STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00414727, IN00415188, and IN00415672. Complaint IN00415672 - State deficiencies related to the allegations are cited at R0240 and R0006. Complaint IN00415188 - State deficiencies related to the allegations are cited at R0052, R9999, R0120 and R0117. Complaint IN00414727 - No deficiencies related to the allegations are cited. Survey date: August 28, 29, 30, 2023 Facility number: 013347 Residential Census: 108 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 6, 2023	R 0000		
R 0006 Bldg. 00	410 IAC 16.2-5-0.5(f)(1-5) Scope of Residential Care - Deficiency (f) The resident must be discharged if the resident: (1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed			

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

Maurice Woolfolk | Excecutive Director | 10/09/2023

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	provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring. Based on observation, interview, and record review, the facility failed to timely discharge a resident with progressing dementia who needed a higher level of care and a resident who required comprehensive nursing care unable to be provided by home health and a resident who needed higher level of care regarding mobility for 3 of 4 residents reviewed for continued stay. (Residents B and L and Z) Findings include: 1. The clinical record for Resident B was reviewed on 7/28/23 at 11:30 a.m. His diagnoses included, but were not limited to: Alzheimer's dementia, depression, Vitamin D deficiency, psychosis, and traumatic brain injury. He was admitted to the facility on 11/29/20. On 8/29/23 at 12:12 p.m., the ED (Executive Director) provided Resident B's admission paperwork from the VA (Veterans Affairs.) It included an 11/4/20 physician note that read, "Needs form completed for admission to [name of facility.] Has history of cognitive impairment, progressive, and unable to provide adequate self care. Main issue is with short term memory. Currently resides in a guest room in his friend's home. He is retired from the military, had some	R 0006	Plan of Correction 09/22/23 Facility ID: 013347 Survey Event ID: RRGE11 R006 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a. All residents had the potential to be affected. Resident B was discharged from the community. Resident L and Z have been re-assessed by licensed nursing staff to ensure needs are appropriately met at the community. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken.** a. All residents had the potential to be affected. No other residents identified to be affected upon review of nurses notes, reportable incidents and interviews.	11/01/2023

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	boxing experience in the past but denies any traumatic brain injury. He was hospitalized in May 2020 for neurocognitive degenerative impairment that is considered likely to progress to early Alzheimer Dementia. Brain MRI was concerning for early Alzheimer dementia...Of note, the patient will likely require higher level of care as his cognitive impairment/dementia progresses." An interview was conducted with CNA (Certified Nursing Assistant) 1 on 8/29/23 at 2:06 p.m. She indicated a lot of the staff were scared to be around Resident B. "He's violent and we're being forced to care for him. I don't feel comfortable and he's a big man." Residents were scared too. Whichever staff member was assigned to provide one on one supervision to him, "complains every time." He "tried to snatch one of the CNAs on the elevator." The staff try to back away, give him a minute, tell the nurse who may be able to calm him down, but most of the time, he can't be. Resident P was scared of him and another resident "carries mace." An interview was conducted with LPN (Licensed Practical Nurse) 14 on 8/29/23 at 2:12 p.m. She indicated Resident B chased CNA 9 down the hallway and tried to lock CNA 4 in the elevator a couple of weeks ago. An interview was conducted with CNA 9 on 8/29/23 at 2:21 p.m. She indicated she was providing one on one supervision to Resident B one night and he thought CNA 9 put something in his water and started saying he didn't like her and he'd hit a woman. She tried to redirect him, but CNA 4 had to come to assist. At first, CNA 9 ran from him, but she didn't want him to chase her. Resident B then got on the elevator. CNA 9 was "in shock."		**3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. All staff in-service on Abuse, Elopement, Resident Rights, Residential Care Discharge Criteria policies and proper reporting procedures. b. In service to include how to identify home health providers, the services they provide and how to contact them. c. Inservice to include how to contact the Ombudsman as a resource to discharge residents where alternative placement is difficult. **4. 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:** a. RDCS, DON or Designee will review nursing notes and incident reports to ensure proper protocols have been followed for any elopement incidents, abuse allegations and care needs being appropriately met. Review will be conducted weekly for 12 weeks, then bi weekly for 12 weeks then monthly for 3 months. **5. By what date will the systematic changes be**	

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	An anonymous interview was conducted with a staff member. They indicated Resident B was currently being provided one on one supervision. "He's swinging on people...anything triggers him." Another staff member called the police on him because "he bucked up [urban slang to challenge someone by getting in their face and disrespect them] at her." A resident saw Resident B "buck at me" and told her to run. "I guess he's chased people before." Afterwards, the staff member was crying and refused to provide him one on one. "He's dangerous....They should have put him somewhere else once his dementia got worse. It started to get bad like a year ago, that's around the time he started targeting [name of Resident M.] During a tour of the facility on 8/28/23 at 11:08 a.m., an interview was conducted with the DON. She indicated Resident B was currently receiving one on one staff supervision, because he was an elopement risk. At the end of July, 2023, Resident B was knocking on the door of his old house. The people who live there now called the facility and they went to get him. He was then placed on hourly checks, but he left the facility again a few days later and ended up at the VA (Veteran's Affairs) hospital in downtown Indianapolis, 8 miles away. The police picked him up and brought him back to the facility. Upon return, Resident B became aggressive with QMA (Qualified Medication Aide) 12 and slammed her arm in a door. Resident B was sent out to a neuropsychiatric hospital and was there for 7 days. For the past 2 weeks, they'd been trying to find alternate placement for him. She had a stack on her desk of all the referrals she'd sent. Everyone was saying no due to his aggression.		**completed.** a. Compliance by : 11/1/23	

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	An interview was conducted with the ED (Executive Director) on 8/28/23 at 1:30 p.m. He indicated they'd been trying to place him elsewhere, in a skilled nursing facility. He was rejected from all male units at 2 different skilled nursing facilities. On 8/28/23 at 1:30 p.m., the ED provided verification of 10 referrals to skilled nursing facilities. One was dated 7/28/23; 3 were dated 8/7/23; 3 were dated 8/8/23, and 3 were dated 8/9/23. The ED (Executive Director) provided the investigative file into the Resident B's 7/28/23 elopement from the facility on 7/28/23 at 11:30 a.m. It included a 7/28/23 follow up incident report and the My Dashboard section of Resident B's EHR (electronic health record.) The 7/28/23 follow up incident report indicated on 7/28/23 at 11:30 a.m., Resident B left the facility to go for a walk and within about 45 minutes, the facility received a phone call stating that he was knocking on caller's door asking if he lived at that address. Facility staff went to pick up Resident B and his family was notified. The preventive measures taken section of the report indicated staff were educated of resident's progressive mental decline and aware that increased safety checks would be performed. Family was aware of mental decline as well and were looking for alternate placement at a higher level of care facility. The follow up section of the report indicated increased safety checks would be performed until final decision was made on choice facility. The My Dashboard section of Resident B's EHR indicated on 7/28/23, "Wellness check every hour.			

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	Verify resident is in community and assist with any needs. Notify nurse on duty or DON if resident is not located...Resident left facility to go for a walk and within about 45 mins [minutes,] facility received a phone call stating that resident was knocking on caller's door asking if he lived at that address. Facility staff went to pick resident up and family was notified. When staffed [sic] arrived [sic], resident [sic] was sitting with local police for safety purposes. Resident reports that he used to live close to where he was at, and forgetting that he no longer lived at his previous address. Family is aware and is actively seeking alternate placement for resident. No injuries [sic] noted or repported [sic].. Facility staff transported resident back to facility." The 7/28/23, 12:08 p.m. note read, "Late entry from 07/26/2023: Careplan meeting held with sister [name of sister] and bother [name of brother,] as weel [sic] as, ED and writer (DON). Writer and ED expressed to family that resident's cognitive function is decreasing, causing more confusion and aggression. Family understands and wishes to seek alternate placement for resident, preferrably [sic] an all male unit. Writer and ED recommended [name of a skilled nursing facility] nursing facility and family agreed to have referral info [information] faced [sic] to that facility." The 7/28/23, 12:10 p.m. note read, "Resident left facility to go for a walk and within about 45 mins, facility received a phone call stating that resident was knocking on caller's door asking if he lived at that address. Facility staff went to pick resident up and family was notified. When staffed arrived, resident was sitting with local police for safety purposes. Resident reports that he used to live close to where he was at, and forgetting that he no longer lived at his previous address. Family is			

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	aware and is actively seeking alternate placement for resident. No injuries noted or reported. Facility staff transported resident back to facility." An interview was conducted with the Marketing Director on 8/29/23 at 3:01 p.m. She indicated the ED told her Resident B was missing, where he'd been found wandering, and for her and another staff member to go pick him up. She was familiar with the east side of Indianapolis. She picked him up on the corner by a woman's house, 2.4 miles away. The Marketing Director gave a specific description of the corner, color of the house and trim, and presence of a low fence. The police had him at the fence. The person who lived at the house was outside of the house and waved nicely at the them. The woman seemed happy they came to get him. She only spoke with the 3 officers present, not the woman in her yard. When Resident B got in the car, he was saying he wanted to go home; that he grew up over there; and on the way back to the facility, pointed out the school to which he used to go and a house in which he used to live. An observation of the above house was made on 8/29/23 at 4:10 p.m. It was 2.4 miles away and a 47 minute walk from the facility per Google Maps. The 8/1/23, 6:19 p.m. note, written by LPN (Licensed Practical Nurse) 13, read, "Client was escorted to clients room, client stated he will be there for the night." The 8/1/23, 7:12 p.m. note, written by LPN 13, read, "Reporting WANDERING. Late entry from 08/01/2023 @ 5 p.m. Client was brought into nursing station by a woman, Woman stated that client was at her home knocking on her door stating he lived there, client and woman escorted			

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	to DON office, DON was made aware of situation." On 8/30/23 at 12:30 p.m., the BOM (Business Office Manager) provided a list of employees who worked the evening shift 8/1/23. The list included LPN 13 who worked until 7:35 p.m.; QMA 12 who worked until 6:00 p.m.; CNA 4 who worked from 5:00 p.m. until 12:00 a.m., and the DON who worked until 6:00 p.m. LPN 13 no longer worked at the facility and was unavailable for interview. An interview was conducted with the DON on 8/29/23 at 11:24 a.m. She indicated on 8/1/23 she received a phone call from LPN 13 that the woman whose house Resident B was at on 7/28/23, stopped by the facility to check on him, not that the woman brought him back that day. Neither Resident B, nor a woman were brought into her office the evening shift of 8/1/23. She stated, "I see how the note reads, and I don't know why, but that didn't happen." Resident B came to the facility on a Medicaid waiver. According to the VA, he hadn't received psychiatric services through them in 2 years. His behaviors didn't last very long. He was easily redirectable. "He just needs to be in a memory care unit, in my opinion." He'd been out to the neuropsyche hospital a couple of times, but they always made the facility sign something saying they would accept him back. She'd considered sending him out to behavioral facilities, but she felt like it was a progression of his dementia, rather than psychological issues. She also had a relationship with the neuropsychiatric hospital, so she chose to send him there instead. An interview was conducted with QMA 12 on			

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	8/30/23 at 3:15 p.m. She indicated she worked the evening of 8/1/23 when Resident B "pretty much eloped again." The woman who brought Resident B into the nursing station was screaming, hollering, looking hysterical, and saying, "This is the 5th or 6th time he came to my house." QMA 12 directed the woman to the DON. At the time, QMA 12 did not know about the hourly checks implemented from his 7/28/23 elopement or that he eloped on 7/28/23. She also worked on 7/29/23 and no one told her about Resident B's 7/28/23 elopement or hourly checks then either. If any staff member signed off on hourly checks, it would be CNAs (Certified Nursing Assistants.) An interview was conducted with CNA 4 on 8/30/23 at 2:01 p.m. She indicated Resident B was brought back into the facility by a woman. Around 5:00 p.m., she was coming down the stairs into the lobby and heard a lady approaching the facility outside, asking if Resident B lived there and saying it was ridiculous. He scared her kids, and she threatened to call the state, because she was a nurse. QMA 12 took Resident B and the woman into the DON's office. CNA 4 didn't know what happened from there. CNA 4 heard Resident B left the facility again the next day. The ED (Executive Director) provided the investigative file into the Resident B's 8/2/23 elopement from the facility on 7/28/23 at 11:30 a.m. It included an 8/8/23 follow up incident report, The 8/8/23 follow up incident report indicated on 8/2/23 at 9:01 a.m. Resident B was discovered by staff to not be in his apartment or in the building. Staff looked for the resident in the community and he was unable to be found. Law enforcement was contacted and a missing person report was filed. Later, the resident was found and was transported			

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	back to the building. The preventive measures taken section of the report indicated due to his continued mental decline, 1 on 1 observations were in place. Family was aware of the cognitive decline and were looking for alternative placement at a higher level of care facility. The 8/8/23 follow up section of the report indicated Resident B was sent to a neuropsychiatric hospital due to behaviors. Family and facility were actively seeking alternate placement at a secure higher level of care facility. The 8/2/23, 6:45 a.m. note read, "RESIDENT ON Q [every] 1 HR CHECKS, HAS REMAINED IN [Resident B's apartment number] SLEEPING DURING NIGHT." The 8/2/23, 9:28 a.m. note read, "Hourly check was seen at 7:19 a.m. going to breakfast." The 8/2/23, 5:39 p.m. note read, "Reporting ELOPEMENT, and WANDERING. Client was on hourly checks due to wondering [sic] and elopement [sic], client was last seen by staff at 7:19 am on his way to eat in the dinning [sic] area, staff went to check on client again and client could not be found, staffed searched building including common areas and areas outside of building and was unable to locate client, hourly checks countinued [sic] throughout the day and client was still unable to be located, management staff as well as family was informed of situation, client was picked up up [sic] by EMS [emergency medical services] on the Northside of Indianapolis and escorted to VA hospital, this facility was made aware of clients location via VA hospital nurse." An interview was conducted with the ED on 8/28/23 at 2:45 p.m. He indicated on 8/2/23,			

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	Resident B was on hourly checks, and within an hour, he left the building. They searched for him and they couldn't find him. "Some hours went by," so he filed a police report. Resident B was found on the northside of Indianapolis and the police took him the the VA Hospital. The ED was not exactly sure when he notified the police Resident B was missing, but it was "certainly in the afternoon." The ED was unsure when the facility received the phone call that he was found. Their receptionist took the call and was told he was being taken to the VA hospital. The ED was unaware of Resident B's 8/1/23 elopement from the facility, but would look into it. An interview was conducted with the ED on 8/29/23 at 9:25 a.m. He indicated the 8/1/23 incident where the woman brought Resident B back into the facility "must have been an oversight." He reported what he was aware of, which were the 7/28/23 and 8/2/23 elopements. On 8/29/23 at 9:24 p.m., the ED provided the 8/2/23, 4:40 p.m. Indianapolis Metropolitan Police Department East District Information Card, indicating a missing person as the incident type, the officer's name, unit number, and case number. An observation of Resident B was made on 8/30/23 at 10:42 a.m. He was sitting in a chair just outside of the dining room with CNA 10, who was providing his one on one supervision, sitting in a different chair nearby. Resident B's service plan, updated 7/29/23, indicated he needed monitoring related to history of mood disturbance. He shadow boxed in the corridor and hall. Resident N's 4/9/23, 5:18 a.m. note read, "The			

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	resident called the police due to being hit in the eye face and body by another resident the can [sic] notified the QMA [Qualified Medication Aide] at 10 pm. the resident stated he didn't want To go to the hospital, he stated he just want [sic] to report the incident to the police the Don [Director of Nursing] notified by the QMA as well of the incident." An interview was conducted with CNA 4 on 8/30/23 at 2:01 p.m. She indicated Resident B had been fighting other residents in the facility, including Resident N a few months ago. It was right by the fireplace in the front lobby area. CNA 4 witnessed it along with 2 residents. Resident N was talking to CNA 4. CNA 4 sat down in a chair near the fireplace. Resident B was standing nearby, when Resident B came over started fighting Resident N "out of nowhere." Resident N was still sitting in a chair while getting punched "maybe 5 fast punches all to the head." When Resident N tried to get up from the chair, he stumbled. CNA 4 caught him. Resident N "was slobbering , out of it." Resident N "hasn't been right ever since." To CNA 4, it seemed like Resident N didn't really "remember as much, like not really right." Resident N did not go to hospital afterwards, but he did call the police. The police said they couldn't do anything, because "it was on the facility to get him help." CNA 4 assisted in taking the police upstairs. CNA 4 told the DON (Director of Nursing) about Resident B hitting Resident N in the head. Resident B was sent out to a psychiatric hospital after the incident. He'd been out to a psychiatric hospital before, but always came back. Other residents were scared of him and staff were scared of him too. "Someone could get hurt in there." Resident B let it be known that "he boxes, shadow boxes, walks up on women. I don't know what's going on." He			

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	slammed QMA 12's hand in a door. Resident B was currently receiving one on one staff supervision, but it agitated and upset him. Staff were being told to stop reporting and documenting things, because it made it harder for him to be placed elsewhere. CNA 4 stated, "Everyone is in fear there over this one resident. He's very, very dangerous." The 5/3/23 neuropsychiatric hospital note indicated Resident B had been physically aggressive with some staff and other residents at a residential place. He was a Golden Gloves boxer and a veteran from the Navy and hit another patient a day ago. A police report was made. Recently, he had a history of sundowning, depression, and Alzheimer dementia and traumatic brain injury. The traumatic brain injury may have been for a history of being a boxer for a while for money. An interview was conducted with the DON (Director of Nursing) on 8/29/23 at 11:24 a.m. She indicated it was called and reported to her that Resident B hit another resident in April, 2023, and she remembered discussing it with Resident B's family member. That was her first instance in dealing with Resident B. An interview was conducted with the ED (Executive Director) on 8/30/23 at 2:49 p.m. He indicated there was no incident report or investigation into the 4/9/23 abuse altercation between Resident B and Resident N, as the facility had a different ED at the time. An anonymous interview was conducted with a staff member. Resident B's dementia started getting worse about a year ago. That's when he "started targeting [name of Resident M.]" They			

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	indicated Resident B had tried to fight Resident M, kicked on her several times. An anonymous interview was conducted with a staff member. They indicated Resident B shadow boxed, and Resident M "is like a trigger. He'll circle her chair and shadow box around her." Resident M asked her to remind management that she was scared of Resident B. An interview was conducted with CNA 4 on 8/30/23 at 2:01 p.m. She indicated Resident B had been "messing with [Resident M,] trying to fight her. They had to protect Resident M from Resident B. Resident M's 8/25/23 Level of Service Assessment indicated she was oriented to person, place and time or sufficiently oriented to function independently if in familiar surroundings. An interview was conducted with Resident M, who was sitting in her motorized wheel chair, in the 2nd floor lounge on 8/30/23 at 11:50 a.m. She indicated Resident B "always messes with me." She usually spent time alone in her room, minding her own business. Resident B "boxes at me and almost hit me" about 3 times. It happened most often in the activity room. She still went to activities, "but I'm scared to go because of him." She told staff, including the ED, "but it doesn't do no good." One time, Resident B threw water on her. Resident M had a cup of ice water and dropped it on the floor. Resident B picked it up and threw it at her. "It made me feel bad." Resident M told Resident B the next time he "messed with me, I was going to call the police." The staff instructed her to just wheel away from him when she saw him, "but I don't know when he's gonna come around." When "everyone is			

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	around me, they look out for me." An interview was conducted with the ED and DON on 8/30/23 at 4:24 p.m. They indicated they hadn't issued a discharge notice to Resident B, because they had nowhere for him to go. They knew he was not appropriate to be there. They hadn't had a discussion with the Ombudsman about alternative placement. 2. The clinical record for Resident L was reviewed on 8/30/23 at 9:50 a.m. His diagnoses included, but were not limited to, hypertension and depression. He was admitted to the facility on 12/22/22. The Home Health Care Plan was provided by the DON on 8/30/23 at 4:25 p.m. It indicated a certification period from 8/8/23 to 10/6/23. A home health aide was to be provided for up to a 1 hour visit, 1-2 times a day, 5-7 days a week, for 9 weeks. The home health aide was to assist with bathing, grooming, hygiene, mobility, activities of daily living, and housekeeping needs. The 7/18/23, 11:56 a.m. QMA [Qualified Medication Aide] note read, "QMA went into clients room to administer medications, client was lying in bed with feces on blanket, QMA told client he needed to be cleaned up and that she would help him, client refused help with being cleaned up by staff, client states he will do it himself." The 8/15/23, 8:22 p.m. QMA note read, "Writer states that a QMA went to deliver medication and found resident on the floor on his knees. QMA called a CNA to assist with lifting him off of floor. Resident was wet with what appeared to be urine. QMA asked resident if they could help get him cleaned up and put dry clothes on. Resident			

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	refused care and stated that he wasn't about to let anyone come into his room and tell him what to do. Resident continued to refuse care from the employees and insisted that they leave his room." The 8/15/23, 8:55 p.m. QMA note read, "Writer left nurse station and as she walked down the hallway she noticed a resident from [Resident L's room number] in his wheelchair. AS she looked at him she noticed his gray sweatpants were covered with a wet substance that smelled of urine. Writer asked resident if she could take him back to his room and freshen him up. Resident said yes to writer asked a CNA to assist. Writer found a clean pair of pants and she and the CNA assisted with washing him up and changing his brief and pants. Writer then assisted him back to the smoking area." An interview and observation of Resident L was conducted in the presence of CNA 15 and CNA 7 on 8/30/23 at 10:33 a.m. He was lying in bed in his room. He indicated he received the assistance he needed in the facility. After leaving the room, CNA 15 indicated if he was not eating or smoking, he was lying in bed. Home Health was in earlier today and assisted him with getting up, showered, and dressed. An interview and observation was conducted with CNA (Certified Nursing Assistant) 15 on 8/30/23 at 10:01 a.m. She indicated one day she was getting a page and Resident L was by the activity room door in his wheel chair, ready to go outside. He didn't' have on any shoes, had soiled himself, and didn't care. She indicated Resident L's issues were "up here," as she pointed to her head. An interview was conducted with CNA 7 on 8/30/23 at 10:01 a.m. She indicated Resident L			

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	needed total care. "He can't do for himself at all. He will lay in bed, pee on himself, but he will find his way out to smoke." He will eventually let staff get him back upstairs to clean him up. An interview was conducted with the DON (Director of Nursing) on 8/30/23 at 11:00 a.m. She indicated Resident L currently received home health services for assistance with care. He was going to need extensive care and she'd spoken with his family member about it, who knew he was headed towards skilled nursing. There's times Resident L didn't want assistance with care, but other times, he'd be out smoking a cigarette in the smoking area. She'd discussed increasing his home health hours to see if that would give him the "additional umph" to stay at this level of care. "I think the next step is a SNF [skilled nursing facility.] That's where I think we are now." Home health aides have said how difficult he is to work with. He's being more verbally aggressive with them. This has been more recent, brought to my attention in the past month. He was pretty much at maximum home health hours now. 3. The clinical record for Resident Z was reviewed on 8/28/23 at 11:00 a.m. The diagnoses for Resident Z included, but were not limited to, kidney disease and type 2 diabetes mellitus. The Level of Service Assessment dated 6/27/23 for Resident Z's indicated resident was oriented to person, place and time. A service plan for Resident Z dated 7/1/23 indicated the resident needed assistance with bathing, personal hygiene, dressing, and with incontinence episodes. A nursing progress note dated 3/23/23 indicated "...Since arriving back to Oasis, resident has			

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	required a higher level of assistance as per previous notes. Writer and [Family Member 13] agreed to meet together with [Resident Z] to reassess and discuss the potential need for a higher level of care if needed. A 6/27/23 level of service evaluation indicated Resident Z can feed self, "can assist with own transfers and position changes, but needs direct assistance 3 or more times in a 7-day period. The client needs cueing most of the time. This includes person who will attempt transfers or position changes unsafely, needs direct assistance from another person for parts of dressing and undressing, ...requires assistance with minimal parts of bathing, always requires assistance with personal hygiene, requires assistance less than daily to manage...incontinency," and mobility requires staff assistance. A hospital discharge summary dated 8/11/23 indicated resident was admitted with a wound on fifth toe of right foot. During hospital stay, Resident Z had amputation of right toe. A nursing note dated 8/17/23 indicated Resident Z had returned to facility from hospitalization of amputation of toe. A physical therapy evaluation note dated 8/21/23 indicated the resident was partial weight bearing. A home health physical therapy note dated 8/24/23 indicated Resident Z was upset about not having her home health aide back after hospitalization. A nursing note for Resident Z dated 8/24/23 indicated "...[Family Member 13] came to nsg			

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	[nursing] station stating that [Resident Z] has to be none wt. [non weight bearing] on her rt [right] foot due to wound reopening she took her to wound dr [doctor] where sutures were removed..." An observation was made of Resident Z on 8/28/23 at 11:12 a.m. The resident was observed sitting in a recliner chair in the living area. The resident's right foot was wrapped with a white bandage covering her whole foot and in a medical boot. The resident was not observed with a call assistance pendant. An interview was conducted with Resident Z on 8/28/23 at 11:14 a.m. She indicated she had her right toe amputated recently. Prior to hospitalization, she did have a home health aide coming in to assist her with care needs. Since she has been back from the hospital; she has not seen the home health aide. She was needing assistance with transferring to her chair, bathing, toileting and dressing. Resident Z indicated she does not have a call for assistance pendant. She has to make her way in the bathroom to pull a call light cord. She does not feel the facility was able to meet her needs and would like to return back to the long term care facility she had recently had stayed at. She has been dependent on Family Member 13 a lot to assist with her care needs. Family Member 13 has to work, and the resident felt she was depending too much on Family Member 13 to assist her. It had been mentioned in the past about long term care placement for her, but nothing came of it. A nursing note dated 8/29/23 indicated Resident Z had a wound vacc placement on her wound [vacuum-assisted device to assist with closure of a wound] that will be changed by outside wound team.			

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	An observation was made of Resident Z on 8/29//23 at 8:34 a.m. The resident was observed dressed sitting in wheelchair screaming for help outside of her door in the hallway. The resident indicated she needed someone to help her with toileting. An interview was conducted with Certified Nursing Assistant (CNA) 10 on 8/29/23 at 8/29/23 at 8:40 a.m. She indicated Resident Z had not used her call light that was located in the bathroom for assistance. She was unsure if the resident had a home health aide that comes in to assist her. She has never seen one. An observation was made of Resident Z with CNA 10 on 8/29/23 at 8:46 a.m. The resident was observed sitting in her wheelchair in the door frame of her door leading out to hallway. The resident had reported to CNA 10 she needed assistance with using the bathroom. CNA 10 indicated to the resident she had to leave for a minute to go get an additional staff person to help CNA 10 assist her. An interview was conducted with Director of Nursing (DON) on 8/28/23 at 10:37 a.m. She indicated resident does receive home health aide services for activities of daily living [ADLs] but unsure frequency. The resident should have a plan of care in her room that states the services the home health will provide and frequency of visits. In March 2023, it had been discussed about the next level of care with resident and Family Member 13 about moving her to a long term care facility. The resident goes back and forth with required care needs. Some days she can do more than other days, so it had not been revisited due to improvement with assistant needs. Family			

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	Member 13 does take Resident Z to wound care appointments. The DON was unaware of the discussion Family Member 13 had with the nursing staff about the resident was needing to be non-weight bearing of her right foot after a wound appointment on 8/24/23. The resident would need to be sent to a rehab facility. She would contact Family Member 13 and reach out to a rehab facility. An interview was conducted with DON on 8/28/23 at 3:18 p.m. She indicated she was unable to find a completed plan of care for home health aide services for ADLS for Resident Z in her room. An interview was conducted with DON on 8/30/23 at 2:00 p.m. She indicated after speaking with the wound nurse from the home health agency on 8/29/23, the resident as of the 8/28/23's wound care visit Resident Z had received a wound vacc on her foot. The resident was receiving home health services for wound care and physcial therapy. She had reached out via email to the home health agency regarding if Resident Z was receiving aide services for ADLS and frequency of those services. The email from the home health agency indicated Resident Z currently was not receiving aide services for ADLs.The Residency Admission and Tenancy Requirement policy was provided by the ED on 8/28/23 at 11:55 a.m. It read, "As required under 410. IAC 16.2.5.05(f)(1-5), the Resident must be discharge if the resident: 1. is a danger to the resident or others; 2. requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight, 3. requires			

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	less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversite, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident's choice to provide those services; 4. is not medically stable; or 5. meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident's needs: A. Requires total assistance with eating. B. Requires total assistance with toileting C Requires total assistance with transferring."This Residential Tag relates to Complaint IN00415672.			
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 provide adequate supervision to a cognitively impaired resident; ensure a resident was free from physical abuse; and ensure a resident was free from mental abuse for 3 of 3 residents reviewed for abuse. (Residents B, M, and N) Findings include: 1. The clinical record for Resident B was reviewed on 7/28/23 at 11:30 a.m. His diagnoses included,	R 0052	Plan of Correction 09/22/23 Facility ID: 013347 Survey Event ID: RRGE11 R052 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. All residents had the potential to be affected. Resident	11/01/2023

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	but were not limited to: Alzheimer's dementia, depression, Vitamin D deficiency, psychosis, and traumatic brain injury. During a tour of the facility on 8/28/23 at 11:08 a.m., an interview was conducted with the DON. She indicated Resident B was currently receiving one on one staff supervision, because he was an elopement risk. At the end of July, 2023, Resident B was knocking on the door of his old house. The people who live there now called the facility and they went to get him. He was then placed on hourly checks, but he left the facility again a few days later and ended up at the VA (Veteran's Affairs) hospital in downtown Indianapolis, 8 miles away. The police picked him up and brought him back to the facility. Upon return, Resident B became aggressive with QMA (Qualified Medication Aide) 12 and slammed her arm in a door. Resident B was sent out to a neuropsyche hospital and was there for 7 days. The ED (Executive Director) provided the investigative file into the Resident B's 7/28/23 elopement from the facility on 7/28/23 at 11:30 a.m. It included a 7/28/23 follow up incident report and the My Dashboard section of Resident B's EHR (electronic health record.) The 7/28/23 follow up incident report indicated on 7/28/23 at 11:30 a.m., Resident B left the facility to go for a walk and within about 45 minutes, the facility received a phone call stating that he was knocking on caller's door asking if he lived at that address. Facility staff went to pick up Resident B and his family was notified. The preventive measures taken section of the report indicated staff were educated of resident's progressive mental decline and aware that increased safety checks would be performed. Family was aware of		B was discharged from the community. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents had the potential to be affected. No other residents identified to be affected upon review of nurses notes, reportable incidents and interviews. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. All staff in-service on Abuse, Resident Rights, and Elopement policy and reporting. b. Inservice to include how to contact the Ombudsman as a resource to discharge residents where alternative placement is difficult. **4. 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:** a. RDCS, DON or Designee will review nursing notes and incident reports to ensure proper protocols have been followed for any elopement incidents, abuse allegations. Review will be	

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	mental decline as well and were looking for alternate placement at a higher level of care facility. The follow up section of the report indicated increased safety checks would be performed until final decision was made on choice facility. The My Dashboard section of Resident B's EHR indicated on 7/28/23, "Wellness check every hour. Verify resident is in community and assist with any needs. Notify nurse on duty or DON if resident is not located...Resident left facility to go for a walk and within about 45 mins [minutes,] facility received a phone call stating that resident was knocking on caller's door asking if he lived at that address. Facility staff went to pick resident up and family was notified. When staffed [sic] arived [sic], reesident [sic] was sitting with local police for safety purposes. Resident reports that he used to live close to where he was at, and forgetting that he no longer lived at his previous address. Family is aware and is actively seeking alternate placement for resident. No injureis [sic] noted or repported [sic].. Facility staff transported resident back to facility." The 7/28/23, 12:08 p.m. note read, "Late entry from 07/26/2023: Careplan meeting held with sister [name of sister] and bother [name of brother,] as weel [sic] as, ED and writer (DON). Writer and ED expressed to family that resident's cognitive function is decreasing, causing more confusion and aggression. Family understands and wishes to seek alternate placement for resident, preferrably [sic] an all male unit. Writer and ED recommended [name of a skilled nursing facility] nursing facility and family agreed to have referral info [information] faced [sic] to that facility." The 7/28/23, 12:10 p.m. note read, "Resident left		conducted weekly for 12 weeks, then bi weekly for 12 weeks then monthly for 3 months. **5. By what date will the systematic changes be completed.** a. Compliance by 11/1/23	

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	facility to go for a walk and within about 45 mins, facility received a phone call stating that resident was knocking on caller's door asking if he lived at that address. Facility staff went to pick resident up and family was notified. When staffed arrived, resident was sitting with local police for safety purposes. Resident reports that he used to live close to where he was at, and forgetting that he no longer lived at his previous address. Family is aware and is actively seeking alternate placement for resident. No injuries noted or reported. Facility staff transported resident back to facility." An interview was conducted with the Marketing Director on 8/29/23 at 3:01 p.m. She indicated the ED told her Resident B was missing, where he'd been found wandering, and for her and another staff member to go pick him up. She was familiar with the east side of Indianapolis. She picked him up on the corner by a woman's house, 2.4 miles away. The Marketing Director gave a specific description of the corner, color of the house and trim, and presence of a low fence. The police had him at the fence. The person who lived at the house was outside of the house and waved nicely at the them. The woman seemed happy they came to get him. She only spoke with the 3 officers present, not the woman in her yard. When Resident B got in the car, he was saying he wanted to go home; that he grew up over there; and on the way back to the facility, pointed out the school to which he used to go and a house in which he used to live. An observation of the above house was made on 8/29/23 at 4:10 p.m. It was 2.4 miles away and a 47 minute walk from the facility per Google Maps. The 8/1/23, 6:19 p.m. note, written by LPN (Licensed Practical Nurse) 13, read, "Client was			

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	escorted to clients room, client stated he will be there for the night." The 8/1/23, 7:12 p.m. note, written by LPN 13, read, "Reporting WANDERING. Late entry from 08/01/2023 @ 5 p.m. Client was brought into nursing station by a woman, Woman stated that client was at her home knocking on her door stating he lived there, client and woman escorted to DON office, DON was made aware of situation." On 8/30/23 at 12:30 p.m., the BOM (Business Office Manager) provided a list of employees who worked the evening shift 8/1/23. The list included LPN 13 who worked until 7:35 p.m.; QMA 12 who worked until 6:00 p.m.; CNA 4 who worked from 5:00 p.m. until 12:00 a.m., and the DON who worked until 6:00 p.m. LPN 13 no longer worked at the facility and was unavailable for interview. An interview was conducted with the DON on 8/29/23 at 11:24 a.m. She indicated on 8/1/23 she received a phone call from LPN 13 that the woman whose house Resident B was at on 7/28/23, stopped by the facility to check on him, not that the woman brought him back that day. Neither Resident B, nor a woman were brought into her office the evening shift of 8/1/23. She stated, "I see how the note reads, and I don't know why, but that didn't happen." An interview was conducted with QMA 12 on 8/30/23 at 3:15 p.m. She indicated she worked the evening of 8/1/23 when Resident B "pretty much eloped again." The woman who brought Resident B into the nursing station was screaming, hollering, looking hysterical, and saying, "This is			

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	the 5th or 6th time he came to my house." QMA 12 directed the woman to the DON. At the time, QMA 12 did not know about the hourly checks implemented from his 7/28/23 elopement or that he eloped on 7/28/23. She also worked on 7/29/23 and no one told her about Resident B's 7/28/23 elopement or hourly checks then either. If any staff member signed off on hourly checks, it would be CNAs (Certified Nursing Assistants.) An interview was conducted with CNA 4 on 8/30/23 at 2:01 p.m. She indicated Resident B was brought back into the facility by a woman. Around 5:00 p.m., she was coming down the stairs into the lobby and heard a lady approaching the facility outside, asking if Resident B lived there and saying it was ridiculous. He scared her kids, and she threatened to call the state, because she was a nurse. QMA 12 took Resident B and the woman into the DON's office. CNA 4 didn't know what happened from there. CNA 4 heard Resident B left the facility again the next day. The ED (Executive Director) provided the investigative file into the Resident B's 8/2/23 elopement from the facility on 7/28/23 at 11:30 a.m. It included an 8/8/23 follow up incident report, The 8/8/23 follow up incident report indicated on 8/2/23 at 9:01 a.m. Resident B was discovered by staff to not be in his apartment or in the building. Staff looked for the resident in the community and he was unable to be found. Law enforcement was contacted and a missing person report was filed. Later, the resident was found and was transported back to the building. The preventive measures taken section of the report indicated due to his continued mental decline, 1 on 1 observations were in place. Family was aware of the cognitive decline and were looking for alternative placement			

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	at a higher level of care facility. The 8/8/23 follow up section of the report indicated Resident B was sent to a neuropsyche hospital due to behaviors. Family and facility were actively seeking alternate placement at a secure higher level of care facility. The 8/2/23, 6:45 a.m. note read, "RESIDENT ON Q [every] 1 HR CHECKS, HAS REMAINED IN [Resident B's apartment number] SLEEPING DURING NIGHT." The 8/2/23, 9:28 a.m. note read, "Hourly check was seen at 7:19 a.m. going to breakfast." The 8/2/23, 5:39 p.m. note read, "Reporting ELOPEMENT, and WANDERING. Client was on hourly checks due to wondering [sic] and elopment [sic], client was last seen by staff at 7:19 am on his way to eat in the dinning [sic] area, staff went to check on client again and client could not be found, staffed searched building including common areas and areas outside of building and was unable to locate client, hourly checks countinued [sic] throughout the day and client was still unable to be located, management staff as well as family was informed of situation, client was picked up up [sic] by EMS [emergency medical services] on the Northside of Indianapolis and escorted to VA hospital, this facility was made aware of clients location via VA hospital nurse." An interview was conducted with the ED on 8/28/23 at 2:45 p.m. He indicated on 8/2/23, Resident B was on hourly checks, and within an hour, he left the building. They searched for him and they couldn't find him. "Some hours went by," so he filed a police report. Resident B was found on the northside of Indianapolis and the police took him the the VA Hospital. The ED was			

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	not exactly sure when he notified the police Resident B was missing, but it was "certainly in the afternoon." The ED was unsure when the facility received the phone call that he was found. Their receptionist took the call and was told he was being taken to the VA hospital. The ED was unaware of Resident B's 8/1/23 elopement from the facility, but would look into it. An interview was conducted with the ED on 8/29/23 at 9:25 a.m. He indicated the 8/1/23 incident where the woman brought Resident B back into the facility "must have been an oversight." He reported what he was aware of, which were the 7/28/23 and 8/2/23 elopements. On 8/29/23 at 9:24 p.m., the ED provided the 8/2/23, 4:40 p.m. Indianapolis Metropolitan Police Department East District Information Card, indicating a missing person as the incident type, the officer's name, unit number, and case number. An observation of Resident B was made on 8/30/23 at 10:42 a.m. He was sitting in a chair just outside of the dining room with CNA 10, who was providing his one on one supervision, sitting in a different chair nearby. 2. The clinical record for Resident N was reviewed on 8/30/23 at 2:34 p.m. His diagnoses included, but were not limited to, schizophrenia and glaucoma. The clinical record for Resident B was reviewed on 7/28/23 at 11:30 a.m. His diagnoses included, but were not limited to: Alzheimer's dementia, depression, Vitamin D deficiency, psychosis, and traumatic brain injury. Resident B's service plan, updated 7/29/23,			

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	indicated he needed monitoring related to history of mood disturbance. He shadow boxed in the corridor and hall. Resident N's 4/9/23, 5:18 a.m. note read, "The resident called the police due to being hit in the eye face and body by another resident the can [sic] notified the QMA [Qualified Medication Aide] at 10 pm. the resident stated he didn't want To go to the hospital, he stated he just want [sic] to report the incident to the police the Don [Director of Nursing] notified by the QMA as well of the incident." An interview was conducted with CNA 4 on 8/30/23 at 2:01 p.m. She indicated Resident B had been fighting other residents in the facility, including Resident N a few months ago. It was right by the fireplace in the front lobby area. CNA 4 witnessed it along with 2 residents. Resident N was talking to CNA 4. CNA 4 sat down in a chair near the fireplace. Resident B was standing nearby, when Resident B came over started fighting Resident N "out of nowhere." Resident N was still sitting in a chair while getting punched "maybe 5 fast punches all to the head." When Resident N tried to get up from the chair, he stumbled. CNA 4 caught him. Resident N "was slobbering , out of it." Resident N "hasn't been right ever since." To CNA 4, it seemed like Resident N didn't really "remember as much, like not really right." Resident N did not go to hospital afterwards, but he did call the police. The police said they couldn't do anything, because "it was on the facility to get him help." CNA 4 assisted in taking the police upstairs. CNA 4 told the DON (Director of Nursing) about Resident B hitting Resident N in the head. Resident B was sent out to a psychiatric hospital after the incident. He'd been out to a psychiatric hospital before, but			

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	always came back. Other residents were scared of him and staff were scared of him too. "Someone could get hurt in there." Resident B let it be known that "he boxes, shadow boxes, walks up on women. I don't know what's going on." He slammed QMA 12's hand in a door. Resident B was currently receiving one on one staff supervision, but it agitated and upset him. Staff were being told to stop reporting and documenting things, because it made it harder for him to be placed elsewhere. CNA 4 stated, "Everyone is in fear there over this one resident. He's very, very dangerous." The 5/3/23 neuropsychiatric hospital note indicated Resident B had been physically aggressive with some staff and other residents at a residential place. He was a Golden Gloves boxer and a veteran from the Navy and hit another patient a day ago. A police report was made. Recently, he had a history of sundowning, depression, and Alzheimer dementia and traumatic brain injury. The traumatic brain injury may have been for a history of being a boxer for a while for money. An interview was conducted with the DON (Director of Nursing) on 8/29/23 at 11:24 a.m. She indicated it was called and reported to her that Resident B hit another resident in April, 2023, and she remembered discussing it with Resident B's family member. That was her first instance in dealing with Resident B. An interview was conducted with the ED (Executive Director) on 8/30/23 at 2:49 p.m. He indicated there was no incident report or investigation into the 4/9/23 abuse altercation between Resident B and Resident N, as the facility had a different ED at the time.			

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	3. The clinical record for Resident M was reviewed on 8/30/23 at 2:00 p.m. Her diagnoses included, but were not limited to, cerebral palsy, depression, and hypertension. The clinical record for Resident B was reviewed on 7/28/23 at 11:30 a.m. His diagnoses included, but were not limited to: Alzheimer's dementia, depression, Vitamin D deficiency, psychosis, and traumatic brain injury. Resident B's service plan, updated 7/29/23, indicated he needed monitoring related to history of mood disturbance. He shadow boxed in the corridor and hall. An anonymous interview was conducted with a staff member. Resident B's dementia started getting worse about a year ago. That's when he "started targeting [name of Resident M.]" They indicated Resident B had tried to fight Resident M, kicked on her several times. An anonymous interview was conducted with a staff member. They indicated Resident B shadow boxed, and Resident M "is like a trigger. He'll circle her chair and shadow box around her." Resident M asked her to remind management that she was scared of Resident B. An interview was conducted with CNA 4 on 8/30/23 at 2:01 p.m. She indicated Resident B had been "messing with [Resident M,] trying to fight her. They had to protect Resident M from Resident B. Resident M's 8/25/23 Level of Service Assessment indicated she was oriented to person, place and time or sufficiently oriented to function			

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	independently if in familiar surroundings. An interview was conducted with Resident M, who was sitting in her motorized wheel chair, in the 2nd floor lounge on 8/30/23 at 11:50 a.m. She indicated Resident B "always messes with me." She usually spent time alone in her room, minding her own business. Resident B "boxes at me and almost hit me" about 3 times. It happened most often in the activity room. She still went to activities, "but I'm scared to go because of him." She told staff, including the ED, "but it doesn't do no good." One time, Resident B threw water on her. Resident M had a cup of ice water and dropped it on the floor. Resident B picked it up and threw it at her. "It made me feel bad." Resident M told Resident B the next time he "messed with me, I was going to call the police." The staff instructed her to just wheel away from him when she saw him, "but I don't know when he's gonna come around." When "everyone is around me, they look out for me." The Abuse, Neglect, and Financial Exploitation Prevention policy was provided by the DON on 8/28/23 at 11:55 a.m. It read, "Residents of the community have the right to be free of abuse, neglect and financial exploitation....Staff behavior that is abusive, neglectful or exploits residents will not be tolerated by the management of the community...REPORTING It is mandatory for staff members to report suspected incidents of abuse, neglect, and financial exploitation. Staff members are required to immediately report suspect behaviors to their Department Manager. Documentation will be initiated by thee Department Manager at the time of the initial report. The Department Manager will immediately inform the Administrator."			

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	This Residential Tag relates to Complaint IN00415188.			
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 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 interview and record review, the facility failed to ensure staff were certified in first aide every shift for 7 of 28 days reviewed. This had the potential to effect 108 of 108 residents that reside in the facility. Findings include: The staff worked schedules for the weeks of 7/1/23 through 7/9/23, 7/16/23 through 7/24/23,	R 0117	Plan of Correction 09/22/23 Facility ID: 013347 Survey Event ID: RRGE11 R117 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	11/01/2023

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	and 8/6/23 through 8/13/23, and the staff Cardiopulmonary Resuscitation (CPR)/First Aide certifications were provided by the Executive Director (ED) on 8/30/23 at 11:00 a.m. The following days and shifts there were no staff members working that were first aide certified: 7/7/23 - night shift, 7/21/23 - night shift, 7/22/23 - day shift, 7/23/23 - day shift, 8/6/23 - day and evening shift, 8/12/23 - night shift, and 8/13/23 - night shift An interview was conducted with ED on 8/30/23 at 4:30 p.m. He indicated he was unable to provide staff that were certified in first aide on 7/7/23, 7/21/23. 7/22/23, 7/23/23, 8/6/23, 8/12/23, and 8/13/23. This Residential Tag relates to Complaint IN00415188.		**practice.** a. No residents experienced adverse effects from the alleged deficient practice. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken.** **a. Deficiency had the potential to effect 110 of 110 residents residing in the community. No residents had adverse effects related to the alleged deficiency.** **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** **a. The Executive Director or designee will schedule in-house basic life support CPR/1st Aid class. ED or designee will place marker on the schedule indicating staff with active CPR/1st Aid certifications to ensure adequate certified staff on duty 24/7. BOM will keep certification binder for active employees.** **4. 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**	

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			into place: **a. The ED or designee will audit employee schedule weekly to ensure certified staff is scheduled 24/7. Quality Assurance (QA) committee will review audits monthly and make reccommendations as needed.** **5. By what date will the systematic changes be completed** a. Compliance by 11/1/23	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually			

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	thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility failed to ensure staff were provided dementia training for 5 of 19 resident rights, abuse and dementia training reviewed. (Certified Nursing Assistant (CNA)s' 1, 4, and 9, Qualified Medication Aide (QMA) 6, License Practical Nurse (LPN) 5) Findings include: Dementia, resident rights and abuse in-service training's for 19 staff members were provided by the Executive Director (ED) on 8/29/23 at 2:53 p.m. The following staff members' trainings did not include current dementia training: CNA 1 - hire date 7/9/21, CNA 4 - hire date 7/7/22, CNA 9 - hire date 5/3/16, QMA 6 - hire date 7/11/22, and LPN 5 - hire date 12/5/22 An interview was conducted with the ED on 8/29/23 at 2:55 p.m. He indicated he was unable to provide current completed dementia training for CNA 1, CNA 4, CNA 9, QMA 6 and LPN 5.	R 0120	Plan of Correction 09/22/23 Facility ID: 013347 Survey Event ID: RRGE11 R120 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. No residents experienced adverse effects from the alleged deficient practice. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken.** a. Deficiency had the potential to effect 110 of 110 residents residing in the community. No residents had adverse effects related to the alleged deficiency.	11/01/2023

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	This Residential Tag relates to Complaint IN00415188.		**3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** **a. The Executive Director or designee will notify staff of any required training. ED or designee will remove any employee from the schedule that failed to comply to this requirement by the date set forth.** ="" p="">"> **4. 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:** a. The ED or designee will audit employee training weekly to ensure certified staff has completed required training in a timely basis. Quality Assurance (QA) committee will review audits monthly and make recommendations as needed. **5. By what date will the systematic changes be completed** a. Compliance by 11/1/23	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.			

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	Based on interview and record review, the facility failed to administer a resident's medications, as ordered, for 1 of 3 residents medications were reviewed, and to ensure coordination of a resident's care regarding a foot wound for 1 of 3 resident's wound reviewed. (Resident B and Resident Z) Findings include: The clinical record for Resident B was reviewed on 7/28/23 at 11:30 a.m. His diagnoses included, but were not limited to: Alzheimer's dementia, depression, Vitamin D deficiency, psychosis, and traumatic brain injury. He was admitted to the facility on 11/29/20. The service plan, last updated 7/29/23, indicated The 5/11/23 neuropsychiatric hospital discharge reconciliation report indicated to administer 50 mcg of Vitamin D3 every day; 1 mg of Risperidone everyday; 10 mg of Memantine every day; and 25 mg of Sertraline every day. The May, 2023 MAR (medication administration record) indicated the Memantine was not administered on the following dates: 5/12/23, 5/13/23, 5/14/23, 5/15/23, 5/21/23, 5/24/23, and 5/30/23. The Risperidone was not administered on the following dates: 5/12/23, 5/13/23, 5/14/23, 5/15/23, 5/21/23, 5/24/23, and 5/30/23. The Sertraline was not administered on the following dates: 5/13/23, 5/14/23, 5/15/23, 5/21/23, 5/24/23, and 5/30/23. The Vitamin D3 was not administered on the following dates: 5/13/23, 5/14/23, 5/15/23, 5/21/23, and 5/30/23. The 6/9/23 psychiatric physician services note	R 0240	Plan of Correction 09/22/23 Facility ID: 013347 Survey Event ID: RRGE11 R240 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a. Resident B has been discharged from the community. Resident Z has been treated by her medical team and is currently receiving services according to her up to date Service Plan. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents receiving medication services had the potential to be affected. No other residents identified to be affected. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. All nursing staff that administer medication were inserviced on medication administration, to notify DON, ED or RDCS if EMAR is not correctly documenting medication administration and to notify DON, ED or RDSC if medications not available, even if	11/01/2023

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	indicated to increase Resident B's Risperidone to 1 mg twice daily for uncontrolled behaviors, and the 6/23/23 psychiatric physician services note indicated to continue the 1 mg of Risperidone twice daily. The June and July, 2023 MARs indicated the Memantine was not administered on 6/17/23, 6/27/23, 7/5/23, 7/10/23, 7/12/23, 7/13/23, 7/14/23, 7/16/23, 7/22/23, 7/23/23, and 7/26/23. The Risperidone was not administered twice on the following dates: 6/10/23, 6/11/23, 6/27/23, 7/5/23, 7/12/23, 7/13/23, 7/14/23, 7/16/23, 7/22/23, 7/23/23, and 7/26/23. The Risperidone was only administered once on 6/13/23, 6/14/23, 6/15/23, 6/20/23, 6/21/23, 6/22/23, 6/24/23, 6/25/23, 6/30/23, 7/1/23, 7/2/23, 7/4/23, 7/6/23, 7/8/23, 7/10/23, 7/11/23, 7/19/23, 7/24/23, 7/27/23, 7/28/23, 7/29/23, 7/30/23, and 7/31/23. The Sertraline was not administered on 6/17/23, 6/27/23, 7/5/23, 7/10/23, 7/12/23, 7/13/23, 7/14/23, 7/16/23, 7/22/23, 7/23/23, and 7/26/23. The Vitamin D3 was not administered on 6/17/23, 6/27/23, 7/5/23, 7/10/23, 7/12/23, 7/13/23, 7/14/23, 7/16/23, 7/22/23, 7/23/23, and 7/26/23. Resident B was admitted to a neuropsychiatric hospital on 8/3/23. He was discharged from this hospital, back to the facility on 8/15/23. The hospital discharge reconciliation report indicated to continue the Vitamin D3 at 50 mcg daily; continue the Memantine at 10 mg daily; to increase the Risperidone to 0.5 mg twice daily and 1 mg twice daily; and Sertraline at 50 mg daily. The August, 2023 MAR indicated the Memantine was not administered on 8/16/23, 8/22/23, 8/25/23, 8/26/23, and 8/27/23. The 0.5 mg of Risperidone was not administered twice on 8/16/23, 8/21/23, 8/22/23, 8/25/23, 8/26/23, and 8/27/23. The 0.5 mg		the facility is not administering those medications b. All nursing staff that administer medications educated on medication refusal documentation and reporting policy c. Licensed nursing staff inserviced on policy to ensure proper transcription of medication changes to the EMAR. **4. 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:** a.RDCS, DON or designee will audit EMAR for correct medication administration documentation weekly x 12 weeks, bi weekly x 12 weeks and monthly x 3 months. b. RDSC, DON or designee will audit 25 % of all new orders for correct transcription to EMAR weekly x 12 weeks, bi weekly x 12 weeks and monthly x 3 months. **5. By what date will the systematic changes be completed.** a. Compliance by 11/1/23	

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	of Risperidone was only administered once on 8/17/23, 8/18/23, 8/23/23, and 8/28/23. The 1 mg of Risperidone was not administered twice on 8/16/23, 8/21/23, 8/25/23, 8/26/23, and 8/27/23. The 1 mg of Risperidone was only administered once on 8/17/23, 8/18/23, 8/22/23, 8/23/23, and 8/28/23. The Sertraline was not administered on 8/26/23 and 8/27/23. The Vitamin D3 was not administered on 8/16/23, 8/21/23, 8/22/23, 8/25/23, 8/26/23, and 8/27/23. An interview was conducted with the DON (Director of Nursing) on 8/29/23 at 11:24 a.m. She indicated there was an issue with the facility's computer software used for medication administration, and IT (Information technology) was aware of the issue. She had no verification to prove whether Resident B received his medications, as ordered, in May, June, and July. Counting the medications from the last pharmacy delivery would be the only way to prove he was currently receiving his medications, as ordered. The Medication Management, Administration, & Storage policy was provided by the DON on 8/30/23 at 10:39 a.m. It read, "Medication Administration: Medication administration shall be administered as ordered by the resident's physician and shall be administered by a licensed nurse or a QMA [Qualified Medication Aide....] Documentation: At the time of administration,, the licensed nurse or QMA administering the medication will document the administration in the medication (or treatment) administration record that includes the following: a. Resident Name bb. Name of Medication or Treatment c. Date, Time d. Route e. Dosage (if applicable) f. Name or initials of the person administering the drug or treatment g. Response to medication for all PRNs [as needed] and if indicated."2. The clinical record for			

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	Resident Z was reviewed on 8/28/23 at 11:00 a.m. The diagnoses for Resident Z included, but were not limited to, kidney disease and type 2 diabetes mellitus. The Level of Service Assessment dated 6/27/23 for Resident Z's indicated resident was oriented to person, place and time. The resident's receptive communication was indicated as "Understands information conveyed. May miss some part or intent of the message." A service plan dated 7/1/23 indicated the resident received home health care for skin condition. The services indicated the following: "home health nurse to report any changes to Licensed Nurse during weekly visits...Nursing staff and family to encourage [Resident Z] to report any significant changes in skin condition to Licensed nurse...Nursing staff and family to encourage [Resident Z] to inspect skin routinely..." A nursing note dated 6/20/23 indicated Resident Z had complaints of right foot pain. A callus was observed, and the resident requested to see a podiatrist. A nursing note dated 6/22/23 indicated the resident had contacted emergency services to be transferred to the hospital, because her foot was painful and swelling. A nursing note dated 6/22/23 indicated the resident had returned from emergency room and was diagnosed with osteomyelitis to her right foot. She was discharged with orders for pain medication and an antibiotic medication. A Nurse Practitioner (NP) 22 note dated 7/3/23 indicated she had seen Resident Z for follow up			

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	on foot infection. The resident had picked up her antibiotics and pain medications from the pharmacy the resident utilizes and started taking the medications without assistance by the staff. The resident was upset about not able to self medicate. The nursing staff found out about having the medications and removed from her room. NP 22 had followed up with nursing staff about the medications, and the resident was not taking the antibiotics correctly. The staff removed the medications from the resident's room. The staff would administer the medications to the resident. A podiatrist visit dated 7/7/23 indicated the removal of 6 hyperkeratotic lesions (thicken skin). A home health wound evaluation dated 7/18/23 indicated Resident Z had a wound on her right foot that measured 2.5 centimeters x 2.5 centimeters x .4 depth. Starting on next visit, the wound nurse was ordered to apply santyl, aquacel alginate dressing and cover with a 4 x 4 dressing and wrap with kerlex twice a week. A wound visit note dated 7/21/23 indicated the wound measurements was 2.5 centimeters in length, 2 centimeters in width, and 0.5 centimeters in depth. The wound dressing was complete but, the santyl medication was not available to administer. A Coordination of Care note from Coordination of Care Manager (CCM) dated 7/24/23 indicated NP 22 sent order for santyl medication for wound debridement. The order was sent to be filled to outside pharmacy the resident utilizes. The resident and NP 22 aware prescription sent to outside pharmacy.			

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	A wound visit note dated 7/25/23 indicated the wound measurements was 2.5 centimeters in length, 2 centimeters in width, and 0.5 centimeters in depth. The wound dressing was complete, but the santyl medication had not arrived. He had notified NP 22 to order santyl medication. He had received an order when santyl arrives to switch from aquacel alginate to calcium alginate. A wound visit note dated 7/28/23 indicated wound measurements was 2.5 centimeters in length, 2 centimeters in width, and 0.5 centimeters in depth. The wound dressing was complete, but the santyl had not arrived. A Coordination of Care note from CCM dated 7/28/23 indicated pharmacy unable to fill santyl order due to needing additional information to fill order. The pharmacist was needing wound size, number of wounds and how many days of supply needed. CCM notified on call provider since they do not provide the wound service they were unable to provide information. CCM will contact wound home health agency on 7/31/23 to get the answers to the additional information needed for pharmacy. A Coordination of Care note from CCM dated 7/31/23 indicated "CCM placed call to [home health agency]...CCM notified coordinator that further information needed for santyl order for patient wound care. CCM left call back number for information. CCM to follow up when return call received. Coordination of care provided." The resident's clinical record nor the service logs by the CCM had no follow up documentation the additional information needed for the santyl medication was provided to the outside pharmacy.			

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	A wound visit note dated 8/1/23 indicated wound measurements was 2.5 centimeters in length, 2 centimeters in width, and 0.5 centimeters in depth. The wound treatment was completed. A wound visit note dated 8/4/23 indicated wound measurements was 2.5 centimeters in length, 2 centimeters in width, and 0.5 centimeters in depth, and the wound was improving. The wound dressing was changed, but the santyl was still not available. The resident's medical provider was aware. A wound visit note dated 8/11/23 indicated wound measurement was 2.5 centimeters in length, 2 centimeters in width, and 1 centimeters in depth. The wound nurse note indicated "...on removing the dressing, the patient's wound contained maggots. The writer didn't take an exact count, but would estimate 30-50 were present and alive in wound. Cleansed the wound bed thoroughly with wound cleanser and gauze. After cleaning, there were no maggots, eggs, or other foreign matter visualized. The maggots had eaten a fair amount of necrotic slough in the wound bed, revealing approximately 50% of the healthy wound bed. The patient's dressing was completely intact prior to this and all other wound care visits that the writer had completed previously. The patient has been ordered santyl, but never received it. Called and spoke to the patient's PCP [primary care provider], NP 22. The writer spoke to her in person. She stated that she didn't wish to send the patient to the hospital at this time, but to continue wound care as ordered. She stated that she would order ivermectin stat [as soon as possible] for treatment of maggots. Spoke to nursing staff at facility, who manage the patient's meds [medications]. Informed them of the situation with the wound, and to call PCP if			

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	ivermectin did not arrive STAT. Skilled nursing educated the patient on the life cycle of flies, and the need to keep them away from wounds to prevent infections..." A transition out note dated 8/11/23 indicated Resident Z had transferred to the hospital, because of her wound. Hospital records with an admission date of 8/11/23 indicated Resident Z was admitted with an open wound on fifth toe of right foot. The wound was found after a wound care visit with maggots in the wound. The assessment concluded right foot osteomyelitis, and the toe was amputated on 8/12/23. A nursing note for Resident Z dated 8/24/23 indicated "...[Family Member 13] came to nsg [nursing] station stating that [Resident Z] has to be none wt. [non-weight bearing] on her rt [right] foot due to wound reopening she took her to wound dr [doctor] where sutures were removed..." An observation was made of Resident Z on 8/28/23 at 11:12 a.m. The resident was observed sitting in a recliner chair in the living area. The resident's right foot was wrapped with a white bandage covering her whole foot and in a medical boot. An interview was conducted with Resident Z on 8/28/23 at 11:14 a.m. She indicated her right toe had been amputated recently. She had a wound on her toe, and a wound nurse would come in twice a week to do the wound dressing changes. During a wound dressing change, the wound nurse had found maggots in her wound. She was sent to the hospital, and she had to have her toe amputated. Prior to amputation, the wound on her			

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	toe was wrapped and covered; but not her entire foot. She sat outside at times and did not always wear a sock over her foot. She believed that was how she came in contact with the fly. Currently the wound nurse comes out twice a week to change her dressing, and FM 13 takes her to the wound clinic once a week. An interview was conducted with the Director of Nursing (DON) on 8/29/23 at 10:37 a.m. She indicated NP 22 had reported to her the home health wound nurse (WN) 25 did reach out to her about getting the santyl medication ordered through the pharmacy. She had told him no she would not send an order. The wound care services was provided by them, so the home health agency medical provider should have written the order for the santyl. The DON was unaware of the request for the santyl order. She has been requesting for the wound visit notes, but it was difficult to get the paperwork from the home health agency. FM 13 does take the resident to her wound clinic appointments. She was unaware FM 13 had discussed with the facility nursing staff on 8/24/23, the resident was suppose to be non-weight bearing. It was difficult getting FM 13 to provide any documentation about the wound condition after the wound clinic appointments. FM 13 will also use an outside pharmacy to get wound medications instead of letting nursing know what was needed. It was difficult to get information regarding wound status and condition from FM 13, and the home health agency that provides the care to the resident's wound. Regardless if it was ordered by a physician or just a request by FM 13; the non-weight bearing status will be provided as requested. An interview was conducted with WN 25 on			

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(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
	8/29/23 at 11:18 a.m. He indicated he was the nurse that had observed the maggots in the resident's wound on 8/11/23. Currently, he provides wound care to the resident on Mondays and Fridays, and the resident goes to the wound care clinic on Wednesdays by FM 13. Prior to the incident with maggots, WN 25 had always observed the resident's wound dressing to be intact and her foot was covered with a sock when he had provided wound care to her. During routine wound dressing changes he wound not provide wound status/condition to the facility nursing staff. The only time he would provide information to the nursing staff regarding the wound status was if there was a change of condition. He was under the impression wound care was not provided by the nursing staff in the facility. He did notified NP 22, and the nursing staff when he observed the maggots in her wound. WN 25 never applied the santyl medication to the resident's wound, because it was never available to apply. The wound was healing, but slowly. On the 8/28/23 wound visit, he had placed a wound vacc [vacuum-assisted device to assist with closure of a wound] to the resident's wound. He did not provide any instructions to the nursing staff at the facility regarding care of the wound vacc. He did provide education to FM 13; if something happens to the wound vacc she needed to notify him to address. An interview was conducted with the DON on 8/29/23 at 3:19 p.m. She indicated she had spoken to FM 13 regarding the resident was to be non-weight bearing. FM 13 had taken Resident Z to a wound clinic appointment on 8/24/23. During that appointment, the physician had recommended the resident to be non-weight bearing. She was unaware of the resident's wound clinic appointment nor did she have the wound			

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		A. BUILDING 00 B. WING	08/30/2023

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	clinic paperwork from that appointment. She would be contacting the wound clinic for the paperwork to be sent over. She has "repeatly" requested via email for the wound notes from the home health agency wound visits to be sent. An interview was conducted with the DON and FM 13 on 8/29/23 4:15 p.m. The DON indicated FM 13 has also had trouble getting information from the home health agency. The email exchanges between DON and the home health agency for the wound visit notes was provided by the DON on 8/29/23 at 3:30 p.m. They indicated the following: An email from the home health agency to the DON on 8/14/23 at 8:55 a.m., indicated the home health agency was inquiring if Resident Z had returned from the hospital, and if not which hospital was she transferred to on 8/11/23. A response email from DON to home health agency on 8/15/23 at 12:35 p.m., indicated she had spoken to FM 13, and the resident had to have her toe amputated. The DON requested for the wound visit notes to be sent for the resident's medical chart. An email from the home health agency to the DON on 8/15/23 at 12:47 p.m., indicated the wound notes were sent via email 5 minutes ago. An email from DON to the home health agency on 8/16/23 at 10:33 a.m., indicated she had not receive the wound notes for Resident Z. "This is an urgent matter and receiving those notes would be greatly appreciated." An email from home health agency to the DON on			

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	8/16/23 at 1:13 p.m., indicated for an agency staff person that was also included in the email to send the wound notes to the facility. An email from the staff person to the DON on 8/16/23 at 1:52 p.m., indicated "here are the most recent notes." An email from the DON to the home health agency on 8/17/23 at 1:48 p.m., indicated the hospital case manager had contacted DON and reported Resident Z would be returning to the facility that day. The resident has chosen to continue using home health agency for wound care and would also need physical therapy services. "It is imperative that whoever does her wound care, get with me after every visit (or at least once per week) so that I can come and view/assess the wounds and be provided with the wound notes." An email from the home health agency to the DON on 8/17/23 at 1:52 p.m., indicated for an agency staff person that was included in the email to inform WN 25 of the DON's request to observe Resident Z's wound at a minimum of once a week and receive wound visit notes. An interview was conducted with conducted with the DON on 8/30/23 at 10:49 a.m. She indicated she did get clarification about the santyl medication not be provided. NP 22 did order santyl after the request from WN 25. NP 22 had sent the order for the santyl medication to Resident Z's outside pharmacy instead of the facility pharmacy. The outside pharmacy could not fill the order due to needing additional information of the size of the wound. The facility pharmacy enters physician orders only for medications they supply. The santyl was not on the resident's Medication/Treatment orders,			

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	because they were not supplying the medication. The DON was unaware, and the santyl was not sent. She had not requested for wound notes from the home health agency until after the resident's toe was amputated. It was difficult to keep track and monitor care needs of the residents when they are able to use any pharmacy they choose and go to appointments independently. Currently the home health agencies that come into the facility to provide services was tracked by signing a visitor/agency log at the receptionist desk. The home health staff person signs in the log with their name, the date, and the name of the resident they are providing services to that day. This Residential Tag relates to Complaint IN00415672.			
R 9999 Bldg. 00	Based on interview and record review, the facility failed to report a resident's elopement from the facility and an allegation of physical abuse to the IDOH (Indiana Department of Health) for 2 of 4 residents reviewed for abuse. (Residents B and N) Findings include: 1. a) The clinical record for Resident B was reviewed on 7/28/23 at 11:30 a.m. His diagnoses included, but were not limited to: Alzheimer's dementia, depression, Vitamin D deficiency, psychosis, and traumatic brain injury. The 8/1/23, 6:19 p.m. note, written by LPN (Licensed Practical Nurse) 13, read, "Client was escorted to clients room, client stated he will be there for the night."	R 9999	Plan of Correction 09/22/23 Facility ID: 013347 Survey Event ID: RRGE11 9999 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. Resident B has been discharged from the community. Incidents have been reported to IDOH. **2. How the facility will identify other residents having the potential to be affected by**	11/01/2023

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	The 8/1/23, 7:12 p.m. note, written by LPN 13, read, "Reporting WANDERING. Late entry from 08/01/2023 @ 5 p.m. Client was brought into nursing station by a woman, Woman stated that client was at her home knocking on her door stating he lived there, client and woman escorted to DON office, DON was made aware of situation." On 8/30/23 at 12:30 p.m., the BOM (Business Office Manager) provided a list of employees who worked the evening shift 8/1/23. The list included LPN 13 who worked until 7:35 p.m.; QMA 12 who worked until 6:00 p.m.; CNA 4 who worked from 5:00 p.m. until 12:00 a.m., and the DON who worked until 6:00 p.m. LPN 13 no longer worked at the facility and was unavailable for interview. An interview was conducted with the DON on 8/29/23 at 11:24 a.m. She indicated on 8/1/23 she received a phone call from LPN 13 that the woman whose house Resident B was at on 7/28/23, stopped by the facility to check on him, not that the woman brought him back that day. Neither Resident B, nor a woman were brought into her office the evening shift of 8/1/23. She stated, "I see how the note reads, and I don't know why, but that didn't happen." An interview was conducted with QMA 12 on 8/30/23 at 3:15 p.m. She indicated she worked the evening of 8/1/23 when Resident B "pretty much eloped again." The woman who brought Resident B into the nursing station was screaming, hollering, looking hysterical, and saying, "This is the 5th or 6th time he came to my house." QMA 12 directed the woman to the DON. At the time, QMA 12 did not know about the hourly checks		**the same deficient practice and what corrective will be taken** a.All residents had the potential to be affected. No other residents were identified to be affected. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. All staff in-service on Abuse and Elopement policy and reporting b. Inservice to include how to contact the Ombudsman as a resource to discharge residents where alternative placement is difficult **4. 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:** a. RDCS, DON or Designee will review nursing notes and incident reports to ensure proper protocols have been followed for any elopement incidents, abuse allegations. Review will be conducted weekly for 12 weeks, then bi weekly for 12 weeks them monthly for 3 months. **5. By what date will the systematic changes be completed** a. Compliance by: 11/1/23	

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	implemented from his 7/28/23 elopement or that he eloped on 7/28/23. She also worked on 7/29/23 and no one told her about Resident B's 7/28/23 elopement or hourly checks then either. If any staff member signed off on hourly checks, it would be CNAs (Certified Nursing Assistants.) An interview was conducted with CNA 4 on 8/30/23 at 2:01 p.m. She indicated Resident B was brought back into the facility by a woman. Around 5:00 p.m., she was coming down the stairs into the lobby and heard a lady approaching the facility outside, asking if Resident B lived there and saying it was ridiculous. He scared her kids, and she threatened to call the state, because she was a nurse. QMA 12 took Resident B and the woman into the DON's office. CNA 4 didn't know what happened from there. CNA 4 heard Resident B left the facility again the next day. The ED provided the April, 2023 to present incident reports on 8/28/23 at 11:00 a.m. There were 2 elopement reports for Resident B. One was from 7/28/23, and the other was from 8/2/23. There was no elopement incident report regarding his 8/1/23 elopement. An interview was conducted with the ED on 8/28/23 at 2:45 p.m. He indicated he was unaware of Resident B's 8/1/23 elopement from the facility, but would look into it. An interview was conducted with the ED on 8/29/23 at 9:25 a.m. He indicated the 8/1/23 incident where the woman brought Resident B back into the facility "must have been an oversight." He reported what he was aware of, which were the 7/28/23 and 8/2/23 elopements, not his 8/1/23 elopement.			

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	b) The clinical record for Resident N was reviewed on 8/30/23 at 2:34 p.m. His diagnoses included, but were not limited to, schizophrenia and glaucoma. The clinical record for Resident B was reviewed on 7/28/23 at 11:30 a.m. His diagnoses included, but were not limited to: Alzheimer's dementia, depression, Vitamin D deficiency, psychosis, and traumatic brain injury. Resident B's service plan, updated 7/29/23, indicated he needed monitoring related to history of mood disturbance. He shadow boxed in the corridor and hall. Resident N's 4/9/23, 5:18 a.m. note read, "The resident called the police due to being hit in the eye face and body by another resident the can [sic] notified the QMA [Qualified Medication Aide] at 10 pm. the resident stated he didn't want To go to the hospital, he stated he just want [sic] to report the incident to the police the Don [Director of Nursing] notified by the QMA as well of the incident." An interview was conducted with CNA 4 on 8/30/23 at 2:01 p.m. She indicated Resident B had been fighting other residents in the facility, including Resident N a few months ago. It was right by the fireplace in the front lobby area. CNA 4 witnessed it along with 2 residents. Resident N was talking to CNA 4. CNA 4 sat down in a chair near the fireplace. Resident B was standing nearby, when Resident B came over started fighting Resident N "out of nowhere." Resident N was still sitting in a chair while getting punched "maybe 5 fast punches all to the head." When Resident N tried to get up from the chair, he stumbled. CNA 4 caught him. Resident N "was			

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	slobbering , out of it." Resident N "hasn't been right ever since." To CNA 4, it seemed like Resident N didn't really "remember as much, like not really right." Resident N did not go to hospital afterwards, but he did call the police. The police said they couldn't do anything, because "it was on the facility to get him help." CNA 4 assisted in taking the police upstairs. CNA 4 told the DON (Director of Nursing) about Resident B hitting Resident N in the head. Resident B was sent out to a psychiatric hospital after the incident. He'd been out to a psychiatric hospital before, but always came back. Other residents were scared of him and staff were scared of him too. "Someone could get hurt in there." Resident B let it be known that "he boxes, shadow boxes, walks up on women. I don't know what's going on." He slammed QMA 12's hand in a door. Resident B was currently receiving one on one staff supervision, but it agitated and upset him. Staff were being told to stop reporting and documenting things, because it made it harder for him to be placed elsewhere. CNA 4 stated, "Everyone is in fear there over this one resident. He's very, very dangerous." An interview was conducted with the ED (Executive Director) on 8/30/23 at 2:49 p.m. He indicated there was no incident report or investigation into the 4/9/23 abuse altercation between Resident B and Resident N, as the facility had a different ED at the time. The Abuse, Neglect, and Financial Exploitation Prevention policy was provided by the DON on 8/28/23 at 11:55 a.m. It read, "REPORTING It is mandatory for staff members to report suspected incidents of abuse, neglect, and financial exploitation. Staff members are required to immediately report suspect behaviors to their			

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	Department Manager. Documentation will be initiated by the Department Manager at the time of the initial report. The Department Manager will immediately inform the Administrator." This Residential Tag relates to Complaint IN00415188			