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	10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GRAND BROOK MEMORY CARE OF ZIONSVILLE	11870 SANDY DRIVE ZIONSVILLE, IN 46077

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00392567. Complaint IN00392567- Substantiated. State deficiencies related to the allegations are cited at R44, R45, and R48. Survey date: October 25, and 26, 2022 Facility number: 014376 Residential Census: 33 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 10, 2022.	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 unless:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jamie Lopez	VP of Operations and HealthCare	12/07/2022

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	(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 initiated an involuntary discharge to a resident who posed no safety or health dangers to the individual or others residing which resulted in psychosocial harm for 1 of 6 residents reviewed for discharge (Resident B). Findings include: During an interview of 10/26/22 at 10:21 a.m., the area Ombudsman indicated she had been contacted on behalf of Resident B with concerns the resident had been discharged from the facility	R 0044	R 044 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Staff education was provided to current management regarding discharge process and regulatory guidelines for emergency discharge. How other residents having the potential to be affected by the	10/28/2022

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	without a 30 day notice. The Ombudsman interviewed the DHC (Director of Healthcare) and was told she and her prior ED (Executive Director) had been given instructions by the corporation to immediately discharge Resident B with a 3 day notice after reports of an alleged sexual assault of a minor visitor on 9/17/22. The Ombudsman indicated she was told on 9/21/22 the resident was sent to a local hospital and the corporate office indicated they would not be letting the resident return. When questioned the DHC indicated she was not familiar with the regulations of discharge including the need to give residents a 30 day notice, involuntary discharge notice, or that a discharge form. When questioned the DHC indicated Resident B was not assessed or checked after the alleged incident to include labs or some type of assessment to rule out an organic cause for the incident. The Ombudsman indicated the facility should have given the resident or responsible party a 30 day notice and choice to appeal the discharge, or if it was an emergent situation should have given an involuntary notice and procured an alternate placement that met the resident's needs. The resident was sent to the ER where she had to sit for several hours, only to be told she did not meet requirements for psychiatric services which was traumatizing and confusing to the resident. Resident B was subsequently placed in a facility farther away from the spouse, the change of environment was significant for the resident with transfer trauma, and during bad weather the spouse would not be able to visit as often which would cause significant distress for the resident. LGBT support was significant to the resident's wellbeing, and she may not have this support as needed in her new facility. Ombudsman indicated, Resident B had once held a prominent position and was well connected in her community among her peers and this situation		same deficient practice will be identified and what corrective actions will be taken: All residents had the potential to be affected by this alleged deficient practice. No residents have been identified as having been issued an emergency discharge notice after review of the past 12 months of discharged residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: When a resident is identified as meeting discharge criteria, the Executive Director, Director of Healthcare, and at least one member of corporate management (Director of Operations, Director of Healthcare, Vice President of Operation, or the President) must be contacted. The criteria will be reviewed and a determination made if the criteria is appropriate for emergency discharge. If emergency discharge criteria is met corporate will approve the emergency discharge. The meeting will be documented and will include identified criteria as well as participants in the meeting. How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place: All discharges	

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	would have "mortified" her if she understood what was going on. Resident B's record was reviewed on 10/25/22 at 1:30 p.m. Diagnoses on Resident B's profile included, but were not limited to, Alzheimer's Disease, hypertension, arthritis, and history of a TIA (transient ischemic attack or stroke). An observation note, dated 10/26/22 at 9:17 p.m., indicated Resident B "continues to bring resident into her room, another resident was found in her bed with no pants on. QMA [Qualified Medication Aide] was notified and resident was removed from room." An observation note, dated 10/26/22 at 10:46 p.m., indicated, "staff call writer over to the lake side. CNA [Certified Nursing Assistant] stated when she was doing rounds she noticed [an unidentified resident] was not in her room. When entering Resident B's room both residents were laying on the bed. The DHC was notified, will continue to monitor." The resident record lacked documentation 10/27/21 - 9/20/22, Resident B exhibited any behaviors, or that family or the physician had been notified and interventions put into place following incident documented on 10/26/21. An Observation note, dated 9/21/22 at 4:20 p.m., the DHC (Director of Healthcare) documented, resident was transferred to the Emergency Department (ED) by the POA (Power of Attorney) for evaluation. Resident was accused of sexual behavior toward a visitor on 9/17/22. The Executive Director (ED) was made aware of the situation on 9/19/22. The authorities were notified and were investigating. The NP (Nurse		emergent or non-emergent will be reviewed at the facilities operations meetings held the third week of the month. The Executive Director, Director of Healthcare, and Director of Sales participate in this meeting along with corporate members including Corporate sales and marketing, VP of Operations, Director of Operations, Director of HR, and Director of asset preservation. Additionally every other week the director of sales will meet with the corporate sales and marketing managers to review discharges including pending discharges. By what date the systemic changes will be completed: 10/28/22	

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	Practitioner) assessed the resident on 9/21/22 and gave orders for Resident B to be removed from facility for safety of others. A Service Plan for Resident B, dated 8/1/22, the DHC indicated was the most recent indicated the resident had no behaviors, and the resident was pleasant and concerned for the residents in the community. A History and Physical for Resident B by NP (Nurse Practitioner) 12, dated 1/14/22, indicated the resident was cooperative and easily redirected. Patient was up ad lib with steady gait. Since last visit, per staff, resident had decreased sexual desires. DHC indicated she had spoken to the current NP and was told the resident had no recent documentation of inappropriate acting out related to sexual desires that must have been in her history. Therefore, the diagnosis of excessive sexual drive was not added to her current diagnoses list or added to her service plan as a concern. A History and Physical for Resident B by NP 12, dated 9/21/22 at 1:30 p.m., indicated the reason for visit was for excessive sexual drive. The resident was under emotional stress related to recent incident. Resident had short term memory loss, inability to learn or remember new information, forgetting names or everyday words, and difficulty communicating. No irritability or agitation, but had symptoms of depression, paranoia, and anxiety. Sexual dysfunction reported by resident. Excessive sexual drive ongoing, associated symptoms included anxiety, depression, and hypersexuality. "Patient presents today for acute visit regarding excess sexual drive. Patient had remained stable and without any outbursts since increase in Lexapro			

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	(antidepressant) in 11/2021. Facility reported recent incident in which patient sexually assaulted minor on 9/17/22. It was reported to facility on 9/19/22 in which emergency 3 day eviction was ordered. Today, patient is off. She is not her usual engaged self ...Given recent event, I would like patient to go obtain psych evaluation, called report to [local hospital emergency room], wife driving patient. Patient to be 1:1 until psych evaluation and safety established. Police notified of situation ...awaiting placement at [hospital based psychiatric unit] ..." During an interview on 10/25/22 at 10:42 a.m., QMA (Qualified Medication Aide) 7 indicated she worked with residents on both units of the facility. There were no longer residents that had to be monitored for behaviors, the residents were generally calm and did their own thing. During an interview on 10/25/22 at 10:44 a.m., QMA 8 indicated she had worked in the facility for 3 years and floated to both units. There were no residents at this time that needed monitored for combative or sexual behaviors. During an interview on 10/26/22 at 9:49 a.m., the DHC indicated the MD did not write an order to discharge the resident. When it was an emergent situation, an order was not required. During the resident's stay she had no history of behaviors, and she never gave the staff cause for concern. After being issued the 3 day noticed the goal was to assist the family in getting Resident B placement elsewhere. It was not that another facility could do something for the resident that this facility could not do, it was a reaction to what had happened with a visitor and the potential when having children visit the facility in the future.			

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	On 10/26/22 at 1:57 a.m., the ADHC (Assistant Director of Healthcare) indicated Resident B did not have behaviors. The other residents took a liking to her from the time of her admission as she would hold the newspaper and attempt to read the New York times to them, was involved in activities with them, she was like the head of their group, and they would all hang out at the front. At no time before her discharge were the residents or staff afraid of Resident B or felt threatened by her. On 10/26/22 at 2:10 p.m., the Director of Community Relations indicated, during her stay Resident B was not hard to care for, she was "pretty much" independent with ADL's, and had no real issues. The decision to give Resident B a 3 day notice was made by the Director of Operations/Clinical and the ED related to safety of visitors. Resident B was not considered a risk to herself, staff, or to another residents, but his understanding was the determination had been made on the potential of what might happen in the future during a child visit. During an interview on 10/26/22 at 2:16 p.m., the Director of Operations/Clinical indicated, once the allegation was made against Resident B and the ED investigation completed, they could not come to a 100% conclusion based on the video surveillance footage and reports. But with the mother's report they weighed the risk of reoccurrence and possible endangerment of another guest or resident and did not feel it was safe to keep Resident B in the facility. They were not able to do one on one (1:1) supervision and from what they could conclude felt like a potential risk was there. A 3 day notice was issued as it was an extended amount of time if given a 30 day notice to leave the resident in the facility with the			

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	risk of possible endangerment to others. With holidays coming up and influx of visitors and children expected, the company felt they could not take the risk. On 10/26/22 at 2:27 p.m., QMA 14 indicated Resident B never portrayed herself as being a risk to herself or others. She was nice, soft spoke, had no behaviors and no anger. On 10/26/22 at 2:40 p.m., RN (Registered Nurse) 15 indicated Resident B did not display behaviors, and at no time did the staff or residents feel like she was a threat to them. The residents were sad and missed Resident B as she was kind of like their ringleader. She was a kind lady, and she was sorely missed. On 10/25/22 at 3:14 p.m., the DHC provided the Resident Agreement, dated 2/2018, and indicated this agreement was the current one being used by the facility for guidance on admissions, discharges, and transfers. The Resident Agreement indicated the facility may terminate this agreement at any time during the resident's stay by giving the responsible party the minimum number of days written notice as allowed by state law, if the resident engaged in behavior which threatened the residents' or other residents' or staff's mental and/or physical health or safety. Indiana State Department of Health Long Term Care Division RESIDENTIAL REGULATIONS 410 IAC 16.25, dated 2008, indicated, "...the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged...(8) Notice may be made as soon as practicable before transfer or discharge when: (A) the safety of individuals in the facility would be			

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	endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is required by the resident's urgent medical needs; or (E) a resident has not resided in the facility for thirty (30) days...." Cross reference R45 and R48. This State Residential Finding relates to Complaint IN00392567.			
R 0045 Bldg. 00	410 IAC 16.2-5-1.2(r)(6-9) Residents' Rights - Deficiency (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with			

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	placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when: (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or (E) a resident has not resided in the facility for thirty (30) days. (9) For health facilities, the written notice specified in subdivision (7) must include the following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or discharged. (D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state			

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	department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " . (E) The name of the director and the address, telephone number, and hours of operation of the division. (F) A hearing request form prescribed by the department. (G) The name, address, and telephone number of the state and local long term care ombudsman. (H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission.			
	Based on interview and record review, the facility initiated an involuntary discharge without reasonable and appropriate notice or opportunity to appeal the process to a resident who had no documented safety or health dangers to the individual or other residents residing in the facility resulting in psychosocial harm for 1 of 6 residents reviewed for discharge (Resident B). Findings include: On 10/25/22 at 2:42 p.m., the DHC (Director of Healthcare) indicated there was no copy of the 3	R 0045	R 045 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Staff education was provided to management regarding discharge process and regulatory guidelines for discharge notices. How other residents having the potential to be affected by the same deficient practice will be	10/28/2022

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	day notice issued to Resident B on 9/20/22 readily available in the facility. She was awaiting a call from the owners. On 10/25/22 at 3:21 p.m., the DHC provided a letter, dated 9/20/22, she indicated it was a copy of the 3 day notice of discharge provided by the corporate office. The typed letter lacked a signature and had only a prompt in parenthesizes to add recipient's information. The letter indicated Resident B's care exceeded the level of supervision than what the facility was equipped to provide. Due to the nature of the incident that occurred on 9/17/22 and the possible endangerment of resident and visitor safety they were issuing this discharge notice. The effective date of this discharge was 9/23/22. During an interview on 10/25/22 at 11:44 a.m., the DHC indicated to her knowledge Resident B was the only resident to have been given an involuntary discharge this year. The facility was required to give residents a 30 days' notice unless it was an emergency which she described as being a danger to self or others. To her knowledge Resident B had not been a danger to the other residents or staff but could have been possibly to the frequent child visitors. The ED and DHC had not known what to do with the allegation against the resident, so they contacted the owners and followed their direction to issue a 3 day discharge notice. Observation notes, dated 10/26/21, indicated another female resident had been found in Resident B's bed, but the note did not indicate anything sexual had happened or that Resident B had invited her. The residents were thought to have been comforting each other. Resident B had her room decorated beautifully and had a lot of artwork she liked to show off so she frequently would ask residents and staff to go into her room.		identified and what corrective actions will be taken: All residents had the potential to be affected by this alleged deficient practice. No residents have been identified as having been issued a discharge notice after review of the past 12 months of discharged residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: When a resident is identified as meeting discharge criteria, the Executive Director, Director of Healthcare, and at least one member of corporate management (Director of Operations, Director of Healthcare, Vice President of Operation, or the President) must be contacted. The criteria will be reviewed and a determination made if the criteria is appropriate for discharge. If the discharge criteria is met corporate will approve the discharge. The discharge notice will be reviewed and approved by a member of corporate prior to issuing the notice. Corporate and the Executive Director will identify names of who will be receiving the notice to ensure all parties required by 410 IAC 16.2-5-1.2(r)(6-9). The Executive director will send confirmation to corporate of the notice sent within 24 hours of issuing.	

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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
	Just because she had women in her room did not mean there had been anything unusual happening. The follow up to that incident was to keep other residents out of her room. Cross reference R44 and R48. This State Residential Finding relates to Complaint IN00392567.		How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place: All discharges emergent or non-emergent will be reviewed at the facilities operations meetings held the third week of the month. The Executive Director, Director of Healthcare, and Director of Sales participate in this meeting along with corporate members including Corporate sales and marketing, VP of Operations, Director of Operations, Director of HR, and Director of asset preservation. Accounts Receivable will also monitor all final billing to ensure proper notices have been submitted into the electronic system. If any discharge is noted to not have a proper notice, AR will notify VP of Operations. By what date the systemic changes will be completed: 10/28/22	
R 0048 Bldg. 00	410 IAC 16.2-5-1.2(r)(18-24) Residents' Rights - Deficiency (18) Prior to any interfacility or involuntary intrafacility relocation, the facility shall prepare a relocation plan to prepare the resident for relocation and to provide continuity of care. In nonemergency relocations, the planning process shall			

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		A. BUILDING 00 B. WING	10/26/2022

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	include a relocation planning conference to which the resident, his or her legal representative, family members, and physician shall be invited. The planning conference may be waived by the resident. (19) At the planning conference the resident ' s medical, psychosocial, and social needs with respect to the relocation shall be considered and a plan devised to meet these needs. (20) The facility shall provide reasonable assistance to the resident to carry out the relocation plan. (21) The facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. (22) If the relocation plan is disputed, a meeting shall be held prior to the relocation with the administrator or his or her designee, the resident, and the resident ' s legal representative. An interested family member, if known, shall be invited. The purpose of the meeting shall be to discuss possible alternatives to the proposed relocation plan. (23) A written report of the content of the discussion at the meeting and the results of the meeting shall be reviewed by: (A) the administrator or his or her designee; (B) the resident; (C) the resident ' s legal representative; and (D) an interested family member, if known; each of whom may make written comments on the report. (24) The written report of the meeting shall be included in the resident ' s permanent record.			
	Based on interview and record review, the facility initiated an involuntary discharge without documentation of a plan for discharge, a care plan conference with family, or alternate placement	R 0048	R 048 What corrective action(s) will be accomplished for those residents found to have been affected by the	10/28/2022

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	procured before discharge for a resident who had no documentaion of safety or health dangers to the individual or other residents residing in the facility resulting in psychosocial harm for 1 of 6 residents reviewed for discharge (Resident B). Findings include: During an interview on 10/25/22 at 12:16 p.m., the DHC (Director of Healthcare) indicated on 9/21/22 Resident B discharged to a local hospital ED psychiatric (pysch) unit for evaluation, but they did not admit her for psych services and were unable to keep her as she was at the baseline. The resident later was discharged to another long term care facility, but she was not sure where. The resident allegedly touched a child visitor inappropriately in the facility on 9/17/22 during an event being held at the facility that included residents, staff, and visitors. The ED was made aware of the allegation the evening of 9/19/22 and had then notified the spouse, physician, and proper authorities. Resident B did not have one on one (1:1) observation before being discharged per the NP order but was monitored closely until she left. To her knowledge Resident B did not display sexual behavior or any other behaviors to indicate she would be a risk to anyone. The owners of the company made the decision to issue a 3 day notice on 9/21/22 and the resident was discharged that day. DHC indicated to her knowledge Resident B had no diagnosis related to inappropriate sexual behavior. On 10/26/22 at 11:30 a.m., Resident B's spouse indicated the facility had never notified her in the past of Resident B having any behaviors. On the evening of 9/19/22 she was called by the DHC and told she needed to go to the facility immediately and speak with the police regarding a complaint of		deficient practice: Education was provided to management regarding required documentation and regulatory guidelines for discharge notices. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents had the potential to be affected by this alleged deficient practice. No residents have been identified as having been issued a discharge notice after review of the past 12 months of discharged residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: When a resident is identified as meeting discharge criteria, the Director of Healthcare and Executive Director will meet with the responsible party in person, via phone, via zoom, or whatever way allows for the responsible party and the ED and DHC to meet and document this care plan meeting. The Director of Sales will also meet with the responsible party to assist in providing alternative options the responsible party may want to consider. All efforts done to assist the responsible party in selecting alternative placement will be	

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	inappropriate behavior made against Resident B. She was told at that time she had 3 days to find alternative placement for the resident or per directive of the corporate office she would have to have 1:1 care to stay there. The DHC indicated she needed to move Resident B because corporate was afraid the family of the minor were going to sue them. On 10/20/22 the spouse started calling home helpers without success and was making calls trying to find alternative placement. The spouse indicated she eventually sought the services of a private contractor to help her find a new facility for the resident. On 9/21/22 the facility called and told the spouse she needed to come take Resident B to a nearby hospital for a psych evaluation and admission into their psych unit. Unbeknownst to her, when the Resident left the facility they had yet to speak with the psych unit or make official arrangements for the resident evaluation and admission. So, when the resident and spouse arrived at the ED they were require to sit in the waiting room from 6:30 p.m. to 11:30 p.m. until finally a bed was found for the resident in the ED. The physician on call stated they would have to send someone from psych unit for intake sometime during the night and it would probably be several hours. During the wait in the ED the resident became very quiet and withdrawn as she would do during times when she didn't understand what was going on, and had been so confused during the night in the ED, they had to get her a sitter due to wandering. On the morning of 9/22/22 the ED social worker indicated the psych unit would not accept the resident as there was nothing wrong with her, and she did not understand how all this happened, stating if there had been more communication from the facility the situation would not have happened. On 9/23/22 Resident B was admitted to an alternative nursing facility, and they could not have been nicer.		documented in the electronic health record and reviewed by corporate. All discharges will be reviewed at operational meetings attended by the Executive Director, Director of Healthcare, and Director of Sales along with corporate representatives and will include review of discharge planning and documentation. How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place: All discharges emergent or non-emergent will be reviewed at the facilities operations meetings held the third week of the month. The Executive Director, Director of Healthcare, and Director of Sales participate in this meeting along with corporate members including Corporate sales and marketing, VP of Operations, Director of Operations, Director of HR, and Director of asset preservation. Additionally, the Executive Director will review and ensure the care plan meeting was completed, the documentation of the meeting was documented, and the documentation of additional placement options was documented at the time of the occurrence. By what date the systemic changes will be completed:	

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	Resident B was settling in, but taking her in first to the ED, then another place to live had a detrimental effect on her, including mental decline, loss of ADL (activities of daily living) independence, she required more cueing, and was working with therapy for balance. The resident now lived further away from friends in the community and the spouse who visited frequently, and this had impacted the resident, and it would become a bigger factor in winter during in bad weather. Spouse indicated before the incident on 9/19/22 the facility staff all loved the resident and spouse, then they swiftly threw them out. She felt Resident B had been terribly mistreated in this situation. The resident and spouse received the 3 day notice from the DHC on 9/21/22 with a discharge date of 9/23/22, which begged the question why the spouse had to remove the resident on 9/21/22. The resident record lacked documentation a physician's order was written to discharge the resident, investigation of the alleged sexual assault, a meeting with the family was held, attempts were made to find the resident alternate placement, or a plan for discharge was made. The DHC indicated upon review of documentation, the resident record lacked documentation of behaviors since admission. Cross reference R44 and R45. This State Residential Finding relates to Complaint IN00392567.		10/28/22	