DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155799	A. BUILDING 00 B. WING	02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE MARION LLC	614 WEST 14TH STREET MARION, IN 46953

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00399248, IN00400281 and IN00400191. Complaint IN00399248 - Substantiated. Federal/State deficiencies related to the allegations are cited at F550, F646 and F658. Complaint IN00400281 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600, F609 and F622. Complaint IN00400191 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600. Unrelated deficiencies are cited. Survey dates: February 6, 7, 8 and 9, 2023. Facility number: 012809 Provider number: 155799 AIM number: 201136580 Census Bed Type: SNF/NF: 42 SNF: 4 Total: 46 Census Payor Type: Medicare: 4 Medicaid: 31 Other: 11 Total: 46 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tamera Shirels	ED	03/08/2023

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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	Quality review completed February 14, 2023.			
F 0550 SS=G Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be			

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	free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to ensure a resident's preferences were met for 1 of 2 resident's reviewed for accommodation of needs. This deficient practice resulted in psychosocial harm related to the resident's fear of the mechanical lift (Resident B). Findings include: Resident B's clinical record was reviewed on 2/6/23 at 11:04 a.m. Diagnoses included amyotrophic lateral sclerosis (ALS), anxiety disorder, peripheral vascular disease, hereditary and idiopathic neuropathy, neuralgia and neuritis, foot drop, unspecified foot, and other abnormalities of gait and mobility. A quarterly MDS (Minimum Data Set), dated 11/25/22, indicated he was cognitively intact. He required extensive assistance of two staff members for bed mobility, transfers, locomotion on and off the unit, dressing, toilet use and personal hygiene. He had an impairment to both sides of his upper and lower extremities. He used a wheelchair. He was occasionally incontinent of bladder and frequently incontinent of bowel. He had a life expectancy of less than six months due to a chronic disease or condition. His orders included aspirin (blood thinner) 81 mg (milligram) daily, clopidogrel bisulfate (blood thinner) 75 mg daily, hydrocodone-acetaminophen (pain reliever) 10-325 mg every four hours, lorazepam (treat anxiety) 0.5 mg every four hours	F 0550	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident B's care plan was updated and staff informed that resident B is to be transferred per 2 person assist.** 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 will be interviewed to ensure their preferences and resident rights are being met. Any reasonable preferences not being met or resident's rights that are being violated will be corrected. Updated preferences will be added to the resident's care plan.** . III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **All staff will be educated on resident rights including preferences and the process for reporting potential violations of**	03/02/2023

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	and mechanical lift transfers only. He had a current care plan problem of being at risk for bladder incontinence related to terminal prognosis of ALS, hospices services, medication, weakness and impaired mobility initiated on 6/10/22. His interventions included ensure the resident had an unobstructed path to the bathroom, initiated on 6/10/22. He had a current care plan of an ADL (Activities of Daily Living) self-care performance deficit including bed mobility, eating, transfers and toileting related to terminal prognosis of ALS, received hospice, PVD, neuralgia, neuropathy, history of dysphagia and foot drop, revised on 9/13/22. His interventions included total staff assistance for toilet use and he required total staff assistance for transfers, revised on 12/8/22. A hospice nurses note, dated 2/2/23, indicated he was alert and oriented. He voiced complaints of the facility nursing staff, as he was not getting his medications like they were ordered and a nurse charted he refused his medications. The nurses would not allow staff to transfer him unless they used the mechanical lift. He refused to use the lift because he was scared of falling out of it. He had only been getting up to use the bedside commode and had since stopped getting up at all. He refused to use a bedpan. He now refused all meals. His reasoning was if he did not eat, he would not have bowel movements. He said he had no need to get out of bed or use the mechanical lift. She tried to encourage him, but he was not having it. She spoke to staff who stated they were aware. The hospice nurse and nurse practitioner were also aware. During an interview with Resident B, on 2/6/23 at		**resident rights. The nursing staff will be educated on charting and communicating resident preferences. Resident preferences will be identified during the care planning process and reviewed during care plan meetings and upon request.** 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; The DON or designee will interview 15 residents weekly x 4 weeks then 5 residents weekly x 4 weeks and then 10 residents monthly to ensure resident rights are being met. **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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1:45 p.m., he indicated he had filed a facility grievance on 1/3/23, and then again on 1/12/23, with the facility. The grievance on 1/3/23 was related to the facility food and the 1/12/23 was related to the nurse who documented he refused his medications when he did not. The entire time he had been at the facility they had pivot - transferred him. He had never used the mechanical lift. Now, they had told him he had to be a mechanical lift. He had worked in healthcare previously and had seen residents dropped from the mechanical lift and he didn't want to be dropped from it. He was 6'1" tall, and by having to use the mechanical lift, he would not be able to get up to use the bedside commode and he would have to use the bedpan. He did not want to use the bedpan, as it made him feel like he was sitting in his own feces. He had not eaten since 1/30/23. He felt if he didn't eat, then he would not have to have a bowel movement. Therapy had not screened him since he first admitted to the facility. He felt since he filed the complaint, they told him he had to be transferred with the mechanical lift. He would rather eat again. That's all he had left, but did not want to use the bedpan to have bowel movements. He preferred to sit on the commode.

During an interview with the Administrator and ADON, on 2/6/23 at 2:32 p.m., the Administrator indicated the resident was very upset about the lift. It had been a great concern with the CNAs that were 5'1" tall. She was not aware he wasn't eating. He was manipulative to staff and dismissed you from his room. He enjoyed manipulating his mom against others. He had an angry side.

During an interview with the hospice nurse, on 2/7/23 at 9:26 a.m., she indicated the resident refused to get out of bed the previous week, and

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he didn't want to use the lift. He didn't want to eat because he didn't want use the lift. He was terrified of it. He refused to use to use the bedpan, which was why he was not eating. He had ALS and weakness, but he could use his legs enough to stand. The facility put a mechanical lift transfer in place. One day they were pivot transferring him, then there was a big uproar, and now they were to use the mechanical lift. CNAs had indicated they didn't mind transferring him. There was a certain nurse who complained about transferring him and had never transferred him. He did not care for her at all, and had dismissed her from his room. If he was not in the mood, he would say ok you can go. Not rude, just he was ok, he was done, and you could go.

During an interview with LPN 5, on 2/7/23 at 11:47 a.m., she indicated the resident could not stand well, he towered over the aides, and was not safe. The facility was a "no-lift facility". There was a short pregnant aide who worked at the facility and she didn't want to transfer him. She, herself, had not transferred him. She assumed it was the DON who had changed him to a mechanical lift transfer. The DON had told her to put the order in the computer system for him to be transferred with the mechanical lift.

During an interview with CNA 35, on 2/7/23 at 1:29 p.m., she indicated the resident had never been mean to her. Certain things irritated him, such as if you couldn't transfer him how he liked to be transferred and if you didn't knock on his door before you entered his room. He didn't liked to be bothered. She had been pregnant and physically could not transfer him. He started to decline, and she went to the DON and told her that he wasn't safe to transfer. They had to use the mechanical lift since his knees would collapse and he was

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	completely dead weight. His family and hospice would transfer him without the use of a lift. During an interview with the hospice CNA, on 2/7/23 at 1:43 p.m., she indicated she took care of him every Monday, Wednesday, and Friday. At first, she didn't know how to take him, since he would get short of breath and did not like to talk a lot. She felt he was just misunderstood. She was 5'4" tall, and when she transferred him, he would grab around her shoulder/neck area and she would put her hands under his armpits. He was not really able use his legs. He was upset about using the mechanical lift. He was terrified of it and he felt LPN 5 was picking on him. She had talked to the aides and they still wanted to transfer him, but LPN 5 threatened them she would call the State and they would lose their jobs. He had stopped eating and he was weak. Yesterday was his eighth day of not eating. He felt if he didn't eat, he would not have to have a bowel movement. He so badly didn't want to have a bowel movement while in the bed and have someone to clean him up. He wanted to keep his dignity. During an interview with the DON, on 2/7/23 at 2:01 p.m., she indicated when the resident first admitted they transferred him with two people, but he had progressed so much. He wanted the staff to bear hug him and they would slam him down on the commode because he was so much taller than them. They were a non-lift facility. Safety came first for him and the staff. Hospice and the family would get him up. Staff felt it wasn't safe anymore to pivot transfer him. She had tried to talk with him, he didn't want to hear it. He said he did not want to be a mechanical lift transfer. The staff needed to be safe and consistent. Hospice and family had left him on the commode, and the			

facility staff had no choice but to lift him into bed.

During a follow up interview with Resident B, on 1/8/23 at 11:50 a.m., he indicated his last bowel movement was 1/31/23 and the last time he ate was 1/30/23. His family did not bring food in for him. He would have the same results, he would still have a bowel movement, whether he ate food from the facility or from his family. He had not used the lift since he had been at the facility. He wanted to keep his last bit of dignity, he wanted them to sit him on the commode and put him back in bed. All they needed to do was tell him he didn't have to use the lift and he would go back to eating. He was so afraid to use the lift.

During an interview with CNA 39, on 2/9/23 at 8:49 a.m., she indicated the resident had been refusing everything. They offered him a meal tray, but he wouldn't take it. She knew he had not eaten breakfast or lunch. They normally transferred him with one CNA holding the commode, and the other CNA would bear hug him. If you lifted him high enough, he would lock his legs and then pivot to the commode. She had no problems transferring him. He refused the bedpan, he indicated it was a dignity issue for him. The commode also got him out of bed and he was safe to sit on the commode by himself.

During an interview with CNA 31, 2/9/23 at 8:58 a.m., she indicated the resident transferred with two CNAs to the commode. He was scared of the lift. She had no problems with transferring him. She would straighten him up and he locked his legs backward and was able bear some weight. One CNA would bear hug him and other CNA would pull his pants down and they would place him on the commode. He did not want to be transferred with the lift, which was why he had

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	refused to eat. They had forced him to be a straight mechanical lift, and he was scared of it. He would rather use the commode than the bedpan. She did not have any problems with pivot transferring him, she actually preferred to transfer him that way. It also helped him stretch out because he was in the bed all day. During a follow up interview with the hospice CNA, on 2/9/23 at 9:10 a.m., she indicated the resident had not had any bowel movements for her lately. His last bowel movement was 1/30/23. Every time she was at the facility she got him up on the commode. He had not eaten at all and she could tell his body was weakening. A current, 1/19/18 revised, facility policy, titled "Transfers - Manual Gait Belt and Mechanical Lifts," provided by the Administrator, on 2/17/23 at 3:06 p.m., indicated the following: "Guidelines...5. The transferring needs of residents will be assessed on an ongoing basis and designated into one of the following categories...2 = 2 person transfer with gait belt (ONLY when use of mechanical lift is not possible).... This Federal tag relates to complaint IN00399248. 3.1-3(a)			
F 0600 SS=D 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 abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment,			

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	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 interview and record review, the facility failed to prevent staff to resident verbal abuse for 2 out of 3 residents reviewed for abuse. (Resident C and Resident E) Findings include: 1. The clinical record for Resident C was reviewed on 2/6/2023 at 11:00 a.m. Diagnoses included surgical amputation, type 1 diabetes with foot ulcer, psychoactive substance abuse, osteomyelitis, peripheral vascular disease and diabetic neuropathy. The resident was assessed as cognitively intact. a. Review of a facility reportable/investigation dated 1/24/2023, indicated Resident C alleged LPN 1 was verbally abusive. The facility substantiated the allegation and the employee was terminated from the facility. During an interview, on 2/6/2023 at 9:59 a.m., Resident C alleged mistreatment by LPN 1. The resident felt their blood sugar was low and requested it to be checked. LPN 1 refused to check the blood sugar and used inappropriate language in the refusal. b. Review of a facility reportable/investigation indicated on 1/25/2023, Resident C had a verbal altercation with a dietary staff member. The staff	F 0600	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **LPN 1 and Dietary aide 2 were both terminated at the conclusion of their investigations.** 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 and staff will be interviewed to identify any potential abuse. Any alleged abuse will be reported to IDOH and investigated III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **All staff will be educated on abuse and abuse reporting. The ED and RVPO will be reeducated on abuse, abuse reporting and professionalism by an outside**	03/02/2023

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	member used inappropriate language during the altercation. The allegation was substantiated and the employee was terminated from the facility. During an interview, on 2/6/2023 at 9:59 a.m., Resident C indicated during breakfast approximately 2-3 weeks ago, another resident (Resident F) was telling him his eggs were cold. Dietary Aide 2 entered the conversation and told Resident F his eggs were not cold. Resident C intervened, which resulted in a verbal altercation with the staff member. During an interview, on 2/6/2023 at a.m., Resident F indicated he had been talking to Resident C about having cold eggs. During the conversation, Dietary Aide 2 interrupted the conversation and told him his eggs were not cold. Resident C intervened and both parties had used inappropriate language. 2. The clinical record for Resident E was reviewed on 2/7/23 at 10:00 a.m. Diagnoses included hemiplegia and hemiparesis following cerebral infarction, dysphagia, depressive disorder. The resident was assessed as being moderately cognitively impaired. During an interview, on 2/7/2023 at 9:45 a.m., the Executive Director (ED) indicated in November 2022 she had been accused of using inappropriate language during a verbal altercation with Resident E. The ED was suspended for two days and the allegations were found to be unsubstantiated. The ED indicated Resident E had been caught smoking in the facility several times and had his smoking privileges revoked. The resident was attempting to participate in a scheduled smoke break with other residents. The ED indicated the resident was wearing a T-shirt and it was cold		**vendor.** 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; The administrator in training will interview 5 residents and 5 staff members weekly to ensure abuse is not occurring. **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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outside. The resident was ramming the door trying to get out. The ED told the resident he was not allowed to smoke and should return to his room. The resident became upset and started yelling and cursing at the ED while returning to the unit. The ED followed the resident and stopped at the nurse station while the resident continued to his room. The ED thought the resident was going to his room to get a coat and would try to go back out to smoke. The resident did not exit his room. Resident E was supposed to have discharged approximately three days prior to the altercation, but the family member had not picked him up. The facility decided to transport the resident to his family member's house and had discharged him from the facility. Staff members packed the resident's belongings and loaded them on the facility van and the ED and Activity Aide 3 transported the resident to a family members house. The incident was reported to the corporate office and the ED was suspended for two days during an investigation.

Review of a progress note, dated 11/23/2022 at 9:31 a.m., indicated the resident was spoken to about smoking in the facility. The resident denied smoking in the facility. The clinical record had no other documentation of Resident E being suspected of, or actual smoking, in the facility.

The clinical record had no documentation or care plan of resident displaying aggressive behaviors. The clinical record lacked a care plan for smoking for the resident.

During an interview, on 2/7/2023 at 11:46 a.m., LPN 4 indicated she witnessed Resident E and the ED exchange inappropriate words during an argument. Resident E was self-propelling in a wheelchair down the hall, and the ED was

following him. Resident E went to his room and the ED stopped at the nurse's station. The ED then went to the door of the resident's room and told him to pack his things- he was being discharged. LPN 4 indicated the ED used inappropriate language and tone. LPN 4 indicated she reported in incident to the corporate office because she felt the behavior of the ED was abusive and inappropriate. LPN 4 indicated she provided a written statement of the incident during the facility investigation.

During an interview, on 2/7/2023 at 1:26 p.m., CNA 5 indicated she witnessed a verbal altercation between Resident E and the ED. The CNA indicated over the prior weekend, Resident E had gotten into an argument with another resident and the ED was called. The ED took away the resident's smoking privileges. The morning in question, the resident attempted to participate in the scheduled smoke break and the ED stopped him. The resident returned to the unit and was screaming something over his shoulder. The ED was following the resident and was screaming at the resident. The ED followed the resident to his room and stood in the doorway. The ED yelled at him to "pack his s _ _ _" (inappropriate language). The ED said the resident was "out of here today and she was tired of his s _ _ _ "(inappropriate language). CNA 5 indicated the resident did not know they were being "kicked out". Staff packed up the resident's belongings while he was in the dining room. The ED and Activity Aide 3 had then transported the resident to a family member's home.

During an interview, on 2/7/2023 at 11:03 a.m., the Regional Vice President of Operations (RVPO) indicated they were informed of the incident via voice mail or email. The RVPO started an

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investigation on the following Monday (11/30/22). The RVPO indicated they had forgotten to bring the investigation documentation, but would provide it the next day.

During an interview, on 2/7/2023 at 9:54 a.m., Activity Aide 3 indicated Resident E had been attempting to participate in the scheduled smoke break. The ED had told the Activity Aide not to allow the resident to participate. The resident was upset and left the area and the ED followed him. The Activity Aide denied hearing the ED yell at or use inappropriate language with the resident.

During an interview, on 2/8/2023 at 10:08 a.m., the RVPO indicated the investigation documentation was not available. He had been unable to retrieve it. However, a summary was provided and indicated CNA 5 stated hearing the ED tell the resident to "pack your s _ _ _, call your family, you are out of here today." CNA 5 indicated the ED did not yell at the resident. The summary also indicated LPN 4 had witnessed the ED tell the resident to pack his "s _ _ _ _," he was gong home. LPN 4 indicated the ED did not yell at the resident. The incident was not reported because he did not feel it was abuse. No further information was provided.

During a phone interview, on 2/8/23 at 6:16 p.m., Resident E's sister indicated the facility had called her and told her the resident needed to be removed from the facility. She was told there was no where to go and he would go to a homeless shelter the day before Thanksgiving. The facility wanted him out of there and were going to put in referrals. She asked them to try the Muncie area. A half- hour later, they said he needed picked up, or he was going to a homeless shelter. On 11/28/22, Resident E called and stated the ED had

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him in the van to drop him off. This was the first she knew of him discharging from the facility. He had been eating dinner when they came and got him. He went to Missouri for a week, came back and was now in another facility. During this interview, the resident was present and indicated the facility tried to say he was smoking in his room, which he denied. They had taken his smoking away, then gave it back. He had been sitting there waiting to go smoke, when the ED told him he couldn't go smoke. The resident and the ED were cussing each other out the day before discharge. The ED called him a little b_ _ _ _ _d. The ED told him that she was gonna take him to the homeless shelter almost everyday over three to four days. While he was eating dinner, some girl carrying his coat and phone, came and got him. They had packed up his stuff and loaded it in the van before he got back to his room.

During an interview, on 2/9/2023 at 11:17 a.m., the Social Service Director (SSD) indicated she was not aware of the resident having any other behaviors, such as smoking in the facility, prior to 11/28/22.

Review of a current policy, dated 11/28/1016, titled "Abuse Prevention and reporting - Indiana" and provided by the facility during the Entrance Conference on 2/6/23 at 9:30 a.m., indicated the following: "...Guidelines: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. ....Definitions: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental,

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and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology...."

Review of the definitions in the "State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities", dated 10/21/2022, indicated the following: "...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:
· Harassing a resident;
· Mocking, insulting, ridiculing;
· Yelling or hovering over a resident, with the intent to intimidate;
· Threatening residents, including but limited to, depriving a resident of care or withholding a resident from contact with family and friends; and
· Isolating a resident from social interaction or activities...."

This federal tag relates to Complaints IN00400281 and IN00400191.

3.1-27(b)

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F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(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 record review and interview the facility failed to ensure allegations of abuse were reported to the appropriate State agency in a timely manner for 1 of 3 residents reviewed for abuse. (Resident E) Findings include:	F 0609	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident E no longer resides in the facility. The alleged incident regarding**	03/02/2023

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The clinical record for Resident E was reviewed on 2/7/2023 at 10:00 a.m. Diagnoses included hemiplegia and hemiparesis following cerebral infarction, dysphagia, depressive disorder. The resident was assessed as being moderately cognitively impaired.

During an interview, on 2/7/2023 at 11:03 a.m., the Regional Vice President of Operations (RVPO) indicated he received a report of an incident on 11/28/22. The allegation involved the mistreatment and probable verbal abuse by the Executive Director (ED) towards Resident E. The ED was suspended pending investigation. The incident was not reported to the State Agency because he did not feel the incident was abuse.

The RVPO was unable to provide the facility investigation for review. However, the RVPO provided a summary of the investigation. The summary indicated the ED was suspended immediately. The RVPO arrived to the facility on 11/30/22 to conduct an investigation of the incident. LPN 4 and CNA (Certified Nurse Assistant) 5 indicated they witnessed the incident between the ED and Resident E. The summary indicated neither LPN 4 nor CNA 5 witnessed the ED speaking to the resident in a raised voice, but had observed the ED tell the resident to pack his s _ _ _, he was going home.

Review of a current facility policy, dated 11/28/16, titled "Abuse Prevention and reporting-Indiana" and provided by the facility during the Entrance Conference on 2/6/23 at 9:30 a.m., indicated the following: ".... Timing of Reporting: All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,

resident E was thoroughly investigated.

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 and staff will be interviewed to identify any potential abuse. Any alleged abuse will be reported to IDOH and investigated

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 ED and RVPO will be reeducated on abuse and abuse reporting by an outside vendor.

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;

The administrator in training will review all grievances and reported alleged abuse incidents weekly as well as interview 5 residents and 5 staff members weekly to ensure all alleged abuse is being reported timely. The results of these audits will be reviewed in Quality Assurance

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	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 no 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 serves where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. The facility will follow the ISDH Incident Reporting Policy criteria...." This federal tag relates to Complaint IN00400281. 3.1-28(c)		**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.**	
F 0622 SS=G 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			

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	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 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			

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	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 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 record review and interview, the facility failed to provide adequate education and preparation prior to discharge. This deficient practice resulted in the resident (Resident E) being discharged to a location unprepared for his arrival, and consequently being moved out of state temporarily, while appropriate placement was sought. Using the reasonable person concept, this alleged deficient practice would cause prolonged anxiety and fear. Findings include: The clinical record for Resident E was reviewed on	F 0622	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident E is currently at a safe location** 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 discharges from the last 30 days were reviewed to**	03/02/2023

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	2/7/23 at 10:00 a.m. Diagnoses included hemiplegia and hemiparesis following cerebral infarction, dysphagia, depressive disorder. The resident was assessed as being moderately cognitively impaired. Review of a progress noted, dated 11/23/22 at 9:31 a.m., indicated the resident was spoken to about smoking in the facility. He denied smoking in the facility. The clinical record had no other documentation of Resident E being suspected of, or actual smoking, in the facility. There was no record of, or care plan for, the resident displaying aggressive behaviors. The clinical record lacked a care plan for smoking for the resident. Review of a Social Service progress note, dated 11/28/22 at 12:30 p.m., indicated the Social Service Director (SSD) informed the family of Resident E about his discharge the same day. The resident had been discharged from therapy. They were also notified the resident had cursed at the administrator several times the same day. The resident's family indicated the resident was exhibiting behaviors because he wanted to leave and come home. The SSD indicated the resident had not displayed this type of behavior before. "He was overall very pleasant and calm to me." The SSD indicated the resident's behavior that day was very different from his normal. During an interview, on 2/7/23 at 9:45 a.m., the Executive Director (ED) indicated Resident E was supposed to have discharged on 11/25/22 to a family member's home. The family member did not		**ensure the transfer discharge requirements were met. All discharges in the last 30 days met the transfer discharge requirements** 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 will be in-service on transfer discharge requirements by The corporate social services consultant. The nurses will be in-service on the transfer discharge requirements. 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 all discharges weekly to ensure all transfer and discharge requirements are met.** **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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pick the resident up, and he had remained in the facility until 11/28/22. On 11/28/23, the ED and the resident had a verbal exchange related to the resident's smoking privileges. The exchange became heated and verbal abuse was alleged. The ED informed the resident to pack his belongings, he would be discharged, and the facility would provide transportation to the resident's home in the facility van. The ED instructed staff to pack the resident's belongings. The ED and Activity Aide 3 then transported the resident to a family member's home, via the facility van.

During an interview, on 2/8/23 at 12:00 p.m., Resident E's family member indicated he had been speaking with the ED about Resident E's upcoming discharge. He had come home after work on 11/25/22 to discuss the discharge. He was unable to get off work when expected, and had been unable to come to the facility as planned. He had been waiting for information about home health, and education on how to care for Resident E. He had questions about his home being ready for Resident E such as bathroom set up for shower support, railings for level changes, etc. No home evaluation was performed. On 11/28/23, while he was at work, he received a phone call from another family member, telling him the resident had called her and stated he was in the facility van on his way to his house. He had to leave work in an attempt to arrive before the facility van. He called the police to complain about the facility just dropping the resident off without proper notification and preparation. Had his other family member not called him, he would not have been able to be there when the van arrived. The police arrived, determined it was a civil matter, and left the area before the facility van arrived. The resident had to be taken out of state to the home of another family member while family

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	attempted to find in-state nursing home placement. During a phone interview, on 2/8/23 at 6:16 p.m., Resident E's sister indicated the facility had called her and told her the resident needed to be removed from the facility. She was told there was nowhere to go and he would go to a homeless shelter the day before Thanksgiving. The facility wanted him out of there and were going to put in referrals. She asked them to try the Muncie area. A half-hour later, they said he needed picked up, or he was going to a homeless shelter. On 11/28/22, Resident E called and stated the ED had him in the van to drop him off. This was the first she knew of him discharging from the facility. He had been eating dinner when they came and got him. He went to Missouri for a week, came back and was now in another facility. During this interview, the resident was present and indicated the facility tried to say he was smoking in his room, which he denied. They had taken his smoking away, then gave it back. He had been sitting there waiting to go smoke, when the ED told him he couldn't go smoke. He felt he was being picked on. The resident and the ED were cussing each other out the day before discharge. The ED called him a little b_ _ _ _ _d. The ED told him that she was gonna take him to the homeless shelter almost every day over three to four days. While he was eating dinner, some girl carrying his coat and phone, came and got him. They had packed up his stuff and loaded it in the van before he got back to his room. He didn't feel he was treated fairly by the facility. During an interview, on 2/9/23 at 8:38 a.m., PTA 7 indicated she could find no documentation of a home evaluation being done for Resident E. Home evaluations were usually done prior to			

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	discharge. PTA 7 called the Therapy Director and indicated no home evaluation had been billed for Resident E. Review of the physical therapy and occupational therapy discharge notes indicated the therapy department believed the resident to be remaining in the facility. PTA 7 indicated she remembered the resident's facility discharge being sudden. He had been discharged from physical therapy on 11/23/22, and occupational therapy on 11/15/22. Review of a current policy, dated 3/22/17, titled "Notice of Transfer and Discharge" and provided by the ED on 2/9/23 at 9:48 a.m., indicated the following: "...Guidelines: Prior to discharge or transfer, the facility will: Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. ...." No further information was provided prior to exit. This federal tag relates to Complaint IN00400281. 3.1-12 (a) (21) 3.1-12 (a) (22)			
F 0646 SS=D Bldg. 00	483.20(k)(4) MD/ID Significant Change Notification §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. Based on observation, interview and record review, the facility failed to notify the physician when blood sugars were above parameters and	F 0646	I. What corrective action(s) will be accomplished for those residents found to have been	03/02/2023

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notify the physician when a resident refused or had missed doses of medications (Resident C and Resident B).

Findings include:

1. Resident C's clinical record was reviewed on 2/6/23 at 11:00 a.m. Diagnoses included type 1 diabetes mellitus with foot ulcer, type 1 diabetes mellitus with hyperglycemia and diabetic neuropathy.

An Admission MDS (Minimum Data Set), dated 12/15/22, indicated he was cognitively intact.

His January MAR (Medication Administration Record) indicated the following:

a. Insulin aspart (insulin) inject per sliding scale: if his blood sugar was 150 - 200 give 2 units; 201 - 250 give 4 units; 251 - 300 give 6 units; 301 - 350 give 8 units; 351 - 400 give 10 units, subcutaneously before meals and at bedtime. If above 401, call the MD/NP (Medical Doctor/Nurse Practitioner).

The resident's blood sugar readings were above parameters, and the clinical record lacked physician notification, for the following:

On 1/7/23 at 4:30 p.m., his blood sugar was 517 and at 9:30 p.m., it was 522. A separate order indicated he received 15 units of insulin one time only for hyperglycemia at 9:18 p.m.

b. Insulin aspart (insulin) inject per sliding scale: if his blood sugar was 151 - 200 give 2 units; 201 - 250 give 4 units ; 251 - 300 give 5 units; 301 - 350 give 6 units; over 351 give 7 units. Notify the MD if his blood sugar was over 351 or below 60.

affected by the deficient practice; **Resident B and C were assessed, and MD notified of blood sugars found out of parameters.**

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 charts will be audited for the last 30 days any unnotified change of conditions in the last 30 days. If any are found the resident will be assessed and the MD notified.**

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 nursing staff was inserviced on change of condition physician notification requirements and process.**

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; **The DON or designee will review the 24 hour report Tuesday-Friday and the 72 hour report on Monday during the clinical meeting for any change of condition and verify**

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	Complete a progress note. The order also indicated subcutaneously before meals for diabetes and to notify MD if blood sugars were above 400 or below 60. The resident's blood sugar readings were above parameters, and the clinical record lacked physician notification, for the following: On 1/14/23 at 5:00 p.m., his blood sugar was 517. A separate order indicated he received 12 units one time only for increased blood glucose. On 1/19/23 at 5:00 p.m., his blood sugar was 393. He received seven units of insulin. On 1/21/23 at 7:30 a.m., his blood sugar was 359 and at 5:00 p.m. it was 351. He received seven units of insulin. On 1/24/23 at 12:00 p.m., his blood sugar was 382. He received seven units of insulin. On 1/25/23 at 7:30 a.m., his blood sugar was 388 and at 12:00 p.m. it was 397. He had received seven units of insulin for each reading. . On 1/26/23 at 7:30 a.m., his blood sugar was 405. He received seven units of insulin. On 1/30/23 at 5:00 p.m., his blood sugar was 361. He received seven units of insulin. c. Insulin glargine (insulin) inject 25 units subcutaneously at bedtime for diabetes mellitus. Notify the MD if his blood sugar was below 60 or above 351 and complete a progress note. The resident's blood sugar readings were above parameters, and the clinical record lacked		**the md was notified. 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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physician notification, for the following:

On 1/22/23, his blood sugar was 392.

On 1/25/23, his blood sugar was 565.

On 1/30/23, his blood sugar was 399.

2. Resident B's clinical record was reviewed on 2/6/23 at 11:04 a.m. Diagnoses included amyotrophic lateral sclerosis (ALS), anxiety disorder, peripheral vascular disease, hereditary and idiopathic neuropathy and neuralgia and neuritis.

A quarterly MDS (Minimum Data Set), dated 11/25/22, indicated he was cognitively intact.

Review of his January MAR indicated the following:

a. A physician order for hydrocodone-acetaminophen 10-25 mg (milligram) (for pain) every four hours at 8:00 a.m. The MAR indicated to see progress notes for the following dates: 1/4/23, 1/5/23, 1/11/23, and 1/18/23. The clinical record lacked progress notes for these dates.

There was no documentation the medication was given at 4:00 a.m. on 1/8/23 and 1/23/23. On 1/25/23, 1/26/23, 1/27/23 and 1/30/23 at 8:00 a.m., the MAR indicated he had refused his medications.

b. A physician order for lorazepam 0.5 mg (for anxiety) every four hours at 8:00 a.m. The MAR indicated to see progress notes for the following dates: 1/4/23, 1/5/23, 1/11/23, and 1/18/23. The clinical record lacked progress notes for these

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dates. There was no documentation the medication was given at 4:00 a.m. on 1/8/23 and 1/23/23. On 1/12/23, 1/25/23, 1/26/23, 1/27/23 and 1/30/23 at 8:00 a.m., the MAR indicated he refused his medications.

During an interview with the DON and ADON, on 1/8/23 at 9:14 a.m., the DON indicated the nurses should put in a progress note if they document in the MAR to see progress notes, or if the resident refused their medications. The ADON indicated it was so easy, a screen pops up when you hit see progress notes and they can type it right there. The DON indicated if the resident was long term, they could communicate with the NP by the communication book, call, or text. Resident B constantly refused his medications and the NP was aware. LPN 5 just would not leave his medications at his bedside, that was why the MAR indicated he either refused or to see progress notes. They had completed education to other nurses for leaving his medication at the bedside. If the resident refused their medications, the system would bring it to their attention when they ran a 24 hour report and then they would address it. If the blood sugars were below or over the parameter, the nurse should contact the MD and then make a nurses note. If the blood sugar was low, they needed to document what they did and recheck the blood sugar. If it was over the parameter, they needed to call the MD and make a nurses note if they needed to give extra insulin.

A current, 11/13/18 revised facility policy, titled "Physician - Family Notification - Change in Condition," provided by the Administrator on 2/7/23 at 2:35 p.m., indicated the following: "Purpose: To ensure that medical care problems are communicated to the attending physician or authorized designee...in a timely, efficient, and

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	effective manner...." A current, undated facility policy, titled "MEDICATION AND TREATMENT REFUSAL," provided by the AIT on 2/7/23 at 3:20 p.m., indicated the following: "...PROCEDURE: 1. Should a resident refuse his or her medication...documentation must be recorded concerning the situation. 2. Documentation pertaining to a resident's refusal will include as a minimum...c. The resident's response and reason(s) for refusal...f. The date and time that the physician was notified as well as the physician's response: If resident continually refuses medication...i.e. two (2) or more consecutive times for three (3) days, Administrator and the attending physician notified...." A current, 1/1/15 revised facility policy, titled "MEDICATION PASS: PROCESS AND PROCEDURE," provided by the AIT on 2/7/23 at 3:22 p.m., indicated the following: "...Documentation...if a medication is not administered, then the licensed nurse will...a. Enter the initials in medication space allocated for the medication. b. Circle initials indicating that the medication was not given. c. Provide written rationale why the medication was not given or refused in the designated area on the MAR. d. Notify the physician when indicated...." This Federal tag relates to complaint IN00399248.			
F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-			

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	(i) Meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure medications were set up and administered by the same nurse and documentation was completed when a resident refused their medication or it was documented to see progress notes for 1 of 2 residents reviewed for medication administration (Resident B). Findings include: Resident B's clinical record was reviewed on 2/6/23 at 11:04 a.m. Diagnoses included amyotrophic lateral sclerosis (ALS), anxiety disorder, peripheral vascular disease, hereditary and idiopathic neuropathy, neuralgia and neuritis, foot drop, unspecified foot, and other abnormalities of gait and mobility. A quarterly MDS (Minimum Data Set), dated 11/25/22, indicated he was cognitively intact. A grievance/complaint resolution report, dated 1/12/23 in the a.m., indicated on 1/12/23 at 11:00 a.m., LPN 5 gave Resident B's medications to the hospice nurse and there were only half of the ordered medications in the cup. Two CNAs reported to LPN 5 right away all his medications were not there, but LPN 5 did not bring his medications back down. Two hours later, the resident's family member went to talk to the ADON. The ADON then went to his room and the resident explained the situation. She indicated she would take care of it and an hour had passed. His family member approached the ADON again and was again told she would take care of it. The resident finally received his pain pill and lorazepam at 3:30 p.m. from a nurse he had not met before. He explained the situation to her about	F 0658	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **resident B was assessed and MD was notified of missed, refused or uncharted medications.** 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 MAR's and progress notes ,when applicable, will be audited for the last 30 days to ensure proper medication pass documentation and MD notification when applicable.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **All nurses will be inserviced on medication pass policy and procedure.** 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; **All MAR's and progress**	03/02/2023

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	how he did not get all of his morning medications. She indicated there was nothing she could do about it, but would talk to the DON. He received his medications at 7:30 p.m. He was worried about not getting his medications, most importantly his blood thinners, with the risk of missing a dose. The Administrator signed the grievance on 1/14/23 and indicated by the time he wanted to take his medication, he indicated he was short a pill, but by then, it was time for the next med pass. He had been missing a pill, however, two different nurses had set up the pills for him. One of the pills went into the trash and the housekeeper had picked up the trash for disposal. He was reminded they could not double up on missed pills and it was charted he had refused his blood thinner for the morning. He and his family were re-educated on not being able to leave medications at bedside and they could not hold medications to double up on them at at later med pass. Resident B's January MAR indicated the following: a. Hydrocodone-acetaminophen (pain reliever)10-25 mg (milligram) every four hours at 8:00 a.m. was documented as see progress notes for the following dates 1/4/23, 1/5/23, 1/11/23, 1/18/23. There was no documentation for the medication at 4:00 a.m. on 1/8/23 and 1/23/23. On 1/25/23, 1/26/23, 1/27/23 and 1/30/23 at 8:00 a.m., the documentation indicated he refused his medications. b. Lorazepam (treat anxiety) 0.5 mg every four hours at 8:00 a.m. was documented as see progress notes for the following dates 1/4/23, 1/5/23, 1/11/23, 1/18/23. There was no documentation for the medication at 4:00 a.m. on 1/8/23 and 1/23/23. On 1/12/23, 1/25/23, 1/26/23,		**notes, when applicable, will be audited 5x a week x 4 weeks then 3x a week x 4 weeks and then weekly to ensure proper medication pass documentation** **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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1/27/23 and 1/30/23 at 8:00 a.m., the documentation indicated he refused his medications.

During an interview with LPN 5, on 2/7/23 at 11:47 a.m., she indicated Resident B had told her not to wake him up to give him his medications. He would let her know when he wanted them. She could not give him his medications late and she would not leave his medications on his table, as it was not an acceptable practice. His family was upset he did not get his medications and she wanted him to get what he wanted when he wanted it. The ADON stepped into the conversation and indicated they had changed his blood thinners to the evening when he was awake so he would not miss them. She took out his medications while the hospice nurse was standing there and the hospice nurse took the lorazepam and hydrocodone-acetaminophen to him. She was told the hospice nurse could do that. The hospice nurse had taken the medication down to him, and he had told her he dropped one pill and the other was still in the cup. The ADON went to his room and came out with his pain pill in the cup. The lorazepam had been allegedly dropped in the garbage.

During an interview with the hospice nurse, on 2/7/23 at 11:19 a.m., she indicated LPN 5 did not go with her when she had taken the two pills to him.

A current, 1/1/15 revised facility policy, titled "MEDICATION ADMINISTRATION POLICY," provided by the AIT (Administrator in Training) on 2/7/23 at 3:22 p.m., indicated the following: "...POLICY 1. LEVEL OF RESPONSIBILITY...Medications shall always be prepared, administered, and recorded by the same

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	licensed nurse...." A current, 1/1/15 revised facility policy, titled "MEDICATION PASS: PROCESS AND PROCEDURE," provided by the AIT on 2/7/23 at 3:22 p.m., indicated the following: "...Documentation...if a medication is not administered, then the licensed nurse will...a. Enter the initials in medication space allocated for the medication. b. Circle initials indicating that the medication was not given. c. Provide written rationale why the medication was not given or refused in the designated area on the MAR. d. Notify the physician when indicated...." A current, undated facility policy, titled "MEDICATION AND TREATMENT REFUSAL," provided by the AIT on 2/7/23 at 3:20 p.m., indicated the following: "...PROCEDURE: 1. Should a resident refuse his or her medication...documentation must be recorded concerning the situation. 2. Documentation pertaining to a resident's refusal will include as a minimum...c. The resident's response and reason(s) for refusal...f. The date and time that the physician was notified as well as the physician's response: If resident continually refuses medication...i.e. two (2) or more consecutive times for three (3) days, Administrator and the attending physician notified...." This Federal tag relates to complaint IN00399248. 3.1-35(g)(1)			
F 0732 SS=B Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily			

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	basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation and interview, the facility failed to update the nurse staffing data for six days. Finding includes:	F 0732	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	03/02/2023

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	During entrance to the facility, on 2/6/23 at 9:25 a.m., the facility Daily Nursing Staffing form was posted in a clear sleeved frame on the front desk. The form was dated 1/31/23. During an interview with the DON, on 2/6/23 at 9:42 a.m., she indicated the QMA/scheduler had been off sick and would normally replace the form daily. The DON would be responsible for updating them when the QMA/scheduler was off. During an interview with the Administrator, on 1/7/23 at 3:07 p.m., she indicated they did not have a policy for the staff posting and they would follow the state/federal regulations.		**no residents were affected by this 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 this alleged deficient practice.** 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 scheduler and DON will be inserviced on the requirements for posting daily nurse staffing information.** 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; **The administrator or designee will audit the daily staffing posting Monday-Friday and the weekend manager will audit it on Saturday and Sunday to ensure updated and accurately listings are posted. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or**	

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			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.	