STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF EAST FISHERS	12950 TALBLICK STREET FISHERS, IN 46037

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00419078, IN00417996, IN00418354 and IN00417289. Complaint IN00419078 - State deficiencies related to the allegations are cited at R036, R052, R091, and R241. Complaint IN00417996 - State deficiencies related to the allegations are cited at R006, R217 and R241. Complaint IN00418354 - State deficiencies related to the allegations are cited at R036, R052, R091, and R241. Complaint IN00417289 - State deficiencies related to the allegations are cited at R217. Survey date: October 4, 5, and 6, 2023 Facility number: 013945 Residential Census: 69 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 12, 2023	R 0000	Plan of Correction for Independence Village Fishers East. R000 Initial Comments. Preparation of execution of this Plan of Correction does not constitute admission or agreement of provider of the truth set forth on the Statement of Deficiencies. The Plan of Correction is prepared and execute solely because it is required by the position of Federal and State Law. The plan of Correction is submitted to respond to the allegation of non-compliance cited during the Annual Survey which included Complaint Survey completed October 6, 2023. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0006 Bldg. 00	410 IAC 16.2-5-0.5(f)(1-5) Scope of Residential Care - Deficiency (f) The resident must be discharged if the resident: (1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or			

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

Richard Robison | Executive Director | 11/08/2023

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	comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring.			
	Based on record review and interview, the facility failed to timely discharge a resident who was no longer suitable for an assisted living facility for 1 of 3 residents reviewed for falls. (Resident D) Findings include: The clinical record for Resident D was reviewed on October 4, 2023. Resident D's diagnoses included, but not limited to, major depressive disorder, nocturia (frequent urination at night), and sleep disorder. A Pre-Admission Level of Care evaluation dated 1/27/23 for Resident D indicated: he transfers independently; does not require staff assistance to transfer; does not require assistance at meal time to open packets, set up, or cut foods; independent with grooming and dressing; required staff assistance and physical assistance of 1 person for bathing; independent on getting to bathroom and required no assistance with incontinent care; and was independent with	R 0006	1. One resident was affected by the alleged deficient practice. 2. The community realizes that all residents have the potential to be affected by the alleged deficient practice 3. Resident sited in this rule was discharged to a higher level of care. 4. Resident Service Plans, Falls, & Interventions will be audited by 11/06/23 by the Wellness Director to ensure residents are within scope for Assisted Living. 5. Wellness Director will Implement Fall & Intervention Tracker & review weekly with the Executive Director to ensure residents remain within in scope for Assisted Living. This practice will be on-going. All findings will be reported to the Wellness Committee (QAPI) for review and	11/05/2023

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	cognitive and psychosocial function; and did not require companion care. The evaluation indicated, Resident D was a Level 1 which means the resident requires a low level of care and need occasional help with their ADLs (activities of daily living). Resident D's brief cognitive rating, completed on 10/2/23, indicated, he had moderate to severe cognitive decline. Resident D's fall risk assessments, completed on 8/20/23, 9/9/23, 9/10/23, 9/21/23, 9/22/23, and 10/2/23, indicated, he was at a high risk for falling. A Wellness Evaluation for Resident D was completed on 2/8/23 and indicated, he required mobility/escort services related to a history of falls if unassisted with ambulation; escort to/from meals and community programs; was independent with transferring and was able to get in and out of bed, chair, car, etc without assistance; and was independent in toileting and able to get to and from toilet. A Wellness Evaluation for Resident D was completed on 7/26/23 and indicated, he was independent with ambulation; did not need escort within the facility to meals, activities, or internal events; could transfer independently, did not require staff assistance to transfer and has fallen in the last 3 months; and required staff attention or physical assistance with bathing. A Fall Service Plan for Resident D created on 2/8/23 and revised on 7/26/23 indicated, he was to remain free from injury and was encouraged to call for assistance when needed. Interventions included, but not limited to: 2/15/23- Post fall: Environment: Safety education		further recommendations as needed.	

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	on clutter and furniture usage 2/21/23- Therapy referral for unsteady gait/ambulation 8/15/23- Position wheelchair next to resident and verify brakes are locked 8/22/23- Recommendations for increase family involvement or 1:1 (one on one) companion for resident at night 9/8/23- Remind/educate resident on importance of locking wheelchair brakes prior to transfers 9/11/23- Family advised resident requires 1:1 (one on one) companion for 8 to 12 hours during night shift for safety 9/12/23- Safety checks for falls- check on resident every 1 hour for safety. 9/17/23- Encourage proper assistive devices, discourage resident from transferring into chairs in common areas 9/21/23- Educate resident on use of emergency call system 9/22/23- Encourage slow changes in position; remind to call for assistance A Transferring Service Plan for Resident D created on 2/8/23 and revised on 9/28/23 indicated, he required weight bearing assistance to get in and out of bed, chair, car, etc. A mobility Service Plan created on 2/8/23 and revised on 9/28/23 indicated, Resident D can not ambulate with walker without guidance and assistance, has a history of falls if ambulating unassisted, and requires an escort to/from activities and/or dining room. A Dressing/Undressing Service Plan last revised on 9/28/23 indicated, Resident D required physical assistance with dressing. A Toileting Service plan revised on 9/28/23			

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	indicated, Resident D required help to navigate clothing after toileting, needs regular or frequent assistance to/from bathroom. A Cognition Service plan dated 9/28/23 indicated, Resident D required reminders for activities, reminders for meals, demonstrated inappropriate judgement related to safety, displayed deficits in judgement, and required safety checks every hour. A review of Resident D's progress notes was completed on 10/5/23. The progress notes indicated, Resident D had fallen approximately 39 times since his admission on 2/8/23. The following progress notes indicated on the following dates/times, Resident D had fallen and the interventions put in place after the fall, if any: * 2/12/23 at 6:11 a.m. - Resident attempting to self transfer from recliner to wheelchair lost balance and fell. Staff found resident lying on the floor. Intervention placed was to remind the resident to call for assistance prior to transferring. * 2/15/23 at 4:44 a.m. - Resident was found sitting on floor in front of recliner. He had slipped on a blanket when attempting to get up. Intervention placed was safety education on clutter and furniture usage. * 2/20/23 at 9:26 a.m. - Resident had an unwitnessed fall resulting in "significant bleeding and laceration to left eyebrow. He was transferred to local emergency room where he received sutures above his left eyebrow, and was found to have a closed nasal fracture and a subdural hemorrhage (brain bleed). An intervention placed on 2/21/23 indicated for community physical therapy services. * 3/7/23 at 11:27 p.m. - Resident fell and got himself up. He forgot to place brakes in lock position on his wheel chair. Resident D was			

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	transferred to local ED (emergency department) where he received sutures for a laceration to his forehead (right between his eyebrows). An intervention placed as a result of this fall was to educate/remind the resident to lock the brakes on his wheelchair prior to getting up or getting in the wheelchair. * 3/31/23 at 2:12 a.m. - Resident had an unwitnessed fall from trying to go to the bathroom. He was found on the floor in front of the recliner. Resident was reminded to lock wheelchair brakes prior to attempting to transfer. * 4/3/23 at 9:40 p.m. - Resident found on floor between his recliner and wheelchair. Resident D had a reddened area to left side of his face and his blood pressure was elevated. No new interventions noted. *4/7/23 at 10:42 p.m. - Resident had an unwitnessed fall from wheelchair. Intervention placed after fall was to remind Resident D to call for assistance prior to transferring from/to wheelchair. * 4/24/23 at 8:23 p.m. - Resident found on floor, sitting against recliner and his tray table was on the floor next to him. Resident D indicated, he was trying to get up from recliner to the wheelchair and tried to steady himself using the tray table. No new intervention noted. * 5/5/23 at 7:03 p.m. - Resident had an unwitnessed fall and was found lying in a supine position in front of his recliner. Resident indicated, he fell trying to transfer into recliner. No new intervention noted. * 5/18/23 at 6:59 p.m. - A visitor informed staff of Resident D found on floor. When staff arrived, Resident D was found to have a laceration to his forehead. Intervention put in place was to call staff prior to attempting to transfer(as previously care planned) and advised visitor to notify staff prior to assisting resident off the floor.			

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	* 5/21/23 at 12:49 a.m. - Resident had an unwitnessed fall. No new interventions noted. * 6/1/23 at 7:10 p.m. - QMA (Qualified Medication Assistant) reported the Executive Director witnessed Resident D fall and get himself back up. Action/Intervention was to encourage to call for assistance (previously in place related to a previous fall) * 6/8/23 at 3:07 p.m. - Resident D had an unwitnessed fall at 12:40 p.m. that day. Action/Intervention noted was to remind resident to ask for assistance with transfers (previously in place related to another fall). * 6/9/23 at 3:07 p.m. - Resident noted to have an unwitnessed fall earlier in shift. Intervention placed was to received a urine culture and sensitivity and to monitor Resident D's blood pressure for 7 days. * 6/11/23 at 2:30 p.m. - A QMA called stating Resident D had an unwitnessed fall trying to transfer himself to the couch. Intervention placed was an incident report was created. * 6/14/23 at 4:08 a.m. - Resident D had an unwitnessed fall at 3:50 a.m. of the same day. Resident D was yelling and combative with staff. Interventions/Action indicated to encourage to call for assistance and close post fall monitoring for safety/changes. * 6/19/23 at 11:18 p.m. - Resident D had an unwitnessed fall. Interventions/Actions were to encourage to call for assistance with transfers and close monitoring. * 7/7/23 at 2:43 p.m. - Resident D had an unwitnessed fall. Intervention was to request primary care physician and pharmacy to review medications. * 7/19/23 at 11:04 p.m. - Resident D had an unwitnessed fall. Resident was yelling and being combative with staff. Intervention was to do post fall monitoring for safety/changes.			

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	* 7/30/23 at 4:34 a.m. - Resident D had an unwitnessed fall. No interventions noted. * 8/3/23 at 11:04 p.m. - Resident D had an unwitnessed fall. No interventions noted. * 8/5/23 at 11:03 p.m. - Resident D had an unwitnessed fall in bathroom after trying to pick up an item from the floor and fell out of wheelchair. Interventions placed were to encourage to call for assistance with items on the floor and close post fall monitoring. * 8/9/23 at 3:43 a.m. - Resident D had an unwitnessed fall and was found lying on right side. Interventions were to encourage to call for assistance, encourage staff to offer assistance and anticipate needs as well as close post fall monitoring. * 8/12/23 at 11:22 p.m. - Resident D had an unwitnessed fall in his bathroom. He was not wearing shoes at the time he was found on the floor. Intervention put in place was to place slip resistant socks on the resident. * 8/12/23 at 9:47 p.m. - Resident D had an unwitnessed fall. No new interventions placed. * 8/15/23 at 9:47 p.m. - Resident D had an unwitnessed fall attempting to transfer from bed to chair. Interventions placed were encourage frequent monitoring related to frequent falls, resident was uncooperative for calling for assistance with transfers. * 8/16/23 at 7:50 a.m. - Resident D fell twice last night. He seems confused and complaining of back hurting. On 8/17/23 resident was sent to local ED related to the fall, increased agitation and restiveness. Resident D had a swollen right eye and a bump on the right side of his head. * 8/19/23 at 4:38 p.m. - Resident D had an unwitnessed fall after attempting to transfer himself in the activity room. He landed on his left side and appeared to be at his baseline. * 8/27/23 at 9:17 p.m. - Resident D sustained a fall			

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	from his wheelchair when he did not keep his feet elevated as a CNA (Certified Nursing Assistant) wheeled him down the hall. Intervention placed was for resident to keep feet off floor or utilize foot pedals while being escorted by staff. * 9/8/23 at 6:03 p.m. - Resident sustained a fall after trying to transfer himself into his wheelchair. He had not locked the brakes and the wheelchair rolled backwards and he fell to the floor. No intervention was noted. * 9/8/23 at 9:45 p.m. - Resident D had an unwitnessed fall in his bathroom. He sustained a laceration to his forehead, near his left eye. He was sent to the local ED for evaluation and treatment. He later returned to the facility with a fractured left arm. * 9/9/23 at 8:35 p.m. - Resident D had an unwitnessed fall after trying to transfer self from recliner to wheelchair. No new intervention noted. * 9/10/23 at 6:17 a.m. - Resident heard yelling out and staff found Resident D on the floor in front of his recliner and lying on his side. Staff reported uncontrolled bleeding from left side of heat at hairline and above left eye. 911 was called related to uncontrolled bleeding and frequency of falls with decreased safety awareness. Intervention was a discussion with resident's daughter regarding further interventions to maintain safety. Resident's daughter stated she would look into 1 on 1 assistance at night. * 9/17/23 at 6:57 p.m. - Resident D had an unwitnessed fall. Intervention Resident D's daughter wanted was to remove resident's wheelchair from his sight after being transferred to a chair or bed so that he has to use his pendant to ask for assistance. * 9/21/23 at 9:51 a.m. - Resident D had an unwitnessed fall in the Bistro area. He sustained a large skin tear to left outer forearm. No new intervention noted.			

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	* 9/22/23 at 2:05 p.m. - Resident D fell again self-transferring. "Angry that staff unable to get him up. Instructed QMA to call triage nurse and 911 [sic, for] lift assist d/t[due to] resident heavy et[and] resistive to care at this time. 2 female residents were attempting to help him up et[sic] he would have pulled them onto the floor had the cna not been there to catch them". No new intervention noted. A triage nurse note dated the same day indicated, she instructed staff to engage the resident with an activity, a book, puzzle, fidget blanket, something to occupy him and to remove his wheelchair from sight. * 9/25/23 at 1:03 p.m. - Resident D had an unwitnessed fall. He had been incontinent of stool and slipped and fell. He sustained a laceration to his posterior head. A Physician's note dated 7/19/23 at 1:40 p.m. indicated, the visit plan was skilled nursing, physical therapy and occupational therapy ordered via task to Case Manager. The note further indicated, Resident D's dementia was progressing, moderate episode of recurrent major depressive disorder was progressing and to continue working with patient, daughter and staff to coordinate care. A Physician's note dated 9/13/23 at 6:51 a.m. indicated, Resident D has had multiple falls over the past couple days that resulted in a laceration to the left side of this scalp. He was sent out the the emergency room where he was found to have a fracture in his left forearm. Nurse reports that patient has issues mostly at night and tries to get up on his own and ambulate with his wheelchair that results in falls. It was suggested that patient may need a care giver throughout the night to sit with him and prevent him from trying to get out of bed on his own.			

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	An interview with PA (Physician's Assistant) 7 conducted on 10/5/23 at 2:27 p.m. indicated, she was very familiar with Resident D and his frequent falls. She indicated, she had spoke to Resident D's daughter 2 to 3 weeks prior about the potential for the need for a facility with a higher level of care, meaning a skilled nursing facility. PA 7 indicated, the amount of monitoring Resident D now requires, was more than what the Assisted Living facility was able to provide. PA 7 indicated, in her professional opinion, Resident D's needs require a Skilled Nursing Facility. An interview with Executive Director (ED), Wellness Director (WD) and Assistant Wellness Director (AWD) was conducted on 10/5/23 at 2:52 p.m. WD indicated, the facility was unable to provide one on one night time supervision for Resident D and that it was the family's responsibility to provide the night time supervision. . ED indicated, the facility could provide one on one supervision for short-term situations, but Resident D's frequent falls were not appropriate for the short-term one on one supervision provided by the facility. ED further indicated, the facility was unable to provide proof of Resident D's safety checks were done every hour at night nor the one on one companion care as per his service plan. When asked about Resident D's current level of care, the WD indicated, he was at a level 5, as per the last evaluation done in October 2023, which was the highest level of care the assisted living could provide and anything beyond that would require a skilled nursing setting. They further indicated, Resident D's current needs/services would be re-evaluated once he had been discharged from the rehabilitation center, but that if his needs/services remained as they were prior to his			

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	last discharge, they would defer his re-admission. A Resident Evaluation and Service Plan policy last reviewed and updated on 2/24/23 was received on 10/6/23 at 10:25 a.m. from AWD indicated, "The purpose of the Resident Evaluation and Service Plan is to establish a process to evaluate and plan for the Resident's needs...Evaluation Frequency: 1. Immediately when the need for care is determined (at move in, return from hospital, change in condition.)...4. Immediately with any change in care of change in condition (return from hospital, fall, rehab stay, etc...) A Discharge Policy received on 10/5/23 at 10:27 a.m. from AWD indicated, "Upon providing the Resident or his or her Authorized Representative thirty (30) days written notice, the Community may discharge a Resident for any of the following events... a. The Resident requires care or services that the Community is unable to provide or which requires staff that are not available at the Community b. The Resident requires nursing care on a continuous basis after becoming ill, injured, or disabled following admission: or...2. The Resident has harmed him or herself or others, or has demonstrated behaviors that pose a risk of serious harm to him or herself or others. Such circumstances may include, but are not limited to, creating unsafe conditions..." This state tag relates to complaint IN00417996.			
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed:			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review, the facility failed to timely notify a resident's representative or medical provider a resident had a change of condition for 1 of 3 residents reviewed for abuse. (Resident C) Findings include: The clinical record for Resident C was reviewed on 10/4/23 at 1:00 p.m. The Resident's diagnosis included, but were not limited to, mild cognitive impairment. The resident resides on the memory care unit. The Saint Louis University Mental Status (SLUMS) Examination (screening tool for dementia) dated 10/21/22 indicated Resident C's assessment was completed, and she did have dementia. A progress note written by Qualified Medication Aide (QMA) 2 dated 9/25/23 at 5:47 p.m., indicated Resident C was observed with bruising on both hands and wrist. The resident indicated "someone hold her hand its hearting [sic] her so bad." A progress note written by QMA 1 dated 9/26/23 at 6:44 a.m., indicated "It was reported to writer by staff that dayshift staff reported to staff that resident has bruises on both wrists and resident stated that someone took her by her hands...Resident showed writer her wrists, writer noticed that both wrists have bruises to them. Writer asked resident what happened and resident	R 0036	1. One resident was affected by the alleged deficient practice. 2. The community realizes that all residents have the potential to be affected by the alleged deficient practice 3. Staff was terminated that failed to report the resident change in condition according to the community's standard operating procedure. 4. Inservice for all nursing staff to include notification to nursing specifically the Wellness Director or Charge Nurse, of any changes in residents condition according to community SOP so Wellness Director or Charge Nurse can immediately notify resident physician and resident legal representative of changes. 5. Wellness Director will monitor 24 hour report, pertinent charting, & Incident / Accident Log Daily to ensure resident physician and legal representative are notified of any resident change of condition within community SOP guidelines. This practice will be on-going.	11/05/2023

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		A. BUILDING 00 B. WING	10/06/2023

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	stated that she didn't know. Writer then called ADOW [Assistant Director of Wellness] and reported the incident..." A progress note written by QMA 1 dated 9/26/23 at 8:00 a.m. indicated, "It was reported to me on 9/26/23 when I was giving report to [QMA 3]. I asked her if she knew what happened to the resident's wrists, and [QMA 3] stated that, 'They' gave her a shower and that was resistant to take her clothes off and get in the shower. [QMA 3] stated that 'We had to make her take a shower." A progress note written by DOW on 9/26/23 10:00 a.m., indicated "Writer arrived at community & asked AWD about incident r/t bruising to residents hands & AWD stated that [Physician Assistant (PA 7)] & [Resident C's Representative 20] were notified, in addition to NP [PA 7] is present in community today & will evaluate resident injury. Writer noted that QMA 1 & 2 had charted notes in PCC [resident's medical charting system] r/t to incident. Writer reviewed shower sheet from yesterday & no injuries were noted to shower sheet. Writer reviewed shift report sheet & noted bruising to residents hands was not noted by day shift yesterday. AWD stated that nothing was reported to her until this morning from QMA 1. Writer assessed resident hands & noted resident had bruising to back of bilateral hands, small bruise noted to bilateral inner wrists, and bruising to LFA [left forearm]. Bruising noted to be purple in color and covered up with foundation [type of make up] by resident. Resident denies pain at this time. Resident stated, 'they did this to me.' Resident unable to state how or when bruises occurred r/t [related to] dementia. [Resident C's Representative 20] present at time of assessment & state, 'I was here yesterday from 10 am to 2:30 pm [10:00 a.m. to 2:30 p.m.] & staff had			

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	asked [Resident C] about taking her shower a few times & she refused.' [Resident C's Representative 20] stated '[Resident C Representative 21] spoke to [Resident C] on the phone last night at 7:30 p.m. & she was telling him that she was covering the bruises with makeup..." A progress note written by DOW on 9/26/23 at 1:21 p.m., indicated "Writer asked QMA 3 if she assisted with resident [C] shower yesterday, QMA 3 stated that CNA [5] attempted to give resident shower multiple times yesterday & resident was refusing. Upon CNA reporting to her that resident refused shower QMA 3 stated that she approached resident & stated, 'Come with me it is time for your shower.' Resident was agreeable & followed staff to sit on side of bed in apartment. QMA 3 stated that when staff began removing clothing for shower that resident became combative & started swinging her arms at staff trying to hit staff. QMA 3 stated that resident then got in shower & bathed herself with minimal assist from staff without any further behaviors. QMA [3] stated that she did not note any bruising to resident's hands at that time & did not report anything to AWD or oncoming shift..." A physician note written by Physician Assistant (PA) on 9/26/23 indicated, "...Patient seen sitting in her apartment today along side her son. Staff reports that patient was found to have bruising along her hands and into her forearms this morning after receiving a shower from nurses yesterday. Patient has a history of refusing showers and becoming very anxious and agitated with them. She is suppose to be receiving Ativan prior to all of her showers, but the order has not been coming up in their system properly to allow them to do so. Nurse [QMA 3] reports that she			

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	had not been showered. She was resistant at first and required some slight restraint to get her clothes off, but once she was in the shower she was able to wash her own hair and then dress herself afterwards. Nurse [QMA 3] states that there were no bruising or injuries noted the evening after shower....She does grab her hands and suggests they are tender to the touch. Her left arm appears to have more bruising than her right and there looks to be some make-up attempting to cover them on her skin. [Resident C's Representative 20] reports that she spoke with Resident C's Representative 21 that evening after the shower and seemed shaken up about the experience. They are not able to get a full story from her due to her dementia..." A progress note written by DOW on 9/27/23 at 2:36 p.m., indicated "...was able to contact [CNA 5] to get statement...CNA [5] stated that she went to QMA 3 to notify her that resident was approached multiple times r/t shower & resident continually refused care. CNA stated that QMA 3 was able to get resident to follow her to sit at bedside by telling resident it was time for her shower & once staff [CNA 5 and QMA 3] attempted to assist resident with removing clothing to prepare for shower resident became combative & was swinging both of her arms at staff trying to hit them. CNA stated then she stepped back at that time & witnessed resident hit back of L [left] hand on nightstand next to bed. CNA also stated that QMA used her hand to block resident from hitting her but that she was not being aggressive or hurtful to resident & resident did calm down after they stepped back & was able to get in shower & bathe herself with minimal assistance from staff." An interview was conducted with Resident C's			

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	Representative 21 on 10/5/23 at 9:09 a.m. He indicated he received a call from Resident C on the evening of 9/25/23. The resident was "upset" about a shower she had received. She reported to him she was covering the bruises with makeup. He nor Resident C's Representative 20 was notified of the bruising on 9/25/23 by staff. He found out something had happened, by Resident C calling him that evening. He would have expected the facility staff to have notified him that evening, but they did not. On 9/26/23, he went into the facility to see Resident C. At that time, it was reported she had bruises on her hands and wrists that was caused by a shower provided on 9/25/23. The shower incident was "disturbing" to him, Resident C and Resident C's Representative 20. An interview was conducted with QMA 2 on 10/5/23 at 2:10 p.m. She indicated she had worked the evening shift from (3:00 p.m. to 7:00 p.m.) on 9/25/23. She had taken over for the day shift staff person, QMA 3. QMA 3 had reported, a shower had been given to Resident C, and she was aggressive which caused bruising on her hands. QMA 3 stated at that time, she would notify the DOW about the shower incident. Later, Resident C had approached QMA 2 and reported to her "someone hold her hands." At that time, QMA 2 had observed the residents hands to be bruised. QMA 2 indicated she did not report the resident had bruises and there had been an incident with her shower to the Executive Director (ED), DOW, ADOW, the triage nurses, medical provider or Resident C's representatives on the evening 9/25/23. An interview was provided by Physician Assistant (PA) 7 on 10/5/23 at 2:22 p.m. She indicated on the morning of 9/26/23, QMA 3 had reported to her, Resident C had not received a			

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	shower in a long time and needed one. CNA 5 and QMA 3 had worked together to provide a shower to Resident C on 9/25/23. The resident had become combative, and QMA 3 had to hold her hands down to get her undress. The resident did get in the shower. During that time, the resident bathed and dressed herself. PA 7 had assessed the resident on 9/26/23. Resident C was observed with "extensive bruising" to her hands and wrists. PA 7 indicated she would have wanted the facility staff to notify her on 9/25/23, when the bruising was recognized. A change of condition policy was provided by the DOW on 10/5/23 at 2:52 p.m. It indicated "...1. Purpose. The purpose of the Change in Resident Condition Policy is to establish a process to evaluate, monitor, plan, implement actions to meet resident needs and to notify family and Healthcare provider of changes in resident...2. The Healthcare provider and legally responsible party will be notified of the residents change in condition and action taken..." This Residential Tag relates to Complaints IN00419078 and IN00418354.			
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to protect residents from physical abuse by other residents for 3 of 4 residents reviewed for	R 0052	1. Three residents were affected by the alleged deficient practice. 2. The community realizes that all residents have the potential to be	11/05/2023

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	abuse (Resident E, Resident F and Resident G). Findings include: 1 a. The clinical record for Resident E was reviewed on 10/4/23 at 12:45 p.m. The Resident's diagnosis included, but were not limited to, dementia and anxiety. A Brief Cognitive Rating Scale Assessment, dated 8/23/23, indicated she had moderate sever cognitive decline. A service plan, initiated on 8/14/23, indicated Resident E had behaviors. The goals were for her to not act out in a way that is harmful to self or others and to identify factors / interventions that help to prevent / minimize inappropriate behaviors. The interventions were to report changes from baseline behavior to nurse, initiated 8/14/23, responds to reorientation and redirection when wandering, initiated 8/14/23, and exhibits inappropriate behaviors such as verbal and physical aggression toward residents and staff, initiated 9/29/23. 1 b. The clinical record for Resident G was reviewed on 10/4/23 at 12:45 p.m. The Resident's diagnosis included, but were not limited to, dementia and mood disturbance. A Brief Cognitive Rating Scale Assessment, dated 4/27/23, indicated she had severe cognitive decline. A service plan, initiated 10/1/23, indicated Resident G had behaviors. The goal was for her to not act out in a way that would be harmful to self or others. The intervention, initiated 10/1/23, was to report changes from baseline behaviors to		affected by the alleged deficient practice 3. Inservice for all staff on community's SOP for abuse & incident / accident reporting completed by the Wellness Director by 11/6/23, which includes but is not limited to the following: *Notifying Wellness Director immediately regarding abuse allegations by any person, resident to resident abuse, and injuries of unknown origin. *Following community SOP for immediate suspension of any staff accused of abuse or involved with an injury of unknown origin. *Wellness Director to notify resident physician & legal representative of resident to resident abuse immediately to discuss interventions such as psychiatric evaluation or 1:1 care for 7-10 days following incident. 4. Memory Care Neighborhood employees will conduct 2 hour wellness checks on all residents within the community & document on 2 hour location check form & notify Wellness Director of any findings during these checks including but not limited to: *Change of Condition, Behaviors, Wandering, or Exit Seeking Wellness Director will review 2 hour location check forms weekly for 4 weeks, then monthly on-going. Wellness Director will report all findings reported from	

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	nurse. A General Note, dated 8/27/23 at 4:58 a.m., indicated that Resident E went into Resident G's room at around 4:15 a.m. Resident G had put Resident E on the floor and "punched" Resident E in the face. Resident G had kicked resident E. Resident E had a bruise on her neck, the left arm and waist. On 10/4/23 at 12:40 p.m., the ED (Executive Director) provided an Incident Reporting Form that had been sent the Indiana Department of Health on 8/28/23 which indicated that on 8/27/23 at 3:01 a.m., Resident E had entered into Resident G's room. Resident G had become alarmed, and an altercation happened between the two residents. Resident E had bruising to her face and neck after the altercation. The residents had been separated and the families of each resident were contacted. The primary care provider for each resident was contacted. The follow-up dated 9/5/23 was that Resident E had not been in other's rooms and is staying in her own room at night. 2. The clinical record for Resident F was reviewed on 10/4/23 at 1:30 p.m. The Residents diagnosis included, but were not limited to, dementia and anxiety. A Brief Cognitive Rating Scale Assessment, dated 6/2/23, indicated Resident F had very severe cognitive decline. A service plan, initiated on 9/12/23, indicated Resident F had behaviors due to her dementia and frustration. The goal was for her not to act out in a way that was harmful to herself or others. The interventions included to observe for wandering aimlessly or in an undirected fashion without		wellness checks to the Wellness Committee (QAPI) for review and further recommendations as needed.	

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	definable purpose and direct back to common area and engage in activities, initiated 9/12/23. A progress note, dated 9/5/23 at 7:59 a.m., indicated that on 9/4/23 at approximately 5:28 p.m., Resident F had been struck on the back by Resident E. The residents were immediately separated by staff and redirected. Resident F was taken back to her room and checked for injuries. No injuries were noted. Resident E's family, the Executive Director and the Nurse Practitioner were notified of occurrence. On 10/4/23 at 12:40 p.m., the ED (Executive Director) provided an Incident Reporting Form that had been sent the Indiana Department of Health on 9/5/23, which indicated that on 9/4/23 at 5:30 p.m., Resident F and Resident E had an altercation. Resident E had smacked Resident F. The residents were separated, and Resident E was sent for a psychiatric evaluation. During an interview on 10/4/23 at 2:10 p.m., CNA (Certified Nursing Assistant) 15 indicated she had worked on 9/4/23, when the incident between Resident E and Resident F had occurred. Resident E had struck Resident F in the back. Resident E had also struck CNA 15 earlier in the shift. Resident E had been sent out due to her behaviors. On 10/4/23 at 1:00 p.m., the Executive Director provided the Abuse, Neglect, or Exploitation policy, last reviewed on 6/7/23, which read "...3. Definitions Abuse- Harm or threatened harm to an adult's health or welfare caused by another person...4. Procedure Abuse, neglect, or exploitation of any resident will not be tolerated. All allegations, suspicions, and incidents of abuse, neglect, or exploitation will be promptly			

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	investigated..." This state residential finding relates to Complaint IN00419078 and IN00418354			
R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request.			
	Based on interview and record review, the facility failed to ensure a resident was protected during an investigation of a resident's bruises of unknown origin and timely report an incident of resident-to-resident physical abuse and bruises of unknown origin to the facility administration and the resident's physician for 3 of 4 residents reviewed for abuse (Resident C, Resident E and Resident G). Findings include: 1. The clinical record for Resident C was reviewed on 10/4/23 at 1:00 p.m. The Resident's diagnosis included, but were not limited to, mild cognitive impairment. The resident resides on the memory care unit. The Saint Louis University Mental Status (SLUMS) Examination (screening tool for dementia) dated 10/21/22 indicated Resident C's assessment was completed, and she did have	R 0091	1. Three residents were affected by the alleged deficient practice. 2. The community realizes that all residents have the potential to be affected by the alleged deficient practice 3. Inservice for all staff on community's SOP for abuse & incident / accident reporting completed by the Wellness Director by 11/6/23, which includes but is not limited to the following: *Notifying Wellness Director immediately regarding abuse allegations by any person, resident to resident abuse, and injuries of unknown origin. *Following community SOP for immediate suspension of any staff accused of abuse or involved with an injury of unknown origin.	11/05/2023

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	dementia. A reportable incident reported to the Indiana Department of Health reported date of 9/27/23 indicated "...incident date: 9/25/23...brief description:..Resident [C] was resistant to taking a shower. Several hours later bruises show up on the wrist of resident. Resident questioned several times and gave different answers on how she got them...Type of injury...Bruising to left and right wrist and arms...Follow up:..10/4/23 Statements have been collected from two care givers that gave the shower. Resident was resisting shower and was swing at the care givers. Resident did hit her arm on a table. The QMA [3] did hold her arms so she would not hurt herself and once resident was in shower she was fine. She dressed herself..." A progress note written by Qualified Medication Aide (QMA) 2 dated 9/25/23 at 5:47 p.m., indicated Resident C was observed with bruising on both hands and wrist. The resident indicated "someone hold her hand its hearting [sic] her so bad." A progress note written by QMA 1 dated 9/26/23 at 6:44 a.m., indicated "It was reported to writer by staff that dayshift staff reported to staff that resident has bruises on both wrists and resident stated that someone took her by her hands...Resident showed writer her wrists, writer noticed that both wrists have bruises to them. Writer asked resident what happened and resident stated that she didn't know. Writer then called ADOW [Assistant Director of Wellness] and reported the incident..." A progress note written by QMA 1 dated 9/26/23 at 8:00 a.m., indicated "It was reported to me on 9/26/23 when I was giving report to [QMA 3]. I		*Wellness Director to notify resident physician & legal representative of resident to resident abuse immediately to discuss interventions such as psychiatric evaluation or 1:1 care for 7-10 days following incident. 4. Memory Care Neighborhood employees will conduct 2 hour wellness checks on all residents within the community & document on 2 hour location check form & notify Wellness Director of any findings during these checks including but not limited: *Change of Condition, Behaviors, Wandering, or Exit Seeking Wellness Director will review 2 hour location check forms weekly for 4 weeks, then monthly on-going. Wellness Director will report all findings reported from wellness checks to the Wellness Committee (QAPI) for review and further recommendations as needed.	

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	asked her if she knew what happened to the resident's wrists, and [QMA 3] stated that, 'They' gave her a shower and that was resistant to take her clothes off and get in the shower. [QMA 3] stated that "We had to make her take a shower." [QMA 3] stated that she reported it to ADOW immediately after the shower. Writer had contacted ADOW via telephone and when writer asked if she was aware that [Resident C] had a bruise on her wrist, ADOW stated that she is not aware. Writer then wrote this follow up progress note upon her findings, writer then notified E.D. via telephone and left a voicemail to call writer back. Writer then notified corporate nurse via telephone and left a voicemail." A progress note written by Director of Wellness (DOW) on 9/26/23 at 8:14 a.m. indicated "QMA 1 reported to writer via telephone that during evening shift report QMA 2 reported to her that resident had bruising to bilateral hands & wrists. QMA 1 stated that during morning shift report she asked QMA 3 if she knew how bruising occurred to resident hands & that QMA 3 stated that she had to force resident to take a shower yesterday & reported bruising to AWD after shower. QMA 1 stated that she called AWD to report incident & AWD stated that she was unaware of any bruising to residents hands & nothing had been reported to her. QMA 1 stated that AWD advised her to call triage nurse to start an incident report for injury of unknown cause pending further investigation. QMA 1 also stated that she left a voicemail for ED." A progress note written by DOW on 9/26/23 10:00 a.m., indicated "Writer arrived at community & asked AWD about incident r/t bruising to residents hands & AWD stated that [Physician Assistant (PA 7)] & [Resident C's Representative			

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	20] were notified, in addition to NP [PA 7] is present in community today & will evaluate resident injury. Writer noted that QMA 1 & 2 had charted notes in PCC [resident's medical charting system] r/t to incident. Writer reviewed shower sheet from yesterday & no injuries were noted to shower sheet. Writer reviewed shift report sheet & noted bruising to residents hands was not noted by day shift yesterday. AWD stated that nothing was reported to her until this morning from QMA 1. Writer assessed resident hands & noted resident had bruising to back of bilateral hands, small bruise noted to bilateral inner wrists, and bruising to LFA [left forearm]. Bruising noted to be purple in color and covered up with foundation [type of make up] by resident. Resident denies pain at this time. Resident stated, 'they did this to me.' Resident unable to state how or when bruises occurred r/t [related to] dementia. [Resident C's Representative 20] present at time of assessment & state, 'I was here yesterday from 10 am to 2:30 pm [10:00 a.m. to 2:30 p.m.] & staff had asked [Resident C] about taking her shower a few times & she refused.' [Resident C's Representative 20] stated '[Resident C Representative 21] spoke to [Resident C] on the phone last night at 7:30 p.m. & she was telling him that she was covering the bruises with makeup..." A progress note written by DOW on 9/26/23 at 1:21 p.m., indicated "Writer asked QMA 3 if she assisted with resident [C] shower yesterday, QMA 3 stated that CNA [5] attempted to give resident shower multiple times yesterday & resident was refusing. Upon CNA reporting to her that resident refused shower QMA 3 stated that she approached resident & stated, 'Come with me it is time for your shower.' Resident was agreeable & followed staff to sit on side of bed in apartment. QMA 3 stated that when staff began removing			

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	clothing for shower that resident became combative & started swinging her arms at staff trying to hit staff. QMA 3 stated that resident then got in shower & bathed herself with minimal assist from staff without any further behaviors. QMA [3] stated that she did not note any bruising to resident's hands at that time & did not report anything to AWD or oncoming shift..." A physician note written by PA 7 on 9/26/23 indicated, "...Patient seen sitting in her apartment today along side her son. Staff reports that patient was found to have bruising along her hands and into her forearms this morning after receiving a shower from nurses yesterday. Patient has a history of refusing showers and becoming very anxious and agitated with them. She is suppose to be receiving Ativan prior to all of her showers, but the order has not been coming up in their system properly to allow them to do so. Nurse [QMA 3] reports that she had not been showered. She was resistant at first and required some slight restraint to get her clothes off, but once she was in the shower she was able to wash her own hair and then dress herself afterwards. Nurse [QMA 3] states that there were no bruising or injuries noted the evening after shower....She does grab her hands and suggests they are tender to the touch. Her left arm appears to have more bruising than her right and there looks to be some make-up attempting to cover them on her skin. [Resident C's Representative 20] reports that she spoke with Resident C's Representative 21 that evening after the shower and seemed shaken up about the experience. They are not able to get a full story from her due to her dementia..." A progress note written by DOW on 9/27/23 at 2:36 p.m., indicated "...was able to contact [CNA			

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	5] to get statement...CNA [5] stated that she went to QMA 3 to notify her that resident was approached multiple times r/t shower & resident continually refused care. CNA stated that QMA 3 was able to get resident to follow her to sit at bedside by telling resident it was time for her shower & once staff [CNA 5 and QMA 3] attempted to assist resident with removing clothing to prepare for shower resident became combative & was swinging both of her arms at staff trying to hit them. CNA stated then she stepped back at that time & witnessed resident hit back of L [left] hand on nightstand next to bed. CNA also stated that QMA used her hand to block resident from hitting her but that she was not being aggressive or hurtful to resident & resident did calm down after they stepped back & was able to get in shower & bathe herself with minimal assistance from staff." During an interview with License Practical Nurse (LPN) 4 on 10/4/23 at 2:35 p.m., she indicated on 9/26/23, QMA 3 had reported to her Resident C had not had a shower in a long time. The resident had become resistant and combative. The resident had to be "forced" to take a shower on 9/25/23. After receiving the report from QMA 3, LPN 4 had conducted a skin assessment on the resident. Bruising was observed on her left arm, and both hands and wrists. QMA 3 was not suspended during the investigation. QMA 3 was able to continue to work in the memory care unit where Resident C resides. An interview was conducted with Triage Nurse (TN) 8 on 10/5/23 at 1:50 p.m. She indicated the facility staff call the triage nurses for any changes in the residents. After reviewing of 9/25/23 notations, the facility staff had not notified the triage nurses; Resident C had bruises on her skin			

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	that day. TN 8 had spoken to QMA 1 on 9/26/23 at 7:34 a.m. At that time, QMA 1 had reported to TN 8 Resident C was observed with bruises on her wrists. TN 8 had instructed QMA 1 to report the resident's bruising to the DOW due to the incident was a reportable incident. The incident would need to be reported the Indiana Department of Health. An interview was conducted with QMA 2 on 10/5/23 at 2:10 p.m. She indicated she had worked the evening shift from (3:00 p.m. to 7:00 p.m.) on 9/25/23. She had taken over for the day shift staff person, QMA 3. QMA 3 had reported, a shower had been given to Resident C, and she was aggressive which caused bruising on her hands. QMA 3 stated at that time, she would notify the DOW about the shower incident. Later, Resident C had approached QMA 2 and reported to her "someone hold her hands." At that time, QMA 2 had observed the residents hands to be bruised. QMA 2 indicated she did not report the resident had bruises and there had been an incident with her shower to the Executive Director (ED), DOW, ADOW, the triage nurses, medical provider or Resident C's representatives on the evening 9/25/23. An interview was conducted with QMA 1 on 10/5/23 at 2:51 p.m. She indicated she had worked the night shift (7:00 p.m. to 7:00 a.m.) on the night of 9/25/23. She had taken over for QMA 2 that had worked the evening shift. During report given by QMA 2, it was reported QMA 3 on day shift had to "make" Resident C take a shower. The resident ended up with bruising on her hands caused by the shower. After report, QMA 1 went to the resident's room and observed "big" bruising on the resident's hands and wrists. The resident was trying to hide the bruising utilizing make-up. The			

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	resident stated, "she didn't know" when asked what happened to her hands. During the report the next morning on 9/26/23, she had inquired about the bruising on Resident C to QMA 3 days shift staff person. QMA 3 reported to QMA 1 she had to "force" Resident C to undress for a shower the previous day. The resident was fine after she was undressed and showered herself. After, QMA 1 contacted ADOW and Triage Nurse (TN 8) via telephone and reported the bruising on the residents skin. ADOW responded she was not aware of any bruising with Resident C. She notify the ED in writing and placed on his desk. An interview was conducted with DOW on 10/5/23 at 3:37 p.m. She indicated the resident's wrist and hands were observed to have bruising. She was not made aware of Resident C's bruising until the morning of 9/26/23. QMA 3 was not suspended during the investigation. The DOW had questioned if QMA 3 should be suspended during the investigation, but the corporate office wanted to make that decision after CNA 5 made her statement of what happened during the shower. After we received the statement, it had been decided QMA 3 would not be suspended. An interview was conducted with the ADOW on 10/5/23 at 4:19 p.m. She indicated she had not been notified by staff; bruising was observed on Resident C on 9/25/23. ADOW was contacted by QMA 1 via telephone prior to arriving to the facility on the morning of 9/26/23. 2 a. The clinical record for Resident E was reviewed on 10/4/23 at 12:45 p.m. The Resident's diagnosis included, but were not limited to, dementia and anxiety. 2 b. The clinical record for Resident G was reviewed on 10/4/23 at 12:45 p.m. The Resident's			

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	diagnosis included, but were not limited to, dementia and mood disturbance. A General Note, dated 8/27/23 at 4:58 a.m., indicated that Resident E went into Resident G's room at around 4:15 a.m. Resident G had put Resident E on the floor and "punched" Resident E in the face. Resident G had kicked resident E. Resident E had a bruise on her neck, the left arm and waist. A Nurses Note, dated 8/28/23 at 6:41 a.m., read "...This writer was informed per staff that resident [Resident E] went into resident [Resident G] room at 3 am on 8/27/23. Resident [Resident G} was kicking resident [Resident E] in the face et choking her. Staff separated Residents et took resident to her room for safety et to calm her. No s/s of distress noted at this time..." On 10/4/23 at 12:40 p.m., the ED (Executive Director) provided an Incident Reporting Form that had been sent the Indiana Department of Health on 8/28/23 which indicated that on 8/27/23 at 3:01 a.m., Resident E had entered into Resident G's room. Resident G had become alarmed, and an altercation happened between the two residents. Resident E had bruising to her face and neck after the altercation. The residents had been separated and the families of each resident were contacted. The primary care provider for each resident was contacted. The follow-up dated 9/5/23 was that Resident E had not been in other's rooms and is staying in her own room at night. During an interview on 10/5/23 at 11:55 a.m., the Wellness Director indicated that the incident of physical abuse of Resident E by Resident G should have been immediately reported to the Wellness Director.			

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	An interview was provided by Physician Assistant (PA) 7 on 10/5/23 at 2:28 p.m., indicated that she had briefly been informed of the incident between Resident E and G on the afternoon on 8/28/23. At the time PA 7 was notified of the incident she was unaware that Resident E was being treated by her practice and did not examine her. On 10/4/23 at 1:00 p.m., the Executive Director provided the Abuse, Neglect, or Exploitation policy, last reviewed on 6/7/23, which read "...3. Definitions Abuse- Harm or threatened harm to an adult's health or welfare caused by another person...4. Procedure Abuse, neglect, or exploitation of any resident will not be tolerated. All allegations, suspicions, and incidents of abuse, neglect, or exploitation will be promptly investigated... Community will address situations in which abuse, neglect, or exploitation are more likely to occur. This includes, but is not limited to, the following... Encouragement of staff to monitor the residents routinely for unexplained unusual bruises... that may be suggestive of skin trauma...Initial Response...If a staff member is accused or suspected of abuse, neglect or exploitation, the staff member will be immediately removed from the community and work schedule pending the outcome of the investigation. The resident's responsible party will be notified of the incident, the resident's attending physician, if appropriate.... Employees are to immediately report any witnessed or suspected incidents of abuse, neglect, or exploitation to the supervisor on duty and with Wellness Director or designee. For the purposes of this policy 'immediately' means as soon as possible, but will not exceed twenty-four [24] hours after the incident or discovery of the injury...			

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	This Residential Tag relates to Complaints IN00419078 and IN00418354.			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to implement a resident's service plan related to frequent falls for 1 of 7 residents reviewed for service plans. (Resident D)	R 0217	1. One resident was affected by the alleged deficient practice. 2. The community realizes that all residents have the potential to be	11/05/2023

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	Findings include: The clinical record for Resident D was reviewed on October 4, 2023. Resident D's diagnoses included, but not limited to, major depressive disorder, nocturia (frequent urination at night), and sleep disorder. Resident D's brief cognitive rating, completed on 10/2/23, indicated, he had moderate to severe cognitive decline. Resident D's fall risk assessments, completed on 8/20/23, 9/9/23, 9/10/23, 9/21/23, 9/22/23, and 10/2/23, indicated, he was at a high risk for falling. A Wellness Evaluation for Resident D was completed on 2/8/23 and indicated, he required mobility/escort services related to a history of falls if unassisted with ambulation; escort to/from meals and community programs; was independent with transferring and was able to get in and out of bed, chair, car, etc without assistance; and was independent in toileting and able to get to and from toilet. A Wellness Evaluation for Resident D was completed on 7/26/23 and indicated, he was independent with ambulation; did no need escort within the facility to meals, activities, or internal events; could transfer independently, did not require staff assistance to transfer and has fallen in the last 3 months; and required staff attention or physical assistance with bathing. A Fall Service Plan for Resident D created on 2/8/23 and revised on 7/26/23 indicated, he was to remain free from injury and was encouraged to call for assistance when needed. Interventions		affected by the alleged deficient practice 3. Resident sited in this rule was discharged to a higher level of care. 4. Resident Service Plans, Falls, & Interventions will be audited by 11/06/23 by the Wellness Director to ensure residents are within scope for Assisted Living. 5. Wellness Director will Implement Fall & Intervention Tracker & review weekly with the Executive Director to ensure residents remain within in scope for Assisted Living. This practice will be on-going. All findings will be reported to the Wellness Committee (QAPI) for review and further recommendations as needed.	

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	included, but not limited to: 2/15/23- Post fall: Environment: Safety education on clutter and furniture usage 2/21/23- Therapy referral for unsteady gait/ambulation 8/15/23- Position wheelchair next to resident and verify brakes are locked 8/22/23- Recommendations for increase family involvement or 1:1 (one on one) companion for resident at night 9/8/23- Remind/educate resident on importance of locking wheelchair brakes prior to transfers 9/11/23- Family advised resident requires 1:1 (one on one) companion for 8 to 12 hours during night shift for safety 9/12/23- Safety checks for falls- check on resident every 1 hour for safety. 9/17/23- Encourage proper assistive devices, discourage resident from transferring into chairs in common areas 9/21/23- Educate resident on use of emergency call system 9/22/23- Encourage slow changes in position; remind to call for assistance A Transferring Service Plan for Resident D created on 2/8/23 and revised on 9/28/23 indicated, he required weight bearing assistance to get in and out of bed, chair, car, etc. A review of Resident D's progress notes was completed on 10/5/23. The progress notes indicated, Resident D had fallen approximately 39 times since his admission on 2/8/23. An interview with Executive Director (ED), Wellness Director (WD) and Assistant Wellness Director (AWD) was conducted on 10/5/23 at 2:52 p.m. WD indicated, the facility was unable to provide one on one night time supervision for			

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	Resident D and that it was the family's responsibility to provide the night time supervision. . ED indicated, the facility could provide one on one supervision for short-term situations, but Resident D's frequent falls were not appropriate for the short-term one on one supervision provided by the facility. ED further indicated, the facility was unable to provide proof of Resident D's safety checks were done every hour at night nor the one on one companion care as per his service plan. A Resident Evaluation and Service Plan policy last reviewed/revised on 2/24/23 was provided by AWD on 10/6/23 at 10:25 a.m. It indicated, "A Service Plan is developed according to the needs of a resident identified throughout the evaluation process. The Service Plan will be reviewed and updated at least annually and when resident's needs or preferences change...7. A resident that required approximately 3 or more hours of continuous care during an 8 hour shift will have 1:1 companion care service added to their services plan for an additional charge based on current community charges." This state tag relates to complaint IN00417996 and IN00417289.			
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview, and record	R 0241	1. One resident was affected by	11/05/2023

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	review, the facility failed to administer clotrimazole cream as ordered for 1 of 4 residents reviewed for medication administrations, and to administer an Ativan (anti-anxiety medication), as ordered by the physician, prior to giving a shower to a cognitively impaired resident with a history of experiencing anxiety and agitation when receiving showers. This failure resulted in the resident experiencing mental anguish and bruising of the skin from injury for 1 of 3 residents reviewed for abuse. (Resident C and Resident D) Findings include: 1. The clinical record for Resident C was reviewed on 10/4/23 at 1:00 p.m. The Resident's diagnosis included, but were not limited to, mild cognitive impairment. The resident resides on the memory care unit. The Saint Louis University Mental Status (SLUMS) Examination (screening tool for dementia) dated 10/21/22 indicated Resident C's assessment was completed, and she did have dementia. A behavior service plan dated 9/28/23 indicated Resident C resisted care that included showers. "The resistive behavior is de-escalated by providing resident with space, attempting multiple times to complete care with strong encouragement for participation, and administering PRN medication as needed after failed attempt..." A physician order dated 9/5/23 indicated the resident was to receive a 1/2 tablet of 0.5 milligrams of lorazapam [Ativan] twice a day as needed for anxiety. The physician's order had instructions that indicated the resident was to receive the lorazapam 30 minutes before bathing.		the alleged deficient practice. 2. The community realizes that all residents have the potential to be affected by the alleged deficient practice 3. PA reviewed PRN medication order sited & clarified order to state medication is to be utilized on shower days PRN for resident behaviors or refusal of care. Wellness Director updated MAR at time of discovery with order clarification made by PA. 4. Inservice for all nursing staff licensed to administer medications by 11/6/23 including but not limited to the following: *Medication Administration, PRN Medication Administration, Medication Cart Auditing, Medication Ordering, Notifying Wellness Director or Charge Nurse immediately of missing Medications. 5. Medication Cart & MAR Audits will be done by the Wellness Director or designated wellness staff for compliance weekly for 4 weekly, then monthly on-going. All finding will be addressed by Wellness Director or designated wellness staff immediately, and will be forwarded to monthly to the Wellness Committee (QAPI) for further review and recommendations as needed.	

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		A. BUILDING 00 B. WING	10/06/2023

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	A physician noted for Resident C dated 9/12/23 indicated the staff "states that she normally gets the most anxious and agitated around when she is getting her showers done, but this is relieved with her Ativan. Otherwise she is doing well without any acute outburst." A progress note written by Qualified Medication Aide (QMA) 2 dated 9/25/23 at 5:47 p.m., indicated Resident C was observed with bruising on both hands and wrist. The resident indicated "someone hold her hand its hearting [sic] her so bad." A progress note written by QMA 1 dated 9/26/23 at 6:44 a.m., indicated "It was reported to writer by staff that dayshift staff reported to staff that resident has bruises on both wrists and resident stated that someone took her by her hands...Resident showed writer her wrists, writer noticed that both wrists have bruises to them. Writer asked resident what happened and resident stated that she didn't know. Writer then called ADOW [Assistant Director of Wellness] and reported the incident..." A progress note written by QMA 1 dated 9/26/23 at 8:00 a.m., indicated "It was reported to me on 9/26/23 when I was giving report to [QMA 3]. I asked her if she knew what happened to the resident's wrists, and [QMA 3] stated that, 'They' gave her a shower and that was resistant to take her clothes off and get in the shower. [QMA 3] stated that 'We had to make her take a shower." A progress note written by DOW on 9/26/23 10:00 a.m., indicated "...Writer assessed resident hands & noted resident had bruising to back of bilateral hands, small bruise noted to bilateral inner wrists, and bruising to LFA [left forearm]. Bruising noted			

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	to be purple in color and covered up with foundation [type of make up] by resident. Resident denies pain at this time. Resident stated, 'they did this to me.' Resident unable to state how or when bruises occurred r/t [related to] dementia. [Resident C's Representative 20] present at time of assessment & state, 'I was here yesterday from 10 am to 2:30 pm [10:00 a.m. to 2:30 p.m.] & staff had asked [Resident C] about taking her shower a few times & she refused.' [Resident C's Representative 20] stated '[Resident C Representative 21] spoke to [Resident C] on the phone last night at 7:30 p.m. & she was telling him that she was covering the bruises with makeup.'..." A progress note written by License Practical Nurse (LPN) 4 on 9/26/23 indicated "Upon assessing resident's hands et [and/plus] wrists, bruising noted to all areas. Resident [C] pulled down sleeves as this writer was looking at arms et hands. Resident said it hurts sometimes. When asked what happened, resident stated 'it was the nurse pulling down.'...QMA [3] told me this morning that she had to force her to take a shower d/t [due to] she hasn't had a shower. She stated that she only held her left hand d/t resident was hitting staff et being resistive to care. Once she was in shower, QMA [3] said she was fine. No s/s [signs or symptoms] distress noted at this time. Denies pain or discomfort presently." A progress note written by DOW on 9/26/23 at 1:21 p.m., indicated "Writer asked QMA 3 if she assisted with resident [C] shower yesterday, QMA 3 stated that CNA [5] attempted to give resident shower multiple times yesterday & resident was refusing. Upon CNA reporting to her that resident refused shower QMA 3 stated that she approached resident & stated, 'Come with me it is time for your shower.' Resident was agreeable			

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	& followed staff to sit on side of bed in apartment. QMA 3 stated that when staff began removing clothing for shower that resident became combative & started swinging her arms at staff trying to hit staff. QMA 3 stated that resident then got in shower & bathed herself with minimal assist from staff without any further behaviors. QMA [3] stated that she did not note any bruising to resident's hands at that time & did not report anything to AWD or oncoming shift. Writer noted in resident orders that resident has a hx [history] of refusing showers & behaviors with showers, in addition writer noted resident has PRN medication order to administer prior to shower for behaviors. Writer asked QMA 3 if she administered medication, QMA 3 stated that she did not see the order in EMAR [electronic medication record] r/t order used to be scheduled on shower days & had been changed to PRN. Writer educated QMA [3] on need to administer medication if resident refuses care multiple times r/t of triggered behaviors from showers." A physician note written by Physician Assistant (PA) on 9/26/23 indicated, "...Patient seen sitting in her apartment today along side her son. Staff reports that patient was found to have bruising along her hands and into her forearms this morning after receiving a shower from nurses yesterday. Patient has a history of refusing showers and becoming very anxious and agitated with them. She is suppose to be receiving Ativan prior to all of her showers, but the order has not been coming up in their system properly to allow them to do so. Nurse [QMA 3] reports that she had not been showered. She was resistant at first and required some slight restraint to get her clothes off, but once she was in the shower she was able to wash her own hair and then dress			

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	herself afterwards. Nurse [QMA 3] states that there were no bruising or injuries noted the evening after shower....She does grab her hands and suggests they are tender to the touch. Her left arm appears to have more bruising than her right and there looks to be some make-up attempting to cover them on her skin. [Resident C's Representative 20] reports that she spoke with Resident C's Representative 21 that evening after the shower and seemed shaken up about the experience. They are not able to get a full story from her due to her dementia..." A progress note written by DOW on 9/27/23 at 2:36 p.m., indicated "...was able to contact [CNA 5] to get statement...CNA [5] stated that she went to QMA 3 to notify her that resident was approached multiple times r/t shower & resident continually refused care. CNA stated that QMA 3 was able to get resident to follow her to sit at bedside by telling resident it was time for her shower & once staff [CNA 5 and QMA 3] attempted to assist resident with removing clothing to prepare for shower resident became combative & was swinging both of her arms at staff trying to hit them. CNA stated then she stepped back at that time & witnessed resident hit back of L [left] hand on nightstand next to bed. CNA also stated that QMA used her hand to block resident from hitting her but that she was not being aggressive or hurtful to resident & resident did calm down after they stepped back & was able to get in shower & bathe herself with minimal assistance from staff." A progress note written by LPN 6 on 9/30/23, indicated "this writer assessed bruising and pain. Resident states her left upper arm hurts, she is unable to accurately state on pain scale what level of pain..."			

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	A reportable incident reported to the Indiana Department of Health reported date of 9/27/23 indicated "...incident date: 9/25/23...brief description:..Resident [C] was resistant to taking a shower. Several hours later bruises show up on the wrist of resident. Resident questioned several times and gave different answers on how she got them...Type of injury...Bruising to left and right wrist and arms...Follow up:..10/4/23 Statements have been collected from two care givers that gave the shower. Resident was resisting shower and was swing at the care givers. Resident did hit her arm on a table. The QMA [3] did hold her arms so she would not hurt herself and once resident was in shower she was fine. She dressed herself..." An observation was made of Resident C on 10/4/23 at 2:00 p.m. Resident C's left hand was observed with a bruise. During the interview, the resident stated, "the lady behind us did this to me." The staff person the resident identified was QMA 3. An interview was conducted with QMA 3 on 10/4/23 at 2:05 p.m. She indicated she had assisted CNA 5 with providing a shower to Resident C on 9/25/23. The resident was not anxious or agitated during that time. The resident had not swung her arms nor did she hit her hand on the nightstand. She was unaware of the resident having any behaviors of being anxious and agitated while receiving showers. QMA 3 indicated she was aware the night shift staff on 9/25/23 had reported Resident C had bruising on her hands, but she had not observed any bruising to the resident's hands or wrists after the shower was completed earlier that day. She did not report to anyone the resident at any time was combative and resistant			

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	while assisting CNA 5 with a shower to Resident C on 9/25/23. An interview was conducted with LPN 4 on 10/4/23 at 2:35 p.m. She indicated QMA 3 had reported to her Resident C had not had a shower in a long time. The resident had become resistant and combative. The resident had to be "forced" to take a shower. LPN 4 had conducted a skin assessment on the resident. Bruising was observed on her left arm, and both hands and wrists. Resident C had appeared to be embarrassed about the bruising and kept pulling down her sleeves trying to cover the bruised skin. An interview was conducted with Resident C's Representative 21 on 10/5/23 at 9:09 a.m. He indicated he received a call from Resident C on the evening of 9/25/23. The resident was "upset" about a shower she had received. She reported to him she was covering the bruises with makeup. The resident since the incident has been observed covering the bruising with make-up and Band-Aids to hide them. The shower incident was "disturbing" to him, Resident C and Resident C's Representative 20. An interview was conducted with QMA 2 on 10/5/23 at 2:10 p.m. She indicated she had worked the evening shift from (3:00 p.m. to 7:00 p.m.) on 9/25/23. She had taken over for the day shift staff person, QMA 3. QMA 3 had reported, a shower had been given to Resident C, and she was aggressive which caused bruising on her hands. QMA 3 stated at that time, she would notify the DOW about the shower incident. Later, Resident C had approached QMA 2 and reported to her "someone hold her hands." At that time, QMA 3 had observed the residents hands to be bruised. QMA 2 indicated she did not report the resident			

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	had bruises and there had been an incident with her shower to the Executive Director (ED), DOW, ADOW, the triage nurses, medical provider or Resident C's representatives on the evening 9/25/23. An interview was conducted with QMA 1 on 10/5/23 at 2:51 p.m. She indicated she had worked the night shift (7:00 p.m. to 7:00 a.m.) on the night of 9/25/23. She had taken over for QMA 2 that had worked the evening shift. During report given by QMA 2, it was reported QMA 3 on day shift had to "make" Resident C take a shower. The resident ended up with bruising on her hands caused by the shower. After report, QMA 1 went to the resident's room and observed "big" bruising on the resident's hands and wrists. The resident was trying to hide the bruising utilizing make-up. The resident stated, "she didn't know" when asked what happened to her hands. During the report the next morning on 9/26/23, she had inquired about the bruising on Resident C to QMA 3 days shift staff person. QMA 3 reported to QMA 1 she had to "force" Resident C to undress for a shower the previous day. The resident was fine after she was undressed and showered herself. An interview was provided by Physician Assistant (PA) 7 on 10/5/23 at 2:22 p.m. She indicated on the morning of 9/26/23, QMA 3 had reported to her, Resident C had not received a shower in a long time and needed one. CNA 5 and QMA 3 had worked together to provide a shower to Resident C on 9/25/23. The resident had become combative, and QMA 3 had to hold her hands down to get her undress. The resident did get in the shower. During that time, the resident bathed and dressed herself. PA 7 had assessed the resident on 9/26/23. Resident C was observed with "extensive bruising" to her hands and wrists.			

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	She was told by the staff, the Ativan medication the resident was suppose to receive prior to showering was not given. The order was not showing up on the EMAR due to an error. An interview was conducted with CNA 5 on 10/5/23 at 3:29 p.m. She indicated on 9/25/23, she had reported to QMA 3 Resident C had been asked multiple times to shower, and she had refused. QMA 3 stated she would assist her with providing a shower to the resident. QMA 3 assisted resident into her room. At that time, the resident asked what they were going to do. QMA 3 had reported to the resident at that time, it was time to take a shower. As QMA 3 was undressing her, the resident had become agitated and combative during the time. She was swinging her arms trying to hit QMA 3, calling QMA 3 nasty names, and one of the resident's arms did come in contact with a night stand. QMA 3 did have to hold the resident's hands, but it was to avoid the resident from continuing to hit objects and/or QMA 3. After the resident was undressed; the resident got into the shower and bathed herself. CNA 5 did not observed any bruising on the resident's skin after the shower was completed. An interview was conducted with DOW on 10/5/23 at 3:37 p.m. She indicated the resident's left arm, and both wrist and hands were observed to have bruising. The resident did cover the bruises with foundation make up. The EMAR was not showing the PRN order for Ativan, so QMA 3 did not see the order in the system to administer it prior to shower. 2. The clinical record for Resident D was reviewed on October 4, 2023. Resident D's diagnoses included, but not limited to, major depressive disorder, nocturia (frequent urination at night), and sleep disorder.			

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	A physician's order for Resident D dated 2/8/23 and discontinued on 8/9/23 indicated, apply Clotrimazole and Betamethasone Dipropionate cream (relieves redness, swelling and itching) topically twice daily. Resident D's May, June, and July's 2023 MAR (medication administration report) received on 10/5/23 at 11:23 from AWD (Assistant Wellness Director) indicated, on the following days and times, Resident D did not have the Clotrimazole cream administered: 5/1/23- 5/12/23: day and evening doses 5/14/23- 5/17/23: day and evening doses 5/18/23- 5/21/23: evening dose 5/22/23- 5/25/23: day and evening doses 5/26/23: evening dose 5/29/23- 5/30/23: day and evening doses 6/1/23: day and evening doses 6/6/23: day and evening doses 6/8/23: day and evening doses 6/11/23: evening doses 6/13/23: day and evening doses 6/15/23: evening dose 6/13/23: day and evening doses 6/15/23: evening dose 6/16/23: day and evening doses 6/16 and 6/17/23: evening doses 6/20/23: day and evening doses 6/22/23: day and evening doses 6/26/23: day and evening doses 7/3/23: day and evening doses 7/8/23: day and evening doses 7/11/23: evening dose 7/13/23: day dose; left blank for evening dose 7/14/23: evening dose 7/20/23: day and evening doses 7/21/23: day dose 7/24/23: day and evening doses 7/25/23: evening dose			

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	7/27- 7/28/23: day and evening doses 7/30/23: day and evening doses All above non-administrations indicated a code "9". The code chart on the MAR indicated, a code "9" was "other/see Nurse Notes". A review of the nurse notes on the days indicated above, revealed the following reasons for not administering the Clotrimazole/Betamethazone cream as: "no inventory", "on order", "not available at the moment", or no reason was given. An Anonymous interview indicated, Resident D had been without his Clotrimazole/Betamethazone cream for over a month at one point. This Residential Tag relates to Complaints IN00419078, IN00418354 and IN00417996.			