STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE KOKOMO	3518 S LAFOUNTAIN ST KOKOMO, IN 46902

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00416939 and IN00418301. Complaint IN00416939 - No deficiencies related to the allegations are cited. Complaint IN00418301 - Federal/State deficiencies related to the allegations are cited at F600 and F622. Survey dates: September 28 and 29, 2023 Facility number: 000025 Provider number: 155064 AIM number: 100274850 Census bed type: SNF/NF: 48 Total: 48 Census payor type: Medicare: 5 Medicaid: 35 Other: 8 Total: 48 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on October 10, 2023.	F 0000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 0600 SS=G Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from			

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

Jeff Attinger | RVP of Operations | 10/23/2023

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

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	abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, interview and record review, the facility failed to ensure a resident was free from mental and verbal abuse and intimidation, failed to ensure a staff member intervened while a resident was being mentally and verbally abused and intimidated, and failed to provide 72-hour psychosocial follow-up for 1 of 3 residents reviewed for abuse. (Resident B) Resident B indicated while being abused by the Executive Director, she thought she was going to be hit, her personal space was invaded, she was in fear for her life, and following the incident she thought the Executive Director (ED) sent an unidentified man "hit man" into the facility to harm her in retaliation for the ED being suspended. Finding includes: On 9/28/23 at 9:45 a.m., the Business Office Manager (BOM) indicated the previous ED was no longer the ED at the facility anymore. A document, titled "Indiana State Department of Health Survey Report System," dated 9/28/23 at 12:39 p.m., indicated on 9/20/23 at 9:15 a.m., during a meeting between the previous ED and Resident	F 0600	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The resident returned to the facility the day after discharge with no adverse outcomes related to the alleged deficient practice. The administrator was terminated on 9/25/2023 II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents had the potential to be affected by this alleged deficient practice. The administrator was terminated on 9/25/2023 III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	10/20/2023

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	B, Resident B indicated the previous ED took her walker out of her hands and was rude to her. After a thorough investigation, the five-day follow-up indicated the previous ED acted in an unprofessional manner leading Resident B to believe she had to discharge from the facility. When the Interim ED spoke to Resident B, he offered her to return to the facility. During an interview, on 9/28/23 at 11:00 a.m., the Interim ED indicated he had spoken (verbal counseling) to the previous ED within the past few weeks for how she was treating the managers and staff in general. She had treated some of the managers "mean" and staff members "rudely" and "mean." She called out managers in the morning meeting instead of waiting to get them by themselves. She called out staff members in the hallways, instead of taking them into an unoccupied room. Many staff members were intimidated by her and afraid of losing their jobs if they reported her, so they would not report her to him when he came to visit the facility. He discovered the intimidation and fear of retaliation of staff members' jobs by the previous ED after he terminated her. During an interview, on 9/28/23 at 1:36 p.m., Resident B was observed sitting in her wheelchair, in her room, with her ex-husband sitting on her bed. She indicated, on 9/20/23, she was getting dressed to go home to see her dogs when the previous Executive Director "busted" in the door of her room. Breakfast had just been served onto her bedside table in front of her. She was sitting in her recliner with her bedside table across the front of her chair with her breakfast on it. She had just started eating her toast. Her ex-husband was sitting on her bed. The previous ED asked Resident B why her ex-husband was at the facility.		All staff were inserviced on abuse and reporting guidelines. IV. 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; Admin/designee will interview residents regarding abuse and abuse reporting. Interviews will be conducted on 5 residents and 5 staff a week for 4 weeks then monthly ongoing. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	The resident indicated he was at the facility because he took care of her and her animals. The previous ED indicated to the resident, he had to leave the facility. The resident indicated to the previous ED, if he had to leave, then she had to leave also, since he was her caregiver. The previous ED indicated she did not have to leave, but her ex-husband had to leave because he was not allowed to stay the night at the facility with her. Resident B indicated if he left, then she would leave also because he was her caregiver, since there was not enough staff at the facility to care for her in a timely manner. The previous ED indicated then the resident was to leave also. The previous ED "jerked" the bedside table out from in front of her and came at her like an "angry bull." She invaded her personal space with her face up close to the resident's face and her arms pulled back and her chest "puffed out" indicating she was to leave the facility now. Resident B indicated to the previous ED, she was invading her personal space and told her to step back, which she did step back out of her face. The resident indicated at that time; she was "scared to death" of the previous ED. She thought the previous ED was going to hit her when she was invading her personal space. The previous ED left the room, but five minutes later, she came back to the room with three to four nurses and boxes to pack her belongings. Resident B had already begun to pack her belongings and the previous ED asked Resident B what she was doing, and the resident indicated she was leaving as the previous ED had told her to do. The previous ED indicated to her; she never told her to leave. She admitted on 7/26/23. The Maintenance Director got her ex-husband a nice chair to sleep in, since he was with her every night providing care for her. He took care of her because there was not enough staff to care for her in a timely manner. She left			

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	with her belongings the day of the incident and went back home with her ex-husband. Resident B indicated after the previous ED was asked to leave the facility and she had returned as a resident, one evening she observed a tall African American male walking down the hallway towards her. She thought the previous ED hired this man as a "hit man" to come and "kill me" in retaliation for her being sent home. The Interim ED called and asked her to come back to the facility the next night (9/21/23) after she went home. The facility bus picked her up at her house and brought her back to the facility. She was anxious to come out of her room when the previous ED was in the facility, but after she was terminated, Resident B started going out to activities. She used to be very social when she lived at home. During an interview, on 9/28/23 at 2:00 p.m., Resident B's ex-husband indicated he stayed at the facility overnight each night from 6:00 p.m. until 10:00 a.m., the next day. His wife was incontinent, and it took the staff so long to answer her call light at times. If he did not stay and take care of her, she would "wet" on herself and he did not want that to happen. Depending on how well she was doing each day determined whether he spent the night to provide care for her or not. One of the nurses told him to park out back and gave him the code to the back door to the facility, so he could leave and come back into the facility as he pleased. He was present when the previous ED came down to the resident's room, on 9/20/23. She got right up into her face, invading her personal space and was "yelling" at her indicating he had to get out of the facility because he could not stay there. He was taken back while the "yelling" was going on and was in "shock." He did not even know what to do because he was not believing what he was witnessing.			

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	During an interview, on 9/28/23 at 2:25 p.m., Qualified Medication Aide (QMA 6) indicated the previous ED and Housekeeping delivered boxes to Resident B's room for her to pack her belongings. The day before (9/19/23) the previous ED was standing in the hallway "yelling" at CNAs 7 and 8, but she did not know why she was "yelling" at them. During an interview, on 9/28/23 at 2:20 p.m., LPN 9 indicated the previous ED was in the hallway on the day before the incident with Resident B (9/19/23) being "very loud and angry" indicating "I need all the CNAs in Room 114 now." She was upset because a housekeeper had told her a CNA refused to pack the resident's belongings up in Room 114 after the CNA was told the resident was being discharged. The record for Resident B was reviewed on 9/28/23 at 3:10 p.m. Diagnoses included, but were not limited to, diabetes mellitus type II, need for assistance with personal care, depression, generalized anxiety disorder, weakness, and chronic kidney disease stage 3. An Admission Minimum Data Set (MDS) assessment, dated 8/24/23, indicated the resident's Brief Interview for Mental Status was coded at an 11, which indicated the resident had mild cognitive impairment. A psychiatry progress note, dated 9/15/23 at 1:00 a.m., indicated the visit was for her initial psych evaluation and medication management and to address an increase in her anxiety symptoms. She was started on Buspirone (an anti-anxiety medication) 5 mg (milligrams) by mouth three times a day that visit. She had no history of			

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	psychotropic medication use prior to her facility admission. She had generalized weakness. She had a changed sleep pattern. Her appearance/behavior was calm and cooperative. Her mood was depressed. She had mild judgement impairment and mild insight impairment. Her attention/concentration was good. Diagnoses for this visit was moderate major depressive disorder, and generalized anxiety disorder. A psychiatry progress note, dated 9/18/23 at 1:00 a.m., indicated the visit was to complete the Mini Mental State Examination (MMSE), which the resident scored a 28/30, which indicated no cognitive impairment. Her Preadmission Screening and Resident Review (PASRR) indicated she had not had previous psychiatric admissions or outpatient mental health services prior to being admitted to the facility. She was dependent for all Activities of Daily Living (ADL) except for feeding herself and she was incontinent. She had no use of psychotropic medication use prior to being admitted to the facility. Her cognition function was intact. Her appearance/behavior was calm and cooperative. Her mood was depressed. She had a fair short-term memory. She had mild impairment of her judgement and insight. Her depression screening test completed on 8/30/23, indicated she was positive for depression. The dementia assessment completed on 8/25/23, indicated she scored 3/6, which indicated she was somewhat dependent with a moderate functional impairment. A progress note, dated 9/20/23 at 9:16 a.m., indicated Resident B's discharge paperwork was explained to her and she refused to sign the Against Medial Advice (AMA) paperwork. The AMA paperwork was signed by two nurses. The resident was provided with medications as			

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	approved by the facility corporate office. She was transported from the facility to home by her husband's vehicle. She took her personal walker with her. There was a lack of 72-hour follow-up in the resident's record for psychosocial monitoring following mental and verbal abuse and intimidation by the previous ED. A care plan for Resident B indicated she had a history of being a social person and enjoying people. During an interview, on 9/28/23 at 4:03 p.m., CNA 7 indicated she came around the Harmony nurses' desk when she heard a loud commotion from down the hall. She heard yelling as she picked up room trays from breakfast. The previous ED was yelling at Resident B and Resident B was telling the previous ED she was not staying at this facility if her ex-husband could not stay with her. She walked up to Resident B's room and observed the previous ED to be standing in front of the resident who was sitting in her recliner. The previous ED was pointing her finger at the resident standing above her as the resident was sitting in her recliner. The previous ED was "towering" over the resident because she was a tall and larger lady. When asked if 0 was quiet and 10 was extremely loud, CNA 7 indicated the previous ED was "yelling" at a level 10 at the resident. When asked why she did not intervene when the previous ED was "yelling" at the resident, CNA 7 indicated she was intimated by the previous ED and now afraid of her due to a situation she and CNA 10 experienced the day before (9/19/23). She was told to go to another resident's room with the previous ED, on 9/19/23, where she waited for CNA 10 to arrive. When			

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	CNA 10 arrived at the resident's room, the previous ED along with the Housekeeping Supervisor in attendance in the room, the previous ED started "screaming" at a level 10 with "aggressive screaming" because she and the Housekeeping Supervisor thought CNAs 7 and 10 refused to pack the discharged resident's belongings. CNA 7 indicated they both wanted to wait to pack her belongings until closer to her being discharged because she had dementia and they did not want her to have any behaviors when she seen them packing her belongings up. If the previous ED was mad at a resident for something, she was "fiery mad and aggressive" with the resident. The ADON (Assistant Director of Nursing) and the Wound Doctor had to have heard the screaming across the hallway because they were over there working on a resident's wounds. She felt she was "bullied" by the previous ED and was scared to break up the interaction between the previous ED and Resident B because of her being "screamed at" the day before. During an interview, on 9/28/23 at 4:31 p.m., the ADON indicated the day prior to the incident with Resident B (9/19/23), she and the Wound Physician was in the room across the hallway from the resident who was to be discharged later that day. They both overheard the previous ED "yelling" at two CNAs while in the resident's room. When asked how loud she was "yelling" if 0 was quiet and 10 was extremely loud, she indicated she was "yelling" at a level 9. The Wound Physician made the statement "Someone's in trouble." The ADON indicated she could hear "anger" in the previous ED's voice while "yelling" at the CNAs. On the day of the incident, (9/20/23), between the previous ED and Resident B, the previous ED told the ADON and the DON			

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	(Director of Nursing) to go down to Resident B's room with her to be her witness when she talked to her. Both the ADON and DON went to the resident's room with the previous ED. The previous ED clarified with Resident B why she was not staying at the facility. Resident B indicated because the previous ED kicked her out of the facility. The previous ED indicated she had not kicked her out and Resident B indicated when she kicked her ex-husband out of the facility, she kicked her out also. The previous ED was re-clarifying and "backsliding" to cover herself on kicking the resident out of the facility because after she left the resident's room, she came from the Redbud hallway to her office talking "angrily" on her cell phone in the hallway, saying "I want her out of here now today" repeatedly. In staff meetings, she called managers out and was "passive-aggressive" with them. She "picked on staff" and made it difficult on staff if she did not like you. The previous ED ran the facility like a "Tyrant" ruler by staff working under "fear" and "intimidation." During an interview, on 9/29/23 at 11:26 a.m., CNA 8 indicated Resident B was her resident the day of the incident between her and the previous ED (9/20/23). The incident happened around breakfast time. Her ex-husband had been in her room staying with her every night to help provide care for her, which all the CNAs where so glad he was there because she did require a lot of care at times and required a lot of emotional care and attention. CNA 8 had been in her room at least twice that day already. The previous ED walked into the room as CNA 8 was walking to the resident's room, so she stayed outside the room, because she did not go in resident's rooms when management or nurses were in their rooms out of respect for the resident's privacy. The previous			

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	ED was "fussing" at Resident B, but she did not know why she was "fussing" at her. The resident was sitting in her recliner with her walker in front of her and the previous ED was standing in front of her walker. Her bedside table was at the side of her recliner. The previous ED was "screaming" at the resident at a level 10 if 0 was quiet and 10 was extremely loud. After she was finished "fussing" at the resident, the previous ED "stormed" out of the resident's room and she pointed to CNA 8 and instructed her to get the resident and her husband some boxes. She pointed to the floor tech girl and instructed her to get the resident and her husband some boxes. The floor tech girl got the boxes for the resident and her husband and CNA 8 got a cart for them, so they were able to wheel their belongings out of the facility to their car. CNA 8 indicated when the previous ED "stormed" out of the resident's room and pointed at her, instructing her to get the boxes, she felt like "a child" and her mom was scolding her. She did not intervene during the "screaming" at the resident because she was shocked it was happening and she was intimidated by the previous ED. A document, titled Human Resources Notice of Corrective Action, dated 9/25/23 and provided by the Interim ED on 9/29/23 at 12:29 p.m., indicated the Previous ED was terminated on 9/25/23, after an allegation of verbal and mental abuse was brought forward about her. After an investigation was complete, it was found that her actions were in violation of Center for Medicare and Medicaid Services (CMS) and the Indiana Department of Health's abuse regulations and the facility's policy on abuse and the companies code of conduct. During a phone interview, on 9/29/23 at 12:19 p.m., the previous ED indicated the Business Office Manager (BOM) told her Resident B's husband			

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	was living there at the facility. She went to the resident's room and found her and her husband in the room. She asked the resident if he was spending the night in her room and the resident indicated she had permission for her husband to sleep at the facility with her. She indicated she spoke to them and told them on the day she admitted he was only allowed to spend one night. The previous ED told them both he was not allowed to sleep at the facility at night, that's when the resident began to escalate and raise her voice toward the previous ED and indicated if the previous ED was kicking out her husband, she would be living also. The previous ED told her that was fine if that was the way it had to be and the resident then escalated more, saying the previous ED was kicking her out of the facility. She tried to tell the resident again she was able to stay, but her husband was not able to sleep in her room anymore. At some point during the conversation, the walker got moved from out in front of the resident and the previous ED did not know how it got moved. The resident accused the previous ED of abusing her and threatening her. She indicated the Regional Vice President terminated her on Monday (9/25/23) for causing psychosocial harm to Resident B. During a phone interview, on 9/29/23 at 12:43 p.m., CNA 10 indicated the previous ED indicated she needed to talk to her on the day before the incident between her and Resident B (9/19/23). A CNA was busy and was not packing up a resident's belongings, who had been discharged. She was not going to pack up the belongings at that time, because that resident would have behaviors. CNAs 7 and 10 were in the room along with the Housekeeping Supervisor when the previous ED was "screaming" at CNAs 7 and 10. When asked what the level of loudness was of the			

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	previous ED's voice if 0 was quiet and 10 was extremely loud, she indicated a level 8. The Wound Nurse from the facility and the Wound Physician was in the room across the hall working on a resident's wounds and they heard the previous ED "screaming" at the CNAs. She was being "aggressive" with the CNAs "for no reason." CNA 10 was confused as to why the previous ED was "coming at her like that." There was a monthly in-service that day and the previous ED brought up packing up resident's belongings. CNA 7 made a comment and the previous ED got very "aggressive" with her during the meeting raising her voice at CNA 7 and cut her off, so she was not able to speak. During an interview, on 9/29/23 at 1:51 p.m., Floor Tech 12 indicated she was cleaning the floors on the 300 Hallway when the incident occurred between the previous ED and Resident B. When the previous ED came out of Room 303, she pointed her finger at her and CNA 8 instructing them to get boxes for the resident in Room 303. She had never seen the previous ED get "upset" like that before with a resident. She got three big sized boxes and took them and sat them at the side of Resident B's door in the hallway, since there were management staff in her room talking with her. 30-45 minutes after the incident with the previous ED, Resident B and her husband packed their belongings and left the facility. During an interview, on 9/29/23 at 2:20 p.m., the Interim DON with the Social Service Director in attendance, indicated she and the ADON witnessed the previous ED being angry and aggressive while walking down the Redbud hallway carrying on a conversation regarding Resident B needing to "leave the facility today." She told her and the ADON to go to Resident B's			

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	room with her to be her witness as to what was being said because she did not want her saying she had been inappropriate with her or threatened her. After she, the ADON, and the previous ED left Resident B's room, she, and the Social Service Director (SSD) went to Resident B's room to talk to her privately. Resident B and her husband indicated she was being "thrown out" of the facility by the previous ED. The DON indicated after the previous ED was terminated, Resident B started coming out of her room more and socializing with other residents. She would do activities now, where she mainly stayed in room before the previous ED was terminated. The SSD indicated she did not perform a psychosocial assessment on her as required following the abuse allegation. A current policy, titled "Abuse Prevention and Reporting-Indiana," dated with a revision date of 10/28/22 and provided by the Interim ED on 9/28/23 at 3:15 p.m., indicated "The facility affirms the right of our residents to be free from abuse...This facility therefore prohibits abuse. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse...This will be done by ...Immediately protecting residents involved in identified reports of possible abuse...Definitions: Abuse: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish to a resident. This also includes the deprivation by an individual, including a caretaker...mental and psychosocial well-being.			

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	The term "willful" in the definition of "abuse" means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm...Mental and Verbal Abuse: Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend or disability. Examples of mental and verbal abuse include, but are not limited to ...Yelling or hovering over a resident with the intent to intimate; threatening residents, including but limited to depriving a resident of care of withholding a resident from contact with family and friends...Orientation and Training of Employees: During orientation of new employees, the facility will cover at least the following topics ...What constitutes abuse...The facility may not discharge, demote, suspend, threaten, harass or deny a promotion or other employment-related benefit to an employee, or in any other manner discriminate against an employee in the terms and conditions of employment because of lawful acts done by the employee; or file a complaint or a report against a nurse or other employee with the appropriate State professional disciplinary agency because of lawful acts done by the nurse or employee...." A current policy, titled "Verbal/Mental Abuse Allegation Staff to Resident Quality Assurance Checklist," undated and provided by the Interim ED on 9/29/23 at 3:46 p.m., indicated "Immediate: Alleged staff member removed from all resident contact. Alleged staff member escorted from the			

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	facility. Alleged staff member placed on suspension pending investigation...Resident assessed for psychological injury & documented...Resident placed on report for 72 hour follow up documentation on incident...INVESTIGATION/PREVENTATIVE MEASURES ...SS (Social Services) Psychosocial Assessment...." This Federal tag relates to Complaint IN00418301. 3.1-27(a)(1) 3.1-27(b)			
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility 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 the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (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 (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the			

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	third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or			

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	discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.			
	Based on observation, interview and record review, the facility failed to ensure a facility-initiated transfer or discharge not in alignment with the resident's goals for care and preferences did not occur when a resident was told to leave the facility by the Executive Director (ED) for 1 of 1 resident being reviewed for transfer and discharge. (Resident B) Finding includes: A document, titled "Indiana State Department of Health Survey Report System," dated 9/28/23 at 12:39 p.m., indicated on 9/20/23 at 9:15 a.m., during a meeting between the previous ED and Resident B, Resident B indicated the previous ED took her walker out of her hands and was rude to her. After a thorough investigation, the five-day follow-up	F 0622	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The resident returned to the facility the day after discharge with no adverse outcomes related to the alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient	10/20/2023

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	indicated the previous ED acted in an unprofessional manner leading Resident B to believe she had to discharge from the facility. When the Interim ED spoke to Resident B, he offered her to return to the facility. During an interview, on 9/28/23 at 1:36 p.m., Resident B was observed sitting in her wheelchair, in her room, with her ex-husband sitting on her bed. She indicated, on 9/20/23, she was getting dressed to go home to see her dogs when the previous Executive Director "busted" in the door of her room. The previous ED asked Resident B why her ex-husband was at the facility. The resident indicated he was at the facility because he took care of her and her animals. The previous ED indicated to the resident, he had to leave the facility. The resident indicated to the previous ED, if he had to leave, then she had to leave also, since he was her caregiver. The previous ED indicated she did not have to leave, but her ex-husband had to leave because he was not allowed to stay the night at the facility with her. Resident B indicated if he left, then she would leave also because he was her caregiver, since there was not enough staff at the facility to care for her in a timely manner. The previous ED indicated then the resident was to leave also. The previous ED "jerked" the bedside table out from in front of her and came at her like an "angry bull." She invaded her personal space with her face up close to the resident's face and her arms pulled back and her chest "puffed out" indicating she was to leave the facility now. The previous ED left the room, but five minutes later, she came back to the room with three to four nurses and boxes to pack her belongings. The Interim ED called and asked her to come back to the facility the next night (9/21/23) after she went home. The facility bus picked her up at her house and brought her		practice. All transfers and discharges during the last 30 days were reviewed and were found to be appropriate. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The IDT and nurses were inserviced on proper transfers/discharges guidelines. IV. 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; Social services or designee will audit 5 transfer/discharges a week x 4 weeks, then monthly x 5 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	back to the facility. During an interview, on 9/28/23 at 2:25 p.m., Qualified Medication Aide (QMA 6) indicated the previous ED and Housekeeping delivered boxes to Resident B's room for her to pack her belongings. The record for Resident B was reviewed on 9/28/23 at 3:10 p.m. Diagnoses included, but were not limited to, diabetes mellitus type II, need for assistance with personal care, depression, generalized anxiety disorder, weakness, and chronic kidney disease stage 3. An Admission Minimum Data Set (MDS) assessment, dated 8/24/23, indicated the resident's Brief Interview for Mental Status was coded at an 11, which indicated the resident had mild cognitive impairment. A progress note, dated 9/20/23 at 9:16 a.m., indicated Resident B's discharge paperwork was explained to her and she refused to sign the Against Medial Advice (AMA) paperwork. The AMA paperwork was signed by two nurses. The resident was provided with medications as approved by the facility corporate office. She was transported from the facility to home by her husband's vehicle. She took her personal walker with her. During an interview, on 9/28/23 at 4:03 p.m., CNA 7 indicated she came around the Harmony nurses' desk when she heard a loud commotion from down the hall. She heard yelling as she picked up room trays from breakfast. The previous ED was yelling at Resident B and Resident B was telling the previous ED she was not staying at this facility if her ex-husband could not stay with her.			

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	She walked up to Resident B's room and observed the previous ED to be standing in front of the resident who was sitting in her recliner. The previous ED was pointing her finger at the resident standing above her as the resident was sitting in her recliner. The previous ED was "towering" over the resident because she was a tall and larger lady. During an interview, on 9/28/23 at 4:31 p.m., the ADON indicated on the day of the incident, (9/20/23), between the previous ED and Resident B, the previous ED told the ADON and the DON (Director of Nursing) to go down to Resident B's room with her to be her witness when she talked to her. Both the ADON and DON went to the resident's room with the previous ED. The previous ED clarified with Resident B why she was not staying at the facility. Resident B indicated because the previous ED kicked her out of the facility. The previous ED indicated she had not kicked her out and Resident B indicated when she kicked her ex-husband out of the facility, she kicked her out also. The previous ED was re-clarifying and "backsliding" to cover herself on kicking the resident out of the facility because after she left the resident's room, she came from the Redbud hallway to her office talking "angrily" on her cell phone in the hallway, saying "I want her out of here now today" repeatedly. During an interview, on 9/29/23 at 11:26 a.m., CNA 8 indicated Resident B was her resident the day of the incident between her and the previous ED (9/20/23). The previous ED walked into the room as CNA 8 was walking to the resident's room, so she stayed outside the room, because she did not go in resident's rooms when management or nurses were in their rooms out of respect for the resident's privacy. The previous ED was			

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	"fussing" at Resident B, but she did not know why she was "fussing" at her. The resident was sitting in her recliner with her walker in front of her and the previous ED was standing in front of her walker. Her bedside table was at the side of her recliner. The previous ED was "screaming" at the resident at a level 10 if 0 was quiet and 10 was extremely loud. After she was finished "fussing" at the resident, the previous ED "stormed" out of the resident's room and she pointed to CNA 8 and instructed her to get the resident and her husband some boxes. She pointed to the floor tech girl and instructed her to get the resident and her husband some boxes. The floor tech girl got the boxes for the resident and her husband and CNA 8 got a cart for them, so they were able to wheel their belongings out of the facility to their car. During a phone interview, on 9/29/23 at 12:19 p.m., the previous ED indicated the Business Office Manager (BOM) told her Resident B's husband was living there at the facility. She went to the resident's room and found her and her husband in the room. She asked the resident if he was spending the night in her room and the resident indicated she had permission for her husband to sleep at the facility with her. She indicated she spoke to them and told them on the day she admitted he was only allowed to spend one night. The previous ED told them both he was not allowed to sleep at the facility at night, that's when the resident began to escalate and raise her voice toward the previous ED and indicated if the previous ED was kicking out her husband, she would be living also. The previous ED told her that was fine if that was the way it had to be and the resident then escalated more, saying the previous ED was kicking her out of the facility. She tried to tell the resident again she was able to stay, but her husband was not able to sleep in her			

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	room anymore. During an interview, on 9/29/23 at 1:51 p.m., Floor Tech 12 indicated she was cleaning the floors on the 300 Hallway when the incident occurred between the previous ED and Resident B. When the previous ED came out of Room 303, she pointed her finger at her and CNA 8 instructing them to get boxes for the resident in Room 303. She had never seen the previous ED get "upset" like that before with a resident. She got three big sized boxes and took them and sat them at the side of Resident B's door in the hallway, since there were management staff in her room talking with her. 30-45 minutes after the incident with the previous ED, Resident B and her husband packed their belongings and left the facility. During an interview, on 9/29/23 at 2:20 p.m., the Interim DON with the Social Service Director in attendance, indicated she and the ADON witnessed the previous ED being angry and aggressive while walking down the Redbud hallway carrying on a conversation regarding Resident B needing to "leave the facility today." She told her and the ADON to go to Resident B's room with her to be her witness as to what was being said because she did not want her saying she had been inappropriate with her or threatened her. After she, the ADON, and the previous ED left Resident B's room, she, and the Social Service Director (SSD) went to Resident B's room to talk to her privately. Resident B and her husband indicated she was being "thrown out" of the facility by the previous ED. This Federal tag relates to Complaint IN00418301. 3.1-12(a)(3) 3.1-12(a)(4)(A)			

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