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	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MANSION ON MAIN, THE	1420 EAST MAIN STREET NEW ALBANY, IN 47150

(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
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00402455. Complaint IN00402455 - State deficiency related to the allegations is cited at R0052. Survey date: March 20, 2023 Facility number: 013994 Residential Census: 101 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on March 29, 2023.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense Based on interview and record review, the facility failed to initiate CPR (Cardiopulmonary Resuscitation) on a resident (Resident B) with a CPR advance directive for 1 of 3 residents reviewed for neglect. Findings include: The clinical record for Resident B was reviewed on 3/20/23 at 10:30 a.m. The diagnoses included, but were not limited to, cardiovascular accident, atrial fibrillation and hypertension. Review of Resident B's face sheet indicated to initiate CPR. The incident report, dated 2/22/23 at 6:01 a.m.,	R 0052	Please accept this submission of our Plan of Correction for R 116. It is prepared and submitted because of requirement under state and federal law. 1. What corrective action will be accomplished: All new admissions will have their Advanced Directives added to the Nurses Report sheet for quick reference. Resident that have an Advanced Directive for “Full Code” will be added to Resident Health Profile Report that will be located with the CPR (Cardiopulmonary Resuscitation) equipment. Nursing staff will receive education	04/30/2023

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

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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	indicated at 5:47 a.m., Resident B placed her call pendant on. CNA (Certified Nurse Aide) 3 responded and found Resident B lying in her bed and not responding. CNA 3 immediately called LPN (Licensed Practical Nurse) 2 who responded and notified EMS (Emergency Medical Services). The progress note, dated 2/23/23 at 5:47 a.m., indicated LPN 2 was called to Resident B's room by CNA 3. Resident B was observed lying on her back, in her bed, with her right leg hanging off of the side of the bed. Resident B had no visible respirations and had bright red blood on her face and hands. A call was placed to EMS. The written statement from CNA 3, dated 2/23/23, indicated on 2/22/23 between 5:45 a.m. and 6:00 a.m., CNA 3 responded to Resident B's call pendant. She knocked on Resident B's door with no answer. She opened the door, walked in and said Resident B's name. The only lighting in the room was the bathroom light and the light from the television that was on. CNA 3 walked over to where the TV was and said Resident B's name again. CNA 3 could tell there was something on Resident B's face.. CNA 3 then exited the room, called LPN 2 and asked her to meet her at Resident B's room. When LPN 2 arrived, CNA 3 was standing outside the door of Resident B's room and told LPN 2 that she was spooked because it looked like something was wrong with Resident B's face. LPN 2 and CNA 3 entered the resident's room and walked over by the television at which time LPN 2 turned on the lamp. Resident B's face was covered in blood and there was blood on the floor in front of the television.. CNA 3 checked to see if Resident B was breathing and she was not. LPN 2 then called 911 from her cell phone and went to the nurses' desk to check and see if the resident was a DNR (Do Not Resuscitate). By the		on facility policy regarding CPR by 04/30/2023. Nursing staff that have not received education by 04/30/2023 will not be able to work after 04/30/2023 until education has been completed. 2. How will the facility identify other residents having the potential to be affected and what corrective action will be taken. All residents have the potential to be affected. The Director of Nursing completed at 100% audit on 03/22/2023 to review all Advanced Directives. All new admissions will have their Advanced Directives added to the Nurses Report sheet for quick reference. Residents that have an Advanced Directive for "Full Code" will be added to the Resident Health Profile Report that will be located with the CPR (Cardiopulmonary Resuscitation) equipment. Nursing staff will receive education on facility policy regarding CPR by 04/30/2023. Nursing staff that have not received education by 04/30/2023 will not be able to work after 04/30/2023 until education has been completed. 3. What measures will be put in place to ensure deficient practice does not recur. Facility policy regarding CPR will be added to the orientation process for all nursing staff. A	

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	time LPN 2 got back to the resident's room the fire department had arrived. The clinical record lacked documentation of an assessment for a pulse or staff initiation of first aid or CPR. During an interview, on 3/20/23 at 11:22 a.m., the DON (Director of Nursing) indicated the aide was not CPR certified, only first aide certified which was why she called the nurse. The nurse let in the fire department and EMS. The fire department thought it could have been a homicide and would not allow the staff back in the room. She said the nurse was very upset and wanted to initiate CPR but was not allowed in the room per the fire department. She was not sure if any CPR was rendered to the resident. During an interview on 3/20/23 at 1:02 p.m., LPN 2 indicated she was down on the basement floor (one floor down from Resident B's room) when she received the call from CNA 3. From the elevators, the resident's room was was to the right and around the corner. She stepped in the room. She did not think the resident was breathing and if she was, it was very shallow. The resident was warm to the touch. She ran to the nurses' station (approximately 88 feet) to look up the resident's code status and called 911 from her cell phone, which was at the nurses' station. When she called 911, they told her to wait at the door to let them in, so they must have been close. It all happened so fast she was not sure how much time had elapsed. EMS was there within a minute or two. She looked up the resident's code status as that was something the nurses do and was not sure if the aides had access to that information. On 3/20/23 at 2:01 p.m., the Director of Nursing		post test will be initiated to ensure nursing staff understand their role during a Code. 4. How will the corrective action be monitored. DON/Designee will conduct a mock Code, alternating shifts, biweekly for three months then monthly for three months beginning on 04/24/2023. All findings will be brought to and discussed at Quality Assurance Meetings that will begin on 05/01/2023 and continue biweekly for three months then monthly for three months. This will be extended if facility has not received 100% compliance. 5. What date will systematic changes be completed. 04/302023 IDR Reason: The facility requests that this deficiency be reviewed and removed based on the attached documentation. The call pendant was responded to timely, EMS notified timely, and staff did not have opportunity to further intervene once EMS arrived on scene in a timely manner. Attached are supporting documents. Thank you.	

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	provided a current copy of the document titled "Advance Directive - Cardiopulmonary Resuscitation" dated 10/10/18. It included, but was not limited to, "Policy...will initiate cardiopulmonary resuscitation in all instances of resident cardiopulmonary arrest...The Director of Nursing Services or designee is responsible for...ensuring that all qualified staff are aware of the resident's wishes regarding resuscitation...." This State tag relates to Complaint IN00402455			