STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155823	A. BUILDING 00 B. WING	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHPOINTE HEALTHCARE CENTER	4904 WAR ADMIRAL DRIVE INDIANAPOLIS, IN 46237

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00366624. Complaint IN00366624 - Unsubstantiated due to lack of evidence. Survey dates: November 15, 16, 17, 18, 19, and 22, 2021 Facility number: 013126 Provider number: 155823 AIM number: 300029591 Census Bed Type: SNF/NF: 99 Total: 99 Census Payor Type: Medicare: 24 Medicaid: 49 Other: 26 Total: 99 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on November 24, 2021.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth on this statement of deficiencies. The plan of correction is prepared and executed solely because it's required by the position of federal and state law. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during a recertification survey on November 22, 2021. Please accept this plan of correction as the provider's credible allegation of compliance.	
F 0600 SS=G Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this			

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

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	subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, interview, and record review, the facility failed to ensure a resident was free from Resident 27 having tried to choke her for 1 of 1 resident reviewed for abuse, which resulted in psychosocial distress with pain and redness around a resident's neck that required acute care hospital evaluation. (Resident 66) Findings include: During dining observation, on 11/15/21 at 12:21 P.M., Resident 66 was seated at a table in the dining room. Resident 27 was seated behind Resident 66. At that time, observed Resident 27, without being provoked, to wrap a cloth napkin over Resident 66's head, wrap the neck around her neck, and then pulled on the napkin. Two nurses, who were present in the dining room, immediately, responded and separated Resident 27's hands from Resident 66. The clinical record of Resident 66 was reviewed on 11/15/21 at 1:00 P.M. Diagnoses included, but were not limited to, anxiety disorder, depression, mood disorder and acute respiratory failure with hypoxia. A quarterly Minimum Data Set (MDS) assessment, dated 10/6/21, indicated, Resident	F 0600	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 27 had been sent to the Emergency Department for a crisis assessment on 11.14.2021, the night prior to this incident, but the licensed mental health counselor and ED physician felt that resident was not a danger to self or others and so resident was returned to facility on 11.15.2021. At the time of the altercation on 11.15.2021, both residents were immediately separated and resident 66 was provided with emotional support; physical assessment by nurse practitioner; pain medication; reassurance of her safety and support for her psychosocial well-being. Resident 66 verbalized that she felt safe and went back to the dining room per her request to finish her lunch. Resident 27 was immediately provided with 1:1 direct supervision and support for mental health symptom	12/16/2021

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	66 was cognitively intact. Resident 66 required limited assistance with one staff member for transfers, supervision with one staff member for eating, and limited assistance with set up only for ambulating. The clinical record of Resident 27 was reviewed, on 11/15/21 at 1:15 P.M. Diagnoses included, but were not limited to, non-Alzheimer's dementia, anxiety, depression, schizophrenia, and post-traumatic stress disorder. A quarterly MDS assessment, dated 10/12/21, indicated, Resident 27 was not cognitively intact and had not exhibited hallucinations, delusions nor behaviors. Resident 27 used a wheelchair and required limited assistance with one staff member for transfers and required supervision with set up assistance for locomotion on unit and eating. A progress note, dated 11/14/21 at 4:44 P.M., indicated, Resident 27 had altered mental status with physical aggression and was a danger to self or others. Resident 27 was sent to the Emergency Department for evaluation. A hospital discharge summary, dated 11/15/21 at 2:44 A.M., indicated, "[Resident 27] did not seem paranoid or delusional and was calm and cooperative in the Emergency Room ...[Resident 27] continues to deny safety concerns and is agreeable to return to facility. Rationale for disposition: "[Resident 27] has been made aware of several treatment options. Inpatient psychiatric hospitalization, outpatient behavioral health services, and intensive outpatient services. The treatment team, in conjunction with [Dr. name] recommends outpatient behavioral health services with current nursing home services		exacerbation. Resident 27 was assessed by in-house NP with new orders given for increased antipsychotic. Facility was able to secure inpatient psychiatric hospital admission and resident 27 was transferred out of facility on 11.16.2021. Resident 27 remained under direct 1:1 staff supervision and was provided with redirection and support until transported for inpatient psychiatric treatment. This altercation was reported to IMPD as required. Resident 66 continued to be observed for any signs/symptoms of increased distress and provided with increased support for psychosocial wellbeing as well as being assessed for pain and provided pain medication as indicated/requested. Resident 27 has secured placement at a long term facility closer to her family and will not be returning to this facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? A facility-wide audit was conducted of all residents and there are no other residents who are exhibiting behaviors related to psychiatric diagnoses. What measures will be put into place and what systemic changes will be made to ensure that the	

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	based on strong safety plan, lack of acute risk factors, denying risk to self and others, verbalizing ability to keep self/others safe and agreeing to following up with outpatient services." On 11/15/21 at 12:35 P.M. Resident 66's neck was observed to be reddened. Interview, at that time, Resident 66 indicated, Resident 27 had put a cloth napkin over her head, then wrapped it around her neck and pulled the napkin until she "couldn't breathe." She wasn't able to breathe until the nurses got Resident 27's hands loose. She was "scared" when that happened. She had "anxiety and pain in her neck" at the time of the incident. During an interview, on 11/15/21 at 1:28 P.M., Licensed Practical Nurse (LPN) 1 indicated, she heard someone yell help. When she looked in that direction, she saw a cloth napkin wrapped around Resident 66's neck and Resident 27 sitting behind her pulling the napkin. LPN 1 immediately ran to the residents and asked Resident 27 to let go of the napkin as the Unit Manager slid her fingers into Resident 27's hands in order to get Resident 27 to release her grip from the napkin. Once we separated Resident 27 from Resident 66, LPN 1 assessed Resident 66 for injuries, pain and emotional distress. Resident 66 had some redness on her neck and complained of pain in the neck area. LPN 1 thought, "the incident was terrifying and caused anxiety" for LPN 1. Resident 27 had never been physical with another resident. Resident 27 had been having increased hallucinations that she saw her daughter, who was murdered in 2012, working in the building and in her room. During an interview, on 11/15/21 at 2:15 P.M.,		deficient practice does not recur? Facility staff strive to identify and safely manage residents who are exhibiting behaviors related to psychiatric diagnoses or who may present a danger to themselves or others. ED/DON will train facility nursing and interdisciplinary staff on the facility behavior management policy including identifying problematic/dangerous behaviors and developing a resident centered plan to safely manage residents with these behaviors. ED/DON will also provide education to facility nursing and interdisciplinary staff regarding when and how to provide one-on-one direct supervision for residents who present a danger to self or others. How the corrective action will be monitored to ensure the deficient practice will not recur (i.e. – what QA program will be put into place)? DON/designee will complete audits of 10 residents to ensure facility nursing staff are identifying/assessing for problematic/dangerous behaviors. These audits will be completed twice weekly for two (2) weeks; once weekly for two (2) weeks and then monthly for four (4) months. Also, ED/DON will complete audits of all residents with problematic/dangerous behaviors to ensure that a	

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	the Unit Manager indicated, she was called in yesterday, on 11/14/21, because Resident 27 was being sent to the Emergency Department for having increased hallucinations that she had been seeing her daughter who was murdered in 2012, working in the building and in her room. Resident 27 had been telling staff she needed money to feed her kids and thought someone was coming after her to murder her. Today, we were in the dining room and heard someone yell help. When I looked in that direction, I saw a cloth napkin on Resident 66's neck with Resident 27's hands pulling on each side of the napkin. She immediately responded with LPN 1 and slid her fingers into Resident 27's hands in order to loosen her grip on the napkin and slid the napkin out of her hands. Once separated, Resident 27 was assessed. The Unit Manager had never experienced an incident like that before and the incident "caused anxiety and emotional distress" for her. Resident 27 has never been physical with another resident. Resident 27 is now on constant supervision with a staff member. During an interview, on 11/15/21 at 3:00 P.M., the Director of Nursing indicated, Resident 27 had been placed on constant supervision. Resident 27 was scheduled to leave the facility, on 11/16/21 at 11:00 A.M., to go to a hospital for treatment. On 11/19/21 at 8:40 A.M., the Director of Nursing provided a copy of a Hospital post-acute care note, dated 11/15/21. A review of the note indicated, " ...[Resident 27] placed a towel around [Resident 66's] neck and pulled ...evaluated the neck and while it had some redness [Resident 66] was able to swallow and move air. Neck pain due to manual strangulation attempt and increased anxiety with incident. Monitor neck, Xanax [a		resident centered behavior management care plan has been developed/implemented. These audits will be completed daily for two weeks; twice weekly for 2 weeks, once weekly for 2 weeks and then monthly for 4 months. The results of these audits/observations will be reported, reviewed and trended for compliance and further follow up through the facility QAPI Committee for a minimum of 6 months and then randomly thereafter.	

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	prescription medication used to treat anxiety] 0.25 mg [milligrams] orally for one dose." On 11/19/21 at 8:40 A.M., the Director of Nursing provided a copy of a pain observation tool, dated 11/15/21 at 1:30 P.M. A review of the pain observation tool indicated, Resident 66 had a pain level of 7 out of 10, in the neck. The November 2021 Medication Administration Record indicated, Resident 66 had received acetaminophen (a medication used to treat pain) 650 mg orally on 11/15/21 at 1:30 P.M. On 11/16/21 at 8:45 A.M. The Director of Nursing provided a copy of a facility policy, titled "Indiana Abuse and Neglect and Misappropriation of Property," dated 9/1/2017, and indicated this was the current policy used by the facility. A review of the policy indicated, "It is the intent of this facility to prevent abuse ..." 3.1-27(a)(1)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---			

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	§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.			
	Based on interview and record review, the facility failed to ensure monitoring for side effects of psychotropic medications for 1 of 8 residents reviewed for unnecessary medication use. (Residents 27)	F 0758	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident discharged from the	12/16/2021

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	Findings include: The clinical record of Resident 27 was reviewed on 11/15/21 at 1:15 P.M. Diagnoses included, but were not limited to, non-Alzheimer's dementia, anxiety, depression, schizophrenia and post-traumatic stress disorder. A quarterly Minimum Data Set (MDS) assessment, dated 10/12/21, indicated, Resident 27 was not cognitively intact and had not exhibited hallucination, delusions nor behaviors. A care plan, dated 12/15/20 and current through 1/31/22, indicated, the resident used anti-depressant medication related to depression. Interventions included, but were not limited to, Observe for side effects of anti-depressant medications, i.e., dystonia, torticollis, anticholinergic sx (dry mouth, blurred vision, constipation, urinary retention, hypotension, sedation, drowsiness, increased falls, dizziness), cardiac abnormalities (tachycardia, bradycardia, irregular heart rate), anxiety, agitation, blurred vision, sweating, rashes, headache, weakness, hang over effects, appetite change, weight change, nausea, insomnia, hallucinations, aggressive behavior, suicidal ideations. A care plan, dated 2/16/21 and current through 1/31/22, indicated, The resident used anti-anxiety medication related to anxiety. Interventions included, but were not limited to, observe for side effects of anti-anxiety medications, i.e., dystonia, torticollis, anticholinergic sx (dry mouth, blurred vision, constipation, urinary retention, hypotension, sedation, drowsiness, increased falls, dizziness), cardiac abnormalities (tachycardia, bradycardia,		facility on 11.16.21 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? A facility audit has been completed for all residents currently prescribed psychotropic medications, to ensure these residents are being monitored for side effects of psychotropic medications and to ensure this monitoring is being documented in the clinical record. – What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The Admissions nurse/designee will identify new admits that have been prescribed psychotropic medications and ensure that the appropriate monitoring orders are in place at time of admission. Any current residents that receive orders for new psychotropic medications will have monitoring orders entered at that time by a licensed nurse. New admissions and new orders for current residents will be reviewed daily by IDT to ensure psychotropic medications have side effect monitoring in place. DON/designee will provide education to licensed nurses on recognizing what medications are classified as psychotropic, as well as what appropriate side effect	

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	irregular heart rate), anxiety, agitation, blurred vision, sweating, rashes, headache, weakness, hang over effects, nausea, depression, hallucinations, aggressive behavior. A care plan, dated 2/16/21 and current through 1/31/22, indicated, resident has a neurologic disorder r/t encephalopathy, epilepsy, schizophrenia. Interventions included, but were not limited to, Administer medications per medical providers orders. Observe for side effects and effectiveness. Report abnormal findings to medical provider, resident or resident representative. The Physician's orders, dated November 2021, indicated, phenelzine (a prescription medication used to treat depression) 15 mg (milligrams) 2 tabs orally 3 times daily (start 10/6/21), Zyprexa (a prescription antipsychotic medication) 5 mg 2 tabs orally in the morning for hallucinations (start 11/10/21), alprazolam (a prescription medication used to treat anxiety) 0.5 mg 3 times daily for anxiety (start 10/6/21), divalproex (a prescription medication used to treat seizures) 250 mg 3 tabs orally in the morning and at bedtime for schizophrenia (start 10/6/21). The November 2021 Medication Administration Record indicated, Resident 27 had received phenelzine 15 mg, Zyprexa 5 mg, alprazolam 0.5 mg and divalproex 250 mg as ordered by the Physician. The clinical record lacked documentation of monitoring for side effects of psychotropic medications phenelzine, Zyprexa, alprazolam and divalproex. During an interview, on 11/19/21 at 10:35 A.M.,		monitoring should be implemented. The IDT will evaluate the resident's response to psychotropic medications, including any noted side effects, in the facility pharmacy and therapeutics meetings. ED/DON will provide education to the IDT regarding facility policy for the Pharmacy and Therapeutics meetings. How the corrective action will be monitored to ensure the deficient practice will not recur (i.e. – what QA program will be put into place)? The DON/designee will conduct an audit for no less than 10 residents that are prescribed psychotropic medications to ensure side effect monitoring is being completed. This audit will be completed twice weekly for 2 weeks, then weekly for 4 weeks, then monthly for 4 months. ED/DON will conduct an audit of the Psychotropic Medication Evaluation for no less than 5 residents to ensure that side effect monitoring information is being reviewed. This audit will be completed monthly x3 months and then quarterly thereafter. The results of the audits/observations will be reported, reviewed and trended for compliance and further follow up through the facility QAPI Committee for a minimum of 6 months and then randomly thereafter.	

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	the Director of Nursing indicated, monitoring of side effects of psychotropics should have been documented. By survey exit, on 11/22/21 at 1:30 P.M., the facility was unable to provide documentation of monitoring for side effects of psychotropic medications for Residents 27. By survey exit, on 11/22/21 at 1:30 P.M., the facility was unable to provide a policy regarding psychotropic medication monitoring prior to exit, which had been requested from the Director of Nursing. 3.1-48(a)(3)			