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	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00349526 Complaint IN00349526 - Substantiated. State Residential Findings related to the allegation are cited at R0044 and R0357. Survey date: March 24 and 25, 2021. Facility number: 004903 Residential Census: 40 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 1, 2021.	R 0000		
R 0044 Bldg. 00	410 IAC 16.2-5-1.2(r)(1-5) Residents' Right - Deficiency (r) The transfer and discharge rights of residents of a facility are as follows: (1) As used in this section, " interfacility transfer and discharge " means the movement of a resident to a bed outside of the licensed facility. (2) As used in this section, " intrafacility transfer " means the movement of a resident to a bed within the same licensed facility. (3) When a transfer or discharge of a resident is proposed, whether intrafacility or interfacility, provision for continuity of care shall be provided by the facility. (4) Health facilities must permit each resident to remain in the facility and not transfer or discharge the resident from the facility			

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

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	unless: (A) the transfer or discharge is necessary for the resident ' s welfare and the resident ' s needs cannot be met in the facility; (B) the transfer or discharge is appropriate because the resident ' s health has improved sufficiently so that the resident no longer needs the services provided by the facility; (C) the safety of individuals in the facility is endangered; (D) the health of individuals in the facility would otherwise be endangered; (E) the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; or (F) the facility ceases to operate. (5) When the facility proposes to transfer or discharge a resident under any of the circumstances specified in subdivision (4)(A), (4)(B), (4)(C), (4)(D), or (4)(E), the resident ' s clinical records must be documented. The documentation must be made by the following: (A) The resident ' s physician when transfer or discharge is necessary under subdivision (4)(A) or (4)(B). (B) Any physician when transfer or discharge is necessary under subdivision (4)(D). Based on interview and record review, the facility failed to follow the policy for continuity of care for discharge of residents for 2 of 4 residents reviewed for discharge. Resident's physicians were not notified of the resident's discharges and a resident's physician was not notified of the resident's increase in behaviors. (Resident B, Resident C) Findings include:	R 0044	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition,	04/30/2021

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	On 3/24/21 at 9:45 a.m., the Community Services Manager provided a list of transferred and discharged residents from the facility. The Community Services Manager indicated the list was complete. The list indicated Resident B was discharged from the facility on 9/26/20. 1. The clinical record for Resident B was reviewed on 3/24/21 at 11:07 a.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), CHF (congestive heart failure), and BPH (benign prostatic hypertrophy). A nurse's note, dated 9/26/20, no time listed, indicated, "Pt (Patient) family arrival (sic) to facility this a.m. for assistance in moving from facility. Pt and family cleared from covid screening. Medications including eye drops, inhalers, neb (nebulizer) txs (treatments), laxatives given to family with print out of MD orders for medication instructions. Pt items removed from facility and pt departed with family in private vehicle." A nurse's note, dated 9/18 21 at 4:25 p.m., indicated "[Name of Home Health Care] nurse here to assess pt (patient). Per HHC (home health care) no increased redness noted to right lower leg. Continue compression stockings during waking hours." During an interview on 3/24/21 at 1:15 p.m., Confidential Interview 1 indicated the resident was discharged from the facility. Confidential Interview 1 indicated the Resident B received services from the Veteran's Administration (VA) agency but the facility had been "pushing him" to take the same services at the facility that were free through the VA.		preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 4/30/2021. The facility will ensure this requirement is met through the following corrective measures: 1.Resident B & C had no longer reside in the community. 2.An audit was conducted to determine appropriate physician notification of current residents with increased behaviors by CSM on 04/14/2021 Any resident identified had their record reviewed to ensure the physician notification was documented. A review of the last 5 discharges were reviewed for physician notification on 04/14/21 by CSM. Any resident identified had their record reviewed to ensure documentation was present for physician notification of discharge. Findings of audits were reviewed with Executive Director. (Attachment #1 and #2) 3.Current nursing staff will be In-serviced on physician	

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	The facility lacked documentation the resident's physician was notified of the discharge, participated in the discharge or a discharge order was received. The facility lacked documentation the home health care agency had been notified of the the resident's discharge for continuity of care 2. On 3/24/21 at 9:45 a.m., the Community Services Manager provided a list of transferred and discharged residents from the facility. The list was accurate and complete. The list indicated Resident C was discharged from the facility on 2/13/21. The clinical record for Resident C was reviewed on 3/24/21 at 12:05 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, and hypertension. A nurse's note, dated 1/9/21 at 3:50 p.m., indicated "Patient has been wandering down the hallway throughout the day and she has been re-directed to her apartment multiple times every hour. While this nurse was in a COVID positive patient's room, she informed me this patient came into her room without a mask on, was looking through her belongings and sat down on her bed without protection, The CSM (Director of Nursing) notified as patient continues to wander and she may be infecting the entire community with COVID. CSM told this nurse to put her (Resident C) on precautions and monitor her for symptoms. Observed patient for approximately 20 minutes and she came out of her apartment 4 times and this nurse educated her every time that she has to stay in her apartment right now as we have COVID cases in the building and we need to make sure she is protected & safe. Called and spoke with daughter-in-law [Name of Daughter-in-Law]. Family notified and spoke with [Name of		notification policies on 04/14/21 by Regional Director of Care Services (Attachment #3) 4.The Executive Director is responsible for sustained compliance. The CSM and/or designee will review discharged resident records for documentation of physician notification. Audits will be completed 5x/week for 4 weeks, then 3x/week for 4 weeks, then weekly for 4 weeks. Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing The Executive Director is responsible for sustained compliance. The CSM and/or designee will review the resident record for residents who display increased behaviors for documentation of physician notification. Audits will be completed 5x/week for 4 weeks, then 3x/week for 4 weeks, then weekly for 4 weeks. Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. 1.April 30th, 2021	

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	Daughter-In-Law] who voiced they (Resident C's family) had called [Name of Person] at [Name of another Facility] already to try to get resident in because of her behaviors lately but they haven't heard back yet. Approximately 5 minutes later, CNA came to this nurse and informed her that this patient and another patient were in the hallway outside of another patient's apartment on the other side of the community. CSM informed this nurse that family either needs to take patient home for duration of quarantine or she would need to be sent to the ER (Emergency Room) as we cannot manage her care at this time. Called and spoke with son, [Name of Son] about CSM's request r/t (related to) mom's behaviors and the risk she is putting other patients in. [Name of Son] became emotional and voiced he didn't want his mother sent to the ER that he would have her come to the house. This nurse overheard family arguing with each other in the backround (sic) about what they were going to do, informed family to discuss it amongst themselves and let me know what they decide. [Name of Son] returned call and voiced they were coming to get patient and take her to their home as they called and spoke with her doctor and he told them nothing will get handled over the weekend at the ER. Family here to take patient home at 4:35 p.m. Educated family on patient's medication regimen. Informed [Name of Son] I was ordering additional medication from [Name of Pharmacy] that they can pick up tomorrow morning. 50 Ativan tablets signed over to [Name of Son] upon discharge, see controlled drug receipt for signature." A nurse's note, dated 1/7/21, no time listed, indicated, "Resident exit seeking on third shift, going to multiple doors trying to get outside. Resident redirected multiple times from the doors. Resident redirected to wear mask. Resident			

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	refused. PRN (As needed) Ativan (a benzodiazepine) given this a.m. due to increased anxiety. Resident angry this morning at staff that won't let her out the door. Will continue to monitor" A nurse's note, dated 1/6/21 at 10:30 a.m., indicated, "Resident given many reminder(s) to stay in her room and wear her mask. Resident angry at this nurse and states she doesn't want to be here. And to get out of her room. Resident continues to leave her room without a mask. Will continue to monitor. " A nurse's note, dated 1/4/21 at 5:20 p.m., indicated, "Resident observed pouring her food in the sink, evening meal, washing it with water, scooping it up with med (medication) cup, and eating it. Resident washing her telephone and cable box in her sink with her food and rinsing it off with water and eating the food, When this nurse stopped her from washing food and scooping it up and eating it, resident started to wash phone and such with food. Will continue to monitor." A nurse's note, dated 1/4/21 at 3:15 p.m., indicated, "Resident given many reminders today to wear her mask and stay in her room. Resident education (sic) on reason why and when. Resident unable to remember. Will continue to monitor." A nurse's note, dated 12/30/20, no time listed, indicated, "Resident some better today. Upset that she had to stay in room. Resident packing and unpacking her room today. Will continue to monitor." A nurse's note, dated 12/29/20 at 2:10 p.m.,			

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	indicated, "Resident upset and angry at staff, throwing away her Christmas. States she doesn't want to be here. States that "this isn't my choice." PRN Ativan given. Will continue to monitor." A nurse's note, dated 12/14/20 at 11:20 a.m., indicated, "[Name of Resident's Physician] office called again requesting d/c (discontinue) of Namenda (a cognition enhancing medication) and Aricept (a cognition enhancing medication). Per office requested opened back up and we will get an answer today." A nurse's note, dated 12/8/20 at 12:10 p.m., indicated, "PCP (Primary Care Physician) called and requested response from fax sent 12/1 regarding Namenda and Aricept. Message left with nurse. Awaiting call back." A nurse's note, dated 12/1/20 at 3:50 p.m., indicated [Name of Physician] updated that holding Aricept and Namenda has greatly improved mood. No agitation noted, in the dining room playing bingo at this time." An "Assessment and Negotiated Service Plan Summary" dated 10/14/20, review type for 90 days, indicated, "Resident AOL (alert and oriented) x (times) 3 (person, place, and time). Pleasant and cooperative. Likes to do things with group as much as possible. Will need reoriented frequently..." During an interview on 3/24/21 at 9:29 a.m., Confidential Interview 2 indicated the facility had refused to allow Resident B's family into the facility or allow the family to hire a sitter for the resident. The family was notified to either take the resident to their home or take the resident to the emergency room as the facility was not able to			

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	provide care to the resident. The clinical record lacked documentation the facility had notified the resident's physician of the resident's discharge or the resident's worsening behaviors prior to discharge. During an interview on 3/24/21 at 2:33 p.m., the Director of Nursing (DON) indicated the resident's behaviors had became worse. The resident had received Namenda and Aricept at one time but the medications had to be stopped as her dementia worsened when she took them. She indicated the resident received prn Ativan which helped. The previous DON had instructed the staff they did not need to notify the resident's physician or obtain an order when the resident was discharged or sent to the emergency room. During an interview on 3/25/21 at 8:40 a.m., the Community Services Manager indicated Resident C's behaviors had worsened. During an interview on 3/25/21 at 12:17 p.m. LPN 1 indicated when a resident was to be discharged, the facility should notify the family, the resident's physician, and fill out the necessary paperwork. LPN 1 indicated she was on duty at the time of Resident C's discharge, but could not remember much of what occurred. The facility lacked documentation of a policy for the notification of the physician upon discharge or with worsening behaviors. This State Residential tag relates to Complaint IN00349526.			
R 0357	410 IAC 16.2-5-8.1(j)(1-3) Clinical Records - Noncompliance			

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Bldg. 00	(j) If a death occurs, information concerning the resident ' s death shall include the following: (1) Notification of the physician, family, responsible person, and legal representative. (2) The disposition of the body, personal possessions, and medications. (3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death. Based on record review and interview, the facility failed to document a resident's death for 1 of 1 residents reviewed for death. The facility did not notify the resident's physician, did not obtain a physician's order for the disposition of the body, personal property, or medications, and did not record the resident's condition prior to the death or the time of the resident's death. (Resident E) Findings include: On 3/24/21 at 9:45 a.m., the Community Services Manager provided a list of admissions, transfers, and discharges from the facility. The Community Services Manager indicated the list was complete. The list indicated Resident E had expired on 1/17/21. The clinical record for Resident E was reviewed on 3/25/21 at 10:39 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, diabetes mellitus type 2, and malignant neoplasm of the prostate. An "Assessment and Negotiated Service Plan Summary" dated 12/14/20, indicated the resident received hospice services. A nurse's note, dated 1/14/21 at 6:40 p.m.,	R 0357	1.Resident E had no longer resides in the community. 2.An audit was conducted of residents who have expired at the community in the past 90 days by CSM on 04/14/2021 to ensure documentation in residents records reflected physician notification, an order for disposition of the body, personal property, o medications, and resident condition prior to the death or at the time of the residents death. Results of audit reviewed with the Executive Director. (Attachment #4) 3.Current nursing staff will be In-serviced regarding proper notification and documentation to physician, coroner and responsible party relating to resident death and also regarding order for disposition of body; notation of residents condition and recent vital signs and symptoms preceding residents death on 04/14/2021 by Regional Director of Care Services. (Attachment #5) 4.The Executive Director is responsible for sustained	04/30/2021

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	indicated "Pt (Patient) has rested comfortable w/ (with) use of PRN (as needed) Roxinol (sic) (a liquid narcotic) and Ativan (a benzodiazepine). Hospice staff here multiple times throughout day. B/P (blood pressure) 111/63 P (pulse) 46 R (respirations) 8 T (temperature) 97.8. Turned and repositioned at RTN (routine) intervals. Has skin break down to bilateral outer hips. F/C (Foley catheter) patent to straight drainage w/ (with) rust colored urine draining d/t (due to) blood. Mouth care completed. Hospice updated, daughter on status". A "Hospice IDG (Interdisciplinary Group) Comprehensive Assessment and Plan of Care Update Report" dated 1/16/21 at 3:02 a.m., indicated the resident had a "death at home" on 1/15/21 at 4:45 a.m. The clinical record lacked documentation the resident's physician, the coroner, or responsible party was notified, a physician's order for the disposition of the body, the resident's personal possessions, and medications, or a notation of the resident's condition and most recent vital signs and symptoms preceding the resident's death. During an interview on 3/25/21 at 10:05 a.m., the hospice office manager indicated the resident notified hospice on 1/15/21 at 3:55 a.m., and informed the hospice RN the resident had expired. The hospice RN arrived at the facility at 4:40 a.m., and verified the resident's death with the facility staff. The hospice office manager indicated it was the facility's responsibility to notify the physician and coroner, obtain an order to release the resident's body and for disposition of the resident's medications, and document the death in the facility clinical record. The family should be notified if they are not present.		compliance. The CSM and/or designee will review deceased resident records to determine physician notification and appropriate documentation. Audits will be completed 5x/week for 4 weeks, then 3x/week for 4 weeks, then weekly for 4 weeks. Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5.April 30th, 2021	

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	During an interview on 3/25/21 at 12:25 p.m., Agency LPN 2 indicated when a resident expired, the facility should notify the physician to obtain an order to release the resident's body and for the disposition of medications. The coroner should be notified and if the family was not present they should be notified. The resident's body should be prepared prior to notifying the funeral home. The death and orders should be documented in the resident's clinical record as well as the resident's condition prior to the death. The current facility policy, "Death of a Resident" dated 9/1/16, provided by the Interim Administrator on 3/25/21 at 11:19 a.m., included, but was not limited to, "Upon death, if a resident is still in the community, the facility should notify the responsible party and/or family member if not already in the community." The facility lacked documentation of a policy for the notification of the physician or coroner, obtaining a physician's order for the disposition of the body, personal possessions and medications upon the death of a resident, and documentation of the resident's condition and vital signs prior to the resident's death. This State Residential tag relates to Complaint IN00349526.			