STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155254	A. BUILDING 00 B. WING	04/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUGAR CREEK REHABILITATION AND CONVALESCENT CENT	5430 W US 40 GREENFIELD, IN 46140

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00257393, IN00257562 and IN00257988. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. Complaint IN00257393 - Substantiated. Federal/State deficiency related to the allegations is cited at F921. Complaint IN00257562 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689 and F9999. Complaint IN00257988 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689 and F9999. Unrelated deficiencies are cited. Survey dates: March 27, 28, 29, 30 and April 2, 2018 Facility number: 000157 Provider number: 155254 AIM number: 100274720 Census Bed Type: SNF/NF: 48 Total: 48 Census Payor Type: Medicare: 6 Medicaid: 36 Other: 6 Total: 48	F 0000	F 000 This plan of correction is to serve as Sugar Creek Nursing and Rehab's credible allegation of compliance effective 4/28/2018. Submission of this plan of correction does not constitute an admission by Sugar Creek Nursing and Rehab or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in the facility, nor does this submission constitute an agreement or admission of the survey allegations. The Facility respectfully disagrees with the scope and severity of the findings and requests a Face to Face IDR for F689	

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

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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 10, 2018			
F 0609 SS=D Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to submit reports to ISDH (Indiana State	F 0609	**F 609** 1. The incident alleged to have	04/28/2018

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	Department of Health) regarding abuse within two hours for 2 of 4 residents reviewed for reporting of abuse. (Residents H and J) Findings include: In an interview on 3-29-18 at 3:30 p.m., with Resident H, she indicated, "I wanted you to know about an incident that just happened. I was in the dining room and this man, he's kind of new here. Well as I was leaving, he grabbed my boob." Resident H demonstrated he grabbed her left breast. "I kind of screamed and he let go. He never said a word and he left, but he kind of kept looking at me." Resident shared she immediately told the nurse on duty, as well as the Director of Nursing (DON). In an interview with Resident H on 3-30-18 at 11:05 a.m., she indicated she has only seen the man at a distance since that time. "I feel safe here. I just don't want him doing that kind of thing to somebody who can't speak up for themselves." A nursing note, dated 3-29-18 at 3:45 p.m., and signed by the MDS Coordinator, indicated she had walked by the dining area when Resident H approached her and told her a male resident "came and sat near her, looked at her and grabbed her by the [term for breast]...Resident continued down the hall and went to the nurse's station and reported the same information to the nurses." In an interview on 3-30-18 at 10:40 a.m., with Administrator 2, she indicated she had yet to complete or submit an initial report to ISDH regarding the the incident with Residents H and J from the previous day. An ISDH reportable event document for Residents H and J was provided on 4-1-18 at 10:12		occurred on 3/29/2018 involving resident's H and J was reported to ISDH via the Gateway Portal on 3/30/2018. 2. An audit of all incidents reported to ISDH in the last 60 days was conducted and no other residents were identified as having been affected. 3. Administration and management staff in-serviced on policies related to Abuse and Abuse Prevention, including timely reporting, was conducted on 4/23/2018. The administrator will use a QAPI audit/tracking form to monitor incident reporting to ensure all elements, including timeliness of reporting, are present. 4. The administrator will use the QAPI tool to monitor timeliness of incident reporting weekly for six months. The results will be recorded and the findings reviewed at the monthly QAPI meeting overseen by the administrator and reviewed by Corporate risk management. If threshold of 95% is not achieved, and action plan will be developed.	

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	a.m. This document indicated on 3-30-18 at 3:30 p.m., Resident H reported to nursing staff Resident J had grabbed her breast. This document was indicated to have been emailed to ISDH on 3-30-18 at 11:33 a.m. In an interview on 4-2-18 at 10:30 a.m., with Administrator 2, she indicated she would correct the date of occurrence to 3-29-18, when the final report was sent to ISDH. On 3-27-18 at 5:25 p.m., Administrator 1 provided a copy of policies related to Abuse and Abuse Prevention. This policy, with a revision date of 9/2011, indicated, "Allegations of abuse are reported to the State survey agency immediately via the ISDH Portal or telephone if the Portal is inactive. (If by telephone, written notice must be received within 24 hours.)...Purpose: To assure all unusual occurrences and allegations of abuse are reported to ISDH immediately by telephone and with written notice 24 hours. Reports of reasonable suspicion of a crime against a resident must be made to ISDH and local law enforcement agencies within 2 hours if there is serious bodily injury..." 3.1-28(c)			
F 0689 SS=J Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			

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	A. Based on interview and record review, the facility failed to provide the supervision necessary to prevent the reoccurrence of the ingestion of potentially hazardous materials, batteries, for 1 of 1 resident with a history of ingestion of foreign bodies for 1 of 3 residents reviewed for accidents and self-harm behaviors. (Resident B) The Immediate Jeopardy began on 3/9/18 at 11:15 p.m. when Resident B informed facility staff he had ingested a battery. Administrator 1 was notified of the immediate jeopardy on 3-28-18 at 3:55 p.m. B. Based on interview and record review, the facility failed to ensure 1 of 3 residents reviewed for accidents and self-harm behaviors did not have access to a secured shower room in which she could obtain a disposable razor, resulting in the resident performing self-mutilation of cuts to her arm. (Resident C) Findings include: A. On 3/27/18 at 8:12 p.m., Administrator 1 provided a copy of an unusual occurrence report sent to the Indiana State Department's Long Term Care Division on 3/21/18. This report indicated, on 3/9/18 at 9:01 p.m., Resident B informed the charge nurse he swallowed a battery. The attending physician was notified of the event and provided an order to send the resident to the local emergency room for evaluation and treatment. In an interview with Administrator 1, on 3/27/18 at 7:35 p.m., he indicated Resident B had removed the battery from his TV remote control, swallowed the battery, and told one of the staff right after he did it. "He was sent out to the emergency room	F 0689	F 689 The Facility respectfully disagrees with the scope and severity of the findings and requests a Face to Face IDR for F689 1. Resident B was admitted on 2/12/2018 with a history of pica and ingesting non-food items. Resident was care planned as such upon admission. On 2/25/2018, batteries were removed from remote control and access to batteries limited following information a battery had been ingested. As a further preventative measure, Resident B was transferred to a private room on 3/9/2018; Staff education was provided in regards to resident B who has the potential to ingest small items and/or non-food items, including most recently a battery; A care plan meeting was held on 3/16/2018 with staff and resident's family to discuss preventative measures to reasonably ensure resident is free from ingesting hazardous objects; The resident's MDS, care plan, and C.N.A. assignment sheet were updated to reflect resident's current care needs; The resident's room is inspected throughout the day to reasonably ensure an environment free from hazardous accidents is maintained. Additional all staff training was provided on 3/28/2018 regarding care and treatment	04/28/2018

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	and then transferred to psych [psychiatric facility]..." Review of the clinical record included a copy of an "Incident/Accident Report," dated 2/25/18 at 11:15 p.m., and signed by LPN 3. This report indicated Resident B was sitting up in his wheelchair watching TV and informed the CNA that he had swallowed a battery. No employee had observed the resident swallow the battery. The attending physician and family were notified of the event and the resident was sent out to an area emergency room. The emergency room was called by the facility at approximately 4:00 a.m. on 2/26/18 and the facility was informed that a battery was present in the resident's abdomen. The Nurse Practitioner's follow up visit, dated 2/28/18, indicated Resident B had passed the battery per staff. "[The resident] has since swallowed coins that have not passed." A written note from CNA 2, dated 3/9/18, detailed between 10:15 p.m. and 10:30 p.m., indicated the CNA responded to Resident B's call light and was informed by the resident that he had swallowed four batteries. The CNA immediately notified the nurse on duty. Review of the emergency room visit, dated 3/10/18 at 12:04 a.m., indicated Resident B was sent to the hospital due to "possibly ate 3 AA batteries." The resident had a history of swallowing things and complained of "belly pain." An X-ray of the abdomen indicated a foreign body in the right upper and lower quadrants of his abdomen. A subsequent CT scan of the abdomen and pelvic area demonstrated foreign bodies within the colon, specifically in the cecum and at the level of the hepatic flexure. "The foreign bodies leading		needs of resident B, including precautions for ingesting small items and or non-food items including hazardous objects; Housekeeping staff educated on room cleaning and “room sweep” for hazardous items on 3/29/2018; Root cause analysis conducted as part of Quality Assurance Program; and, resident was placed on 15-minute checks on 3/28/2018, ongoing. Regarding Resident C: Per resident preference and facility assessment of independence with ADLS, resident showers self independently and has done so without incident. The resident reported her self-injury immediately, the physician was notified, and treatment was provided. The door lock code to the shower room was changed the same day. Resident was instructed to inform staff when she desires a shower and agreed to supervision. Staff instructed to maintain disposable razors inaccessible to residents. Social services and Psych services monitoring resident’s mental and psychosocial status ongoing. 2. Audit of facility residents’ diagnoses and history was completed and no other resident has the potential for Pica behavior or self-harm practices. 3. Resident B has been placed on	

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	to significant streak artifacts and are actually better assessed on prior radiographic examinations. This may reflect the patient's known history of of battery ingestion." The emergency room physician's recommendations included, but were not limited to a diagnosis of "foreign body ingestion," with orders to inspect the resident's stool for the presence of a battery and to have a repeat abdominal X-ray on 3/16/18. A physician visit note, dated 3/14/18, indicated "Patient went out to ER again on 3/10/18 for foreign body ingestion. It was presumed that he swallowed three AA batteries from a remote control, but patient was unable to give history." The note indicated an abdominal X-ray, dated 3/10/18, indicated foreign bodies were located in Resident B's right upper and lower area of the abdomen. During an interview with Administrator 2 and the Corporate Nurse, on 3/28/18 at 3:01 p.m., Administrator 2 indicated the facility did not file a report of an unusual occurrence related to the battery ingestion on 2/26/18, "because the doctor said there was no proof of him ever actually swallowing a battery." The Corporate Nurse added Resident B went out to an area psychiatric hospital for inpatient services soon after the 2/26/18 event. "When he came back on the 9th or 10th, he told several different stories to different staff, that he had swallowed a battery at the psych hospital to he had swallowed several [batteries] here." She was aware that the emergency room visit, on 3/9/18 identified foreign bodies in his colon, but had no information as to if rays had been conducted during the 2/26/18 emergency room visit. In an interview, on 3/28/18 at 1:02 p.m., with the		15-minute checks ongoing and monitoring is being documented. A QAPI tool will be used by housekeeping daily to ensure the resident room is free of hazardous objects that could be potentially ingested. Regarding Resident C, a QAPI tool has been developed to monitor the changing of the shower lock code monthly or more often as needed; and a daily check by nursing staff to ensure shower area is free of any hazardous objects including disposable razors. Staff to be educated again on environmental hazards such as objects that can be used for self-harm or swallowed before 4/28/2018. 4. The daily QAPI audits will be conducted by housekeeping and nursing and the administrator will review them weekly for three months and biweekly for six months. The results will be recorded and the findings reviewed at the monthly QAPI meeting overseen by the administrator and reviewed by Corporate risk management. If threshold of 95% is not achieved, and action plan will be developed.	

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attending physician's Nurse Practitioner, she indicated she was aware Resident B had two different times in which he had swallowed batteries since he was admitted, on 2/12/18, to the facility. "From my understanding, this [ingestion of foreign bodies] has been an issue at any facility he has been at. Most recently, he was at [name of other facility], a sister facility. His history includes some type of abdominal surgery for foreign body removal...He has a long-standing history of mental health issues."

In an interview, on 3/28/18 at 10:10 a.m., with Resident B, he indicated, "Yes, I swallowed some coins and batteries not too long ago. I've done that off and for years...The stuff still hasn't passed yet, but I guess they will..."

Resident B's clinical record was reviewed on 3/28/18 at 12:27 p.m. His diagnoses included, but were not limited to, schizophrenia, epilepsy with recurrent seizures, cerebral palsy, depression, GERD, constipation, and moderate intellectual disabilities. Additional diagnoses, from his psychiatric hospital stay, dated 2/28/18, added swallowed foreign body and abdominal pain. An admission Minimum Data Set assessment, dated 2/19/18, indicated he was moderately cognitively impaired, usually understands and sometimes was understood. His behaviors were identified as verbal behaviors toward others and rejection of care, each occurring 1 to 3 days out of 7 days.

Review of the care plans developed for Resident B included, but were not limited to, a care plan for a concern of being at risk for stomach upset related to a history of pica due to the resident swallows small objects. "Has swallowed batteries most recently, sent to hospital with hospital returning resident with no new orders." This care

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	plan was initiated on 2/14/18 and revised on 3/13/18. Interventions initiated, on 2/14/18, included, but were not limited to, administer stool softener as ordered, notify the physician and POA (power of attorney) of suspected pica activity, notify the physician, POA and Director of Nursing if resident swallows inappropriate items, obtains vitals signs, and remove all small items from resident's general area in his room. Interventions initiated ,on 3-13-18, included, but were not limited to, notify the physician if the resident swallows (inappropriate) items and follow physician orders, provide supervision during activities programs to ensure resident does not obtain small items to swallow, and resident moved to different room to aide in the management of what he was able to obtain. The Immediate Jeopardy began on 3-9-18 and was removed on 3-30-18 when the facility instituted monitoring every 15 minutes and the documentation of the monitoring of Resident B continued staff education regarding the care needs of Resident B in relationship to ingestion of small items and/or non-food items. The noncompliance remained at a lower scope and severity level of isolated, no actual harm with the potential for more than minimal harm that is not immediate jeopardy because the facility has not completed staff education with all staff and the resident has the potential for continued ingestion of small items and/or non-food items. B. The facility provided a copy of an unusual occurrence report indicating on 3-24-18 at 11:30 a.m., Resident C obtained a safety razor from the locked shower room, then cut herself with a disposable razor. This report was denoted to have been sent to the Indiana State Department of			

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	Health on 3-26-18 at 12:30 p.m. In an interview with Resident C on 3-27-18 at 6:14 p.m., she indicated she has resided at the facility for approximately 4 years and doesn't think the code to the locked shower room has been changed during that time frame. She indicated she has "borderline personality and kind of a split personality with two other people in my head." Resident C identified the reason her left arm got cut is that "Lila [the name of one of her other personalities] came out and caused this to happen...What happened is that I went into the shower room and got a new disposable razor from in there and cut myself." She explained she had multiple cuts to arm that were not deep cuts. " I've been out to the psych hospital several times, for stuff like cutting myself. But usually by the time I get there, I have settled down and they just send me back." Resident C insisted the cutting was not a suicide attempt. An observation at this time demonstrated the left arm was wrapped in gauze from wrist to elbow with no obvious drainage, with the resident able to move both arms with no difficulty. Resident B indicated she received care for her cuts at the facility and was not sent out to the hospital. In an interview on 3-28-18 at 1:07 p.m., with the Nurse Practitioner, she indicated this was the first time she was aware in which Resident C had displayed self-mutilation behaviors. "She tells me she has done this before, and I heard for the first time the issue of possible multiple personality disorder. This morning when I saw her, she was very cheerful and pleasant. A short time after that, therapy staff came to me and said she was screaming & cussing at them, demanding more therapy...Her disposition can change very rapidly."			

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	In an interview with Administrator 1 on 3-27-18 at 7:35 p.m., he indicated Resident C "is able to do her own shower without assistance and it is not uncommon for her to to go into the shower room unsupervised. Apparently she got a safety razor...She self-reported to one of the aides that she had cut her arms and the aide immediately notified the nurse, who then assessed her. The nurse notified the doctor . Apparently the cuts were fairly superficial and the resident said she was not trying to commit suicide. She does have a history of self-cutting. When I talked with the resident, she told me that she had another personality and she did it. This was the first I was aware of any multiple personality issue with this person and could not find any documentation that reflected such a diagnosis. She was scheduled to see psych services today." On 3-28-18 at 10:07 a.m., the MDS Coordinator indicated the lock code for the shower room door was changed on 3-24-18, after the incident. On 3-28-18 at 10:15 a.m., LPN 4 indicated the cuts on Resident C's arms were looking inflamed and were warm to touch with a fair amount of weeping on the previous day, but this date, the areas were looking less inflamed and no warmth, with very little weeping. She added the Nurse Practitioner changed Resident C's antibiotic due to an allergic reaction of a fine rash on her trunk. The clinical record of Resident C was reviewed on 3-27-18 at 8:27 p.m. Her diagnoses included, but were not limited to bipolar disorder, recurrent depression, recurrent severe psychotic symptoms and chronic pain. Her most recent MDS [Minimum Data Set] assessment, dated 2-21-18, indicated she is cognitively intact, demonstrated			

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	behaviors, specific to unspecified physical behaviors toward others and has mood issues specific to depression, tiredness/lack of energy, feels bad about her self and has difficulty with concentration. It indicated she currently takes an antidepressant at least daily. This Federal tag relates to Complaint IN00257562 and Complaint IN00257988. 3.1-45(a)(1) 3.1-45(a)(2)			
F 0712 SS=D Bldg. 00	483.30(c)(1)-(4) Physician Visits-Frequency/Timeliness/Alt NPP §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. Based on interview and record review, the facility failed to ensure physician visits were conducted	F 0712	**F 712** 1. Resident J admission date was	04/28/2018

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SUGAR CREEK REHABILITATION AND CONVALESCENT CENT	5430 W US 40 GREENFIELD, IN 46140

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	for 1 of 1 residents reviewed for abuse and timely physician visits. (Resident J) Findings include: The clinical record of Resident J was reviewed on 3-30-18 at 10:30 a.m. His diagnoses included, but were not limited to vascular dementia with behavioral disturbance, CVA (cerbrovascular accident or stroke) with hemiplegia (paralysis of one side) affecting right side, hypertension, depression, diabetes, dysphasia (difficulty with speech) and expressive language disorder. His admission date was identified as 1-26-18. The review of the clinical record failed to locate any physician visit notes. In an interview with Administrator 2 on 4-2-18 at 2:48 p.m., she indicated, "We could not find any doctor or nurse practitioner visits for [name of Resident J]. 3.1-22(d)(1) 3.1-22(d)(2) 3.1-22(d)(3) 3.1-22(d)(4)		1/26/2018. Clinical record shows that he was seen by physician on 1/31/2018, and documentation is available for review. 2. Chart audit completed to identify other residents who have the potential to be affected by alleged deficient practice. No other residents were identified to have been affected. 3. Following a physician visit, the clinical record(s) generated by the visit will be incorporated in resident's chart immediately. A QAPI audit tool will be used by the director of nursing or designee to track timely physicians' visits and to ensure clinical records generated by visit have been placed in residents' charts. Licensed nursing staff in-serviced on the maintenance of physician clinical records by 4/28/2018. 4. Director of nursing and/or designee will review timeliness of physician visits and record keeping weekly for six months. The results will be recorded and the findings reviewed at the monthly QAPI meeting overseen by the administrator and reviewed by Corporate risk management. If threshold of 95% is not achieved, and action plan will be developed.	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for			

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	residents, staff and the public. Based on interview and record review, the facility failed to ensure the safety and sanitary condition of 1 of 4 residents in which facility staff placed one resident in the bed of another resident who had been sent to the local emergency room for projectile vomiting without appropriate cleaning being conducted. (Resident D and Resident G) Findings include: In an interview with RN 5 on 3-27-18 at 6:30 p.m., she indicated she was working the evening Resident D had the projectile vomiting and went to the local emergency room (ER). She recalled speaking with the attending physician regarding the vomiting and receiving an order to send him to the ER. "[Name of Resident D] ended up coming back the same evening, even though the hospital had told me that they were going to keep him. In the meantime, a little later, two male patients were yelling and screaming and arguing with each other over the TV. I called the Administrator and he told me to separate them and move the one man, [name of Resident G]. So, we moved him [Resident G] into [name of Resident D]'s bed and told him it was just for the night. We changed the linen on the bed and cleaned up the room with disinfectant wipes from the vomitus, even though there may have still been some particles on the wall. When the ambulance returned [name of Resident G], we ended up moving [name of Resident G] to another bed and got [name of Resident G] put back in his bed after we got his linens changed...I would guess that [name of Resident G]was in [name of Resident D]'s bed for less than 15 minutes. Can't remember the exact date this happened, but probably within in the last 2 or 3 weeks."	F 0921	**F 921** 1. Resident D's room was deep cleaned. 2. No other residents were immediately affected. However, all resident rooms were deep cleaned. 3. Housekeeping staff has been in-serviced on room cleaning schedule and procedures, including deep cleaning. Nursing staff will be inserviced on and provided a daily roster of unoccupied beds that have been cleaned and available for emergency use or a new admission. The room cleaning schedule will be used as a QAPI tool to track the completion of rooms that have been deep cleaned, and those available for emergency use or new admissions. 4. The room cleaning and bed availability QAPI tool will be used by the housekeeping supervisor to monitor the completion of rooms cleaned and beds available for occupancy weekly for six months and ongoing. The results will be recorded and the findings reviewed at the monthly QAPI meeting overseen by the administrator and reviewed by Corporate risk management. If threshold of 95% is not achieved, and action plan will be developed.	04/28/2018

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	In an interview with a community member on 3-28-18 at 4:08 p.m., she indicated she was present in the building on 3-13-18 when Resident D returned from the ER. She indicated the nurse seemed surprised he was returned. "She then said that she already had someone in his bed...The nurse was in there with a rag and a spray bottle of something, trying to wipe the wall down with the patient in the bed...They sent the other man out into the hall, he seemed to be able to walk with help. All he said was he was tired and wanted to go to bed." She indicated she did not report this information to the facility staff or management team. In an interview on 3-29-18 at 2:25 p.m., with Administrator 1, he indicated he recalled receiving a phone call from one of the nurses on the night [name of Resident D] was sent out to the hospital for vomiting. "She said there had been an issue between two of the male residents over their TV. So, I told her she just needed to separate them and to move them. I rely on the nurses to make good decisions about things like room moves. She never made any mention to me about putting anyone in the bed of someone who had just gone out to the emergency room. I would have expected her to say something about this. And, we would not put someone in another person's bed unless the room had been thoroughly cleaned. That is just not our practice. Each room should have a thorough cleaning between residents." In a second interview with Administrator 1 on 3/29/18 at 2:30 p.m., he shared, "We were trying to separate them, for safety purposes. 'Was there somewhere we could move him, temporarily,' is what I asked. She, the nurse, didn't tell me about a room that had been occupied. I got the call in the			

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	evening and I was working off a visual where the rooms were and who was present. I would have never moved him to an occupied room that had not been terminally cleaned. I don't even think I came up the following day. That would not be our practice. I didn't worry to much because housekeeping is good about cleaning between resident transfers." In an interview on 3-28-18 at 10:35 a.m., with the Housekeeping Supervisor, she indicated, "We found out about [name of Resident G] being moved into [name of Resident D]'s bed the next morning. So we did a deep clean to [name of Resident D]'s room the next morning. I don't recall anyone saying anything about it being a big mess or smelling like vomit. We deep clean each room at least once a month or more often if it is needed. Each room is to be deep cleaned before a new resident moves into the space. Some places will call this a terminal cleaning. We use special cleaning products to get this done." In an interview on 3/29/18 at 8:55 a.m., with Housekeeper 6, she indicated resident rooms are deep cleaned every other day, as well as upon admission or with room transfers. She explained this includes the bathroom, dressers, wiping down doors, trash is removed and sweeping and mopping the floors, including under the beds. "The supervisor will let me or someone else know about a pending admission. Our supervisor won't know until Administration tells her. I'm not sure if that actually happened (with having a resident admit and the room not being deep cleaned). Sometimes there is a miscommunication where we aren't aware of any admits after hours and we deep clean the room the following day, after we find out they are here...We don't have any evening/night time housekeeping. We used to			

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	and they would be here in case of an emergency admit or cleaning in those hours." This Federal tag relates to Complaint IN00257393. 3.1-19(f)(5)			
F 9999 Bldg. 00	3.1-13 ADMINISTRATION AND MANAGEMENT (g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately inform the division by telephone, followed by written notice within twenty-four hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents Based on interview and record review, the facility failed to report unusual occurrences to the Indiana State Department (ISDH) within 24 hours for 2 of 2 residents experiencing unusual occurrences. (Residents B and C) Findings include: 1. Resident B's clinical record was reviewed on 3/28/18 at 12:27 p.m. His diagnoses included, but were not limited to, schizophrenia, epilepsy with recurrent seizures, cerebral palsy, depression, GERD, constipation, and moderate intellectual disabilities. Additional diagnoses, from his psychiatric hospital stay, dated 2/28/18, added	F 9999	**F999** 1. The incident involving Resident B was reported to the ISDH on 3/21/2018. The incident involving Resident C was reported to the ISDH on 3/26/2018. 2. An audit of all incidents involving unusual occurrences reported to ISDH in the last 60 days was conducted and no other residents were identified as having been affected. 3. Administration and management staff in-serviced on policies related to unusual occurrences, including timely reporting, was conducted on 4/23/2018. The administrator will use a QAPI audit/tracking form to monitor incident reporting to ensure all elements, including timeliness of reporting, are present. 4. The administrator will use the QAPI tool to monitor timeliness of incident reporting weekly for six months. The results will be recorded and the findings reviewed at the monthly QAPI meeting overseen by the administrator and	04/28/2018

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	swallowed foreign body and abdominal pain. An admission Minimum Data Set assessment, dated 2/19/18, indicated he was moderately cognitively impaired, usually understands and sometimes was understood. His behaviors were identified as verbal behaviors toward others and rejection of care, each occurring 1 to 3 days out of 7 days. During the initial tour of the facility on 3-27-18 at 4:45 p.m., with the MDS Coordinator, she indicated Resident D had a history of pica, that was identified upon admission, of eating or swallowing small items. "He has been sent out at least 3 times to the hospital for this." A copy of an "Incident/Accident Report," dated 2/25/18 at 11:15 p.m., and signed by LPN 3 was located in the clinical record. This report indicated Resident B was sitting up in his wheelchair watching TV and informed the CNA that he had swallowed a battery. No employee had observed the resident swallow the battery. The attending physician and family were notified of the event and the resident was sent out to an area emergency room. The emergency room was called by the facility at approximately 4:00 a.m. on 2/26/18 and the facility was informed that a battery was present in the resident's abdomen. A Nurse Practitioner Visit note, dated 2-28-18, indicated the visit was for a follow up visit following resident swallowing of battery on 2-25-18, indicated "Per staff, battery was passed. Patient has since swallowed coins that have not passed." An interview on 3-28-18 at 1:02 p.m. with the Nurse Practitioner indicated Resident B had swallowed batteries at least 2 different times while at the facility. "From my understanding, this has		reviewed by Corporate risk management. If threshold of 95% is not achieved, and action plan will be developed.	

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been an issue at any facility he has been at." She added Resident B's history included some type of abdominal surgery for foreign body removal and a long-standing history of mental health issues.

In an interview with Resident B on 3-28-18 at 10:10 a.m., he indicated, "I swallowed some coins and batteries not too long ago. I've done that off and on for years. Got sent to the hospital for it not too long ago. The stuff still hasn't passed yet, but I guess they will. I like this room. I haven't swallowed any more stuff since they moved me to this room."

On 3/27/18 at 8:12 p.m., Administrator 1 provided a copy of an unusual occurrence report sent to the Indiana State Department's Long Term Care Division on 3/21/18. This report indicated, on 3/9/18 at 9:01 p.m., Resident B informed the charge nurse he swallowed a battery. The attending physician was notified of the event and provided an order to send the resident to the local emergency room for evaluation and treatment.

In an interview with Administrator 2 on 3-28-18 at 3:01 p.m., she indicated the facility did not file unusual occurrence reports for ISDH because the doctor said there was no proof of him ever actually swallowing a battery. In interview with Administrator 2 on 3-29-18 at 10:05 a.m., she indicated there were no other reportables for this resident, except for the one from the event of 3-9-18. On 3-29-18 at 11:23 a.m., Administrator 2 shared the unusual occurrence was on 3-9-18, but she was not made aware of it until 3-21-18, the date she filed the unusual occurrence & emailed it to ISDH.

An area hospital emergency room note, dated 3-10-18 indicated an abdominal xray for the battery

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	ingestion on 3-9-18 indicated a foreign body was located in the right upper quadrant. An abdominal and pelvic CT scan identified a foreign body in the colon within the cecum at level of hepatic flexure, but contained within the colonic lumen. A follow up abdominal xray, conducted on 3-16-18, indicated at least six 2.5 cm oval metallic density foreign bodies, projecting over the expected location of the distal ileum and ascending colon, were present. 2. The clinical record of Resident C was reviewed on 3-27-18 at 8:27 p.m. Her diagnoses included, but were not limited to encephalopathy, unspecified neuropathy, bipolar disorder, recurrent depression, recurrent severe unspecified psychotic symptoms and chronic pain. On 3-27-18 at 8:12 p.m., Administrator 1 provided a copy of an ISDH provided a copy of an unusual occurrence report emailed to the Indiana State Department's Long Term Care Division on 3/26/18 at 12:30 p.m. This report indicated on 3-24-18 at 11:30 a.m., Resident C entered a locked shower room and obtained a safety razor and cut her left forearm. In an interview with Administrator 1 on 3-28-18 at 12:45 p.m., he clarified the cutting happened on 3-24-18 around 11:30 a.m. and was reported to ISDH on 3-26-18. On 3-27-18 at 5:25 p.m., Administrator 1 provided a copy of policies related to Abuse, Abuse Prevention and Unusual Occurrences. This policy, with a revision date of 9/2011, indicated, "Purpose: To assure all unusual occurrences and allegations of abuse are reported to ISDH immediately by telephone and with written notice 24 hours. Reports of reasonable suspicion of a			

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	crime against a resident must be made to ISDH and local law enforcement agencies within 2 hours if there is serious bodily injury..." This State tag relates to Complaint IN00257562 and IN00257988. 3.1-13(g)(1)			