or angrily. How did [Resident B] respond? He was very agitated. [Resident G] was sitting next to [Resident C], and she was screaming and hollering. Anything else that you want to add? It all happened so fast and I had another resident in the shower, and I tried to diffuse the situation as best that I could. As long as I have been working, I have never neglected, abused or mistreated a resident. So I am at a loss. After everything was diffused, [Registered Nurse (RN) 6] provided care for [Resident C]. Do you think you work too much? I like to work. I like what I do, and I take my license very seriously..." A statement by Registered Nurse (RN) 6 on 12/5/23 indicated "...I was called back to the unit by CRCA 5. She was giving a shower to another resident. She came out because [Resident C] was already on the floor. [Resident C] did not appear to have other injuries that to her right cheek and brow. All I did was, she had a full range of motion and did not appear to have any other injuries other than what I saw. I did not witness any interaction between [CRCA 5] and [Resident B] once we took care of [Resident C]. I was laser focused on [Resident C]."			

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	An interview was conducted with Director of Nursing Services (DNS) on 5/3/24 at 2:18 p.m. She indicated on 12/1/23, CRCA 5 was the only aide in the unit. CRCA 5 was giving a shower and was notified by two other residents Resident B had pushed Resident C out of the wheelchair. CRCA 5 had observed Resident B standing over Resident C lying on the floor. She then assisted with ensuring the safety of Resident C by separating the residents, but during the fall investigation it was determined CRCA 5 provided rough care when she intervened to separate the residents. The DNS at that time, demonstrated the separation of the two residents. While Resident B was standing over Resident C, Resident B's chair was positioned behind him. CRCA 5 approached Resident B from behind and grabbed his clothes and "snatched" him in his chair. The DNS indicated her expectations in the situation, CRCA 5 should have walked in front of Resident B, spoken in a calm manner and explained what she was going to do prior to transferring him to his chair. An interview was conducted with CRCA 5 on 5/3/24 at 2:48 p.m. She indicated Resident B was aggressive toward the staff. He would hit and kick. "you couldn't turn your back on him." The resident was "always" into something. He would turn stuff over, dug in the trash and opened drawers. On 12/1/23, CRCA 5 was working in the memory care unit. She was the only staff person working on the unit. CRCA 5 was in a resident's bathroom providing a shower to a resident. During that time, another resident came into the resident's room and reported Resident B had pushed Resident C out of her chair. She then walked out of the resident's room and observed Resident B standing over Resident C that was out of her wheelchair lying on the floor with her head			

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	bleeding. CRCA 5 then pushed Resident B's wheelchair behind him, and at that time he sat down in his wheelchair. She then pushed his wheelchair away from Resident C. After, CRCA 5 called for assistance from RN 6 who was over in the health center. Prior to that incident that night, Resident B had gotten a hold of Resident HH's cane earlier and was swinging it near another resident. CRCA 5 stood in front of the resident, so Resident B would hit her with the cane instead of the resident. When RN 6 had come in the unit, she had asked where the other CRCA was. The "young lady" that was suppose to be in the memory care unit with CRCA 5 never came back to the unit to help her. CRCA 5 stated she did not abuse Resident B. An interview was conducted with the Clinical Support on 5/3/24 at 4:40 p.m. She was unable to provide a developed dementia care policy regarding addressing a resident exhibiting behaviors with a diagnosis of dementia. A resident rights policy was provided by the Clinical Support on 5/3/24 at 4:40 p.m. It indicated "...Purpose. To ensure resident rights are respected and protected and provide an environment in which they can be exercised...Procedures:..2. Our residents have a right to...a. Be treated with dignity and respect...f. Be treated fairly, courteously and with respect by all staff..." This citation relates to Complaint IN00424020.			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the			

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	twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on observation, interview and record review, the facility failed to ensure adequate staffing was provided in the memory care unit to closely monitor a resident with behaviors and falling for 1 of 3 reportable incidents reviewed. (Resident B and Resident C) Findings include: 1. The clinical record for Resident B was reviewed on 5/3/24 at 11:00 a.m. The diagnoses for Resident B included, but were not limited to, dementia, Alzheimer's disease, psychotic disturbance and agitation. The resident was admitted to the facility on 11/1/23. A service plan for Resident B dated 11/1/23 indicated "...Mobility Performance: requires	R 0117	1 Resident B was affected. Resident was without adverse effect. 2 All residents with behavioral expressions have the potential to be affected. All nursing staff have been educated on behavioral expressions and resident monitoring, as well as asking for assistance from other halls to take a team approach to care. 3 As a measure of ongoing compliance, DHS or designee to complete random audits of staffing to ensure the memory care unit is appropriately staffed based on acuity and behavioral expressions. Audits to be completed on 5	05/20/2024

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	physical assistance - requires a person to push wheelchair, use gait belt to steady during ambulation or some type of physical assistance...Mobility Service: encourage safety precautions, provide assistance of two as needed...Transfer Performance: physical assistance - requires physical assistance of one person to transfer. Transfer Service Plan: provide assistance of two (describe) - sundown (a mental state of confusion which can cause behaviors such as anxiety, aggression, wandering)...Hygiene/Dressing Performance: Requires physical assistance - physical assistance to get dressed by the staff...Mood and Behavior: No mood or behavior concerns - resident does not exhibit any mood or behavior concerns...BIMS [Brief Interview for Mental Status] Summary: severe impairment..." A behavior and mood event dated 11/6/23 indicated "...1) Description of Behavior or Mood Expression. What behavioral expression was exhibited? Resident is continuing to remove clothes, attempting to use bathroom in inappropriate areas, arguing with staff, attempting to grab staff and verbally belligerent. He is also taking things, moving things and throwing things away from the desk. When did the behavior occur? 11/6/23 at 10:00 a.m. Where did the behavior occur? Resident room, main areas and TV room. 2) Evaluation. Other (describe) - recent environment change. 3) Intervention. Engaged in a different activity (describe) - Encouraged to participate in activities, Made Environmental Adjustments (describe) - send resident to different area and sat with this resident for awhile, One on One support (describe) - stayed 1:1 with nurse supervisor. Were the interventions successful?..Temporarily, the behaviors come and go depending on the time of the day. Resident		shifts weeklyx4 weeks; then 5 shifts biweekly x8 weeks, then 5 shifts monthly x3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	does not sleep." A nursing progress note dated 11/6/24 at 9:15 a.m., indicated "Idt [interdisciplinary team] post fall 11/6/23 no visible injuries noted. No c/o [complaints of] pain. Rom [range of motion] intact. Res [Resident B] stated that he does not remember how he fell. Res [resident] alert and oriented all meds given no issues....Post fall intervention is for staff to ensure that res bed is in lowest position while in bed q [every] shift..." A nursing progress note dated 11/06/2023 at 11:01 a.m., indicated "Spoke with [medical provider] regarding behaviors over the weekend. NO [new order] received to increase Trazodone to 50 mg [milligrams] QHS[every night] and start Seroquel 25 mg once daily to be administered between 5:00 p.m. -7:00 p.m." A nursing progress note dated 11/08/2023 at 6:17 p.m., indicated "Clarification on fall intervention for 11/6/23 - Intervention changed to not to leave in room alone while up in wc [wheelchair]..." A nursing progress note dated 11/9/23 "Resident found on his knees trying to climb into his wheelchair. Resident in the common area of Legacy [assisted living - memory care unit]. Resident a/o [alert and oriented] x [times] 1. Unable to explain what happened or what he was trying to do. When asked resident starts talking about things unrelated to the subject..." A nursing progress note dated 11/10/2023 "Resident agitated and restless. He was napping in the recliner in the day room and started stripping his clothes off. Attempted to take resident to the restroom and he refused. Attempted to lay resident down for a nap but he			

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	would not stay in the bed. Continuously trying to strip clothes off in front of other residents and swinging at staff for trying to assist him. PRN ativan given for restlessness and agitation..." A nursing progress note dated 11/12/23 indicated Resident B had a fall in his room. A psych visit note for Resident B dated 11/14/23 indicated "...Nursing reports increased sundowning behaviors of hitting staff, disrobing, attempting to disassemble items in his room. Seroquel 25 mg daily ordered and Trazodone increased to 50 mg every HS [night]." The treatment plan was to discontinue seroquel 25 mg daily. The staff was to start 0.25 milligrams of Risperidone twice a day due to psychosis." A nursing progress note dated 11/16/23 indicated Resident B had fallen by his bed unclothed from waist down. An IDT note dated 11/17/2023 indicated "IDT: Resident had unwitnessed fall on 11/16/23 from bed around breakfast time. Staff found resident at foot of bed with brief and pants removed. Resident unable to remember reason why assisting self out of bed possibly d/t dx Dementia in other diseases classified elsewhere, unspecified severity, with psychotic disturbance. No delayed injuries noted and ROM [range of motion] per resident norm. Intervention: early morning riser get up list..." A nursing progress note dated 11/18/2023 at 12:21 a.m., indicated "Resident hitting at staff, opening drawers in unit dining room and throwing things, cursing at staff. Per staff, resident has not taken a nap or anything of the sort today. Resident is restless, and not wanting to sleep. Exit seeking			

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	currently. PRN medication administered, awaiting effectiveness. Resident currently safe in wheel chair with close staff supervision. Provided snack and drink, refused toileting." A nursing progress note dated 11/19/2023 at 5:14 a.m., indicated "Resident did not sleep this shift. Up walking around in room, continuously disrobing, cursing and hitting at staff. Resident picking things up throughout unit all shift and moving them around. Exit seeking most of shift, set door to patio alarm off." A nursing progress note dated 11/20/2023 at 5:35 a.m., indicated "Resident awake all 8 hours of this shift. Cursing and hitting at staff all shift. Wandering into others rooms and being intrusive of space. Taking things on unit and dragging them about. Exit seeking. Snacks given, attempted to assist with toileting multiple times, resident continually refusing care. Frequent visual checks to maintain safety as resident refused to use wheelchair most of shift." A nursing progress note dated 11/21/2023 at 4:59 a.m., indicated "Resident awake all night. Toileted multiple times. Resident not as combative on this shift. Has been more receptive of redirection." A nursing progress note dated 11/25/2023 at 12:01 p.m., indicated "[medical provider] was called to resume PRN ativan 0.5 mg order for increased anxiety and ok with. Order resumed and administered d/t [due to] pushing/hitting on exit doors and staff when being redirected by trying to get up from wc..." A nursing progress note dated 11/26/2023 at 8:22 p.m., indicated "Resident is extremely restless and likes to go through drawers, cabinets, trash cans			

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	and other various things. He is difficult to redirect at times because he gets angry. He is a safety and fall risk. He has been 1:1 supervision in the evenings over the weekend d/t the risk." A behavior and mood event dated 11/26/24 indicated "This resident has had 1:1 direct supervision over the weekend d/t roaming and getting into things. He is a safety risk and a fall risk. At times he can be redirected and other times he can not and becomes angry, aggressive and has even been physically violent with staff members. No one has been injured, but he has attempted to hit and bite staff. He is very restless and needs activities to occupy his time...3) intervention: gave a snack, moved to different areas, still 1:1 with staff, alternate staff members doing 1:1, quieted environment...Were the interventions successful?...rarely..." A nursing progress note dated 11/27/2023 at 11:52 a.m., indicated "writer called to legacy d/t resident getting outside and falling. res unable to articulate what happened..." A medical provider note dated 11/27/23 indicated "...Chief complaint...Resident [B] is being seen today for safety concerns and after being found on the floor of the facility staff. Per facility staff, resident was very restless over the weekend. He became exit seeking and difficult to redirect. PRN ativan was resumed by oncall. He was one on one supervision with facility staff due to increased behaviors...11/27/23: The resident experienced an unwitnessed fall outside today. He sustained a small abrasion..." An IDT review post fall note dated 11/30/2023 indicated "IDT review post fall 11/27/23. Resident found lying on the ground of the legacy courtyard			

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	with a walker. Resident was fully clothed, confused per baseline, and unable to explain what happened. Laceration sustained to right side of chin. 0 other injuries noted. Prior to event resident was sitting in his wheelchair near the dining area. Staff left to assist other residents. Resident took the walker of another resident and let himself out to the legacy courtyard. Post fall intervention is to increase monitoring for resident due to his short attention span, restlessness, inattentive behavior, and lack of safety awareness. Resident [B]'s [Representative] is currently working on finding a daily sitter for extra support..." A skin event dated 12/1/23 indicated Resident B had obtained a skin tear to his right hand. The skin tear was caused by an "accident". 2. The clinical record for Resident C was reviewed on 5/3/24 at 11:15 a.m. The diagnoses for Resident C included, but were not limited to, dementia with behavior disturbances and anxiety. The resident resides on the memory care unit. A service plan dated 9/22/23 indicated "...Mobility Performance: Total dependence on staff to move about - unable to move from one place to another without staff assistance. Mobility Service Plan: provide escort and/or supervision as needed, Encourage safety precautions, provide assistive device (describe) - wheelchair, provide assistance (describe) - x 1, provide assistance of two as needed...Transfers: total assist to transfer to/from bed or chair - totally dependent on staff to transfer from bed to chair...Tolieting and Continence Care: incontinent, with assistance of one..Mood and Behaviors: no mood or behavior concerns - resident does not exhibit any mood or behavior concerns...BIMS...severe impairment..."			

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	A nursing progress note for Resident C dated 12/01/2023 at 5:29 p.m., indicated "Writer summoned to legacy unit by staff, observed resident lying on right side in front of w/c, resident alert to self only has late stage dementia with all needs anticipated and provided per staff. Resident assisted to w/c per staff...Resident has 1.5 cm [centimeters] x 0.5 cm laceration to rt [right] eyebrow, cleansed with normal saline and closed with 3 steri strips and covered with foam dressing for oozing of wound, tolerated procedure. Appropriate staff notified of episode and resident will continue to be observed per staff..." A reportable incident to the Indiana Department of Health dated 12/5/23 indicated an incident had occurred on 12/1/23 at 4:09 p.m. An allegation was reported Resident B had pushed Resident C out of her wheelchair resulting in a fall in the memory care unit. The investigation of the reportable incident between Resident B and Resident C was provided by the Clinical Support on 5/3/24 at 3:42 p.m. It included the following: A timeline of events document indicated at 12/1/23 at 3:25 p.m., Resident C "was found on floor in front of wheelchair in common area." 12/1/23 at 4:15 p.m. "Staff member [Certified Resident Care Assistant (CRCA) 5] notified ED [Executive Director] 8 that she thought that resident [B] pushed resident [C] out of her wheelchair. [Registered Nurse 6] assessed resident [C] post fall. Residents immediately separated. There was no staff witnesses to the fall. 12/1/23 at 4:45 p.m. "ED reviewed video footage had fallen secondary to [Resident B] standing up and bracing himself on the arm rest of [Resident C]'s wheelchair..."			

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	A statement by ED 8 on 12/1/24 indicated "...Upon investigation and review of camera footage, it appears that resident [B] was attempting to stand from a seated position in his wheelchair by placing his left hand on top of the right handle of resident [C]'s wheelchair. As [Resident B] attempted to stand, the wheelchair tipped forward and rested on top of [Resident C] with her bottom near the front edge of the seat. [Resident B] picked the wheelchair up and returned it to all wheels on the floor. It appeared that [Resident B] was attempting to stand again when CRCA [5] came out from [another resident room] and intervened. CRCA [5] moved [Resident B] in his wheelchair away from resident [Resident C] who was on the floor, then sought help from the nurse on the rehab unit adjacent to Legacy's secured doors. Upon nurse assessments, [Resident B] appeared to have a skin tear on the inside of his right hand near his thumb, possibly from picking up the wheelchair. [Resident C] had a laceration to her right brow and abrasions to her right cheek bone. There were no witnesses to the event..." A written statement by CRCA 5 on 12/1/23 indicated "res [C] found on floor. I came out of a res room. Res [F] was pushing res [B] out of her room. Res [B] grabbed res [HH]'s cane and started swinging the cane. I stood between the res so no one would be hurt. I pushed res [B] in his wheelchair to the outside of the living room. I returned to [resident room] to finish her shower. When I came out I saw res [C] on the floor out of her wheelchair and res [B] standing with his left hand on the right handle of res [C]'s wheelchair. I went to get nurse for assistance." A behavior event dated 12/3/23 11:24 a.m. indicated on 12/3/23 at 8:30 a.m., "...Resident [B]			

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	continue to display aggressive behavior with verbal and profanity. He is destructive to facility property and hits and kicks things. He goes into other residents room and disturbs them, gets into their things and takes them. He is a danger to himself as he has gotten into cabinets and attempted to plug things into outlets...3) Intervention: encouraged to participate in activities, stayed 1:1 with staff...Were the interventions successful?...No, he is unable to be redirected until he gets tired. when is awake, he requires continuous obs [observations]..." A nursing progress note dated 12/04/2023 indicated "Resident [B] became agitated and physically aggressive when staff attempted to assist with a.m. cares. Reapproached resident, still agitated. Will notify next shift." An IDT note dated 12/04/2023 indicated, "IDT: Increased behaviors noted towards staff. Resident not easily redirected and becomes combative when staff intervene or given redirection. Poor safety awareness noted and resident exit seeks by pushing/kicking on doors/windows. Resident disrobes in common areas and is noncompliant and resistant with care. Resident with poor safety awareness and repeatedly tries to get up from wc to walk w/o assistance/assistive device. Busy activities, music, reproaches, space, snacks, general conversation or about military, TV programs all ineffective. PRN medication, administered and noneffective. [Psych medical provider] notified with recommendation to send resident out for psych evaluation." A nursing note dated 12/04/2023 at 8:00 p.m., indicated "Writer was called to unit at 7:00 p.m. Resident hitting and cursing at staff, pushing on exit door aggressively, trying to get into employee			

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	bathroom, throwing items. Fumbling with items on med cart and going through trash. Unable to redirect resident. PRN Ativan given at 7:05 p.m. which was effective. Resident sat self on the floor from his wheelchair by med cart and starting fumbling with items around the chair. Resident calming down and stated he was tired. Was assisted by 2 into his wheelchair and into his bed at 8:00 p.m." A nursing noted dated 12/5/24 indicated Resident B was sent to psych hospital. A 12/1/23 daily attendance schedule indicated 1 staff person was assigned to work day, evening and night shift in the Legacy Memory Care Unit. An interview was conducted with Executive Director 1 on 5/3/24 at 4:00 p.m. The resident census in the Legacy Memory Care Unit on 12/1/23 was 7 residents resided in the unit. An observation was made of the memory care unit on 5/3/24 at 11:08 a.m. Upon on entering the unit a resident was standing at the door of the unit. 1 resident was sitting in a chair in the dining room and 2 residents were observed with eyes closed in front of a television that was on in a common area. The unit was quiet and there was no observation of a staff member at that time. During a walk through of the unit, Certified Resident Medication Aide (CRMA) 7 was observed walking out of one of the resident's rooms. At that time, an interview was conducted with CRMA 7. She indicated she had worked over a year in the facility. There was currently 7 residents that reside on the memory care unit. She was the only staff person working on the unit. There usually was only one staff person that works on the unit. If she was needing additional assistance she would have someone			

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	working on the health center side to come to the unit. An interview was conducted with Director of Nursing Services (DNS) on 5/3/24 at 2:18 p.m. She indicated an investigation was initiated regarding Resident C's fall. On 12/1/23, Resident B was not on 1 on 1 supervision. The intervention that had been put in place was close monitoring which meant Resident B was to be up in a common area, so staff could visually see him. An interview was conducted with CRCA 5 on 5/3/24 at 2:48 p.m. She indicated Resident B was aggressive toward the staff. He would hit and kick. "you couldn't turn your back on him." The resident was "always" into something. He would turn stuff over, dug in the trash and opened drawers. On 12/1/23, CRCA 5 was working in the memory care unit. She was the only staff person working on the unit. CRCA 5 was in a resident's bathroom providing a shower to a resident. During that time, another resident came into the resident's room and reported Resident B had pushed Resident C out of her chair. She then walked out of the resident's room and observed Resident B standing over Resident C that was out of her wheelchair lying on the floor with her head bleeding. CRCA 5 then pushed Resident B's wheelchair behind him, and at that time he sat down in his wheelchair. She then pushed his wheelchair away from Resident C. After, CRCA 5 called for assistance from RN 6 that was over in the health center. Prior to that incident, Resident B had gotten a hold of Resident H's cane and was swinging it near another resident. CRCA 5 stood in front of the resident, so Resident B would hit her with the cane instead of the resident. When RN 6 had come in the unit, she had asked where the other CRCA was. The "young lady" that was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155815	A. BUILDING 00 B. WING	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	suppose to be in the memory care unit with CRCA 5 never came back to the unit to help her. An interview was conducted with the Memory Care Director on 5/3/24 at 3:56 p.m. she indicated all the residents that reside in the memory care need assistance with bathing, dressing, toileting, and/or incontinent care. There was only 1 staff person that works in the memory care unit. She had not observe Resident B displaying any behaviors, but she had heard he did have sundowning. The intervention that was put in place for Resident B that indicated the resident was to be closely monitored; meant the staff needed to make sure he was in a common area, so they can watch him. An interview was conducted with the Clinical Support on 5/3/24 at 4:40 p.m. She was unable to provide a developed dementia policy regarding addressing a resident exhibiting behaviors with a diagnosis of dementia. This citation relates to Complaint IN00424020.			