STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155215	A. BUILDING 00 B. WING	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PLAINFIELD HEALTH CARE CENTER	3700 CLARKS CREEK RD PLAINFIELD, IN 46168

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00446484, IN00449428, IN00451783, IN00451862, IN00452158, IN00452303, IN00452675, IN00452714, IN00453379, IN00453464, and IN00453723. Complaint IN00446484 - No deficiencies related to the allegations are cited. Complaint IN00449428 - Federal/state deficiencies related to the allegations are cited at F602, F609, and F610. Complaint IN00451783 - No deficiencies related to the allegations are cited. Complaint IN00451862 - No deficiencies related to the allegations are cited. Complaint IN00452158 - No deficiencies related to the allegations are cited. Complaint IN00452303 - No deficiencies related to the allegations are cited. Complaint IN00452675 - No deficiencies related to the allegations are cited. Complaint IN00452714 - No deficiencies related to the allegations are cited. Complaint IN00453379 - No deficiencies related to the allegations are cited. Complaint IN00453464 - Federal/state deficiencies related to the allegations are cited at F760 and F842.	F 0000	Preparation and submission of this Plan of Correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the facility has prepared and submits this Plan of Correction solely as a requirement under State and Federal law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and 19 programs and to provide the best possible care to our residents as possible. The facility respectfully requests a desk review for this plan of correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Burton	Administrator	03/18/2025

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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	Complaint IN00453723 - State deficiencies related to the allegations are cited at 9999. Survey dates: February 11, 12, 13, 14, 17, 18, 19, and 20, 2025 Facility number: 000121 Provider number: 155215 AIM number: 100290940 Census Bed Type: SNF/NF: 107 Total: 107 Census Payor Type: Medicare: 6 Medicaid: 76 Other: 25 Total: 107 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 27, 2025.			
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation Based on observation, interview and record review, the facility failed to protect the resident's right to be free from misappropriation of property for 1 of 3 residents reviewed for misappropriation of property (Resident B). The deficient practice was corrected on 12/19/24, prior to the start of the survey, and was therefore past noncompliance. Findings includes: A facility reported incident (FRI) report, dated 12/17/24 at 2:01 p.m., indicated the local police had	F 0602	Past non-compliance. No plan of correction required.	03/14/2025

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	entered the building at the request of Resident B's sister to investigate potential fraudulent charges on Resident B's account. The facility immediately opened an investigation into this concern along with a review of previous involvement in concerns with Resident B's bank account. On October 28, 2024, Resident B received her bank statement and noticed that there were charges on her account that she did not recognize. She went to the Business Office Manager (BOM) who helped her call the bank to make a report of possible fraudulent charges and deactivate her current debit card. The bank took care of this for Resident B and set her up with a new debit card. On October 28, 2024, Resident B received confirmation from the bank that she was reimbursed for the charges she was unaware of ($500.59) and would investigate the issue further. Resident B did not share at this time that she had any concerns with a former staff member having access to her debit card. BOM and Resident B agreed that going forward the debit card would be locked in the business office when Resident B was not using the card. The facility investigation was concluded on 12/18/24, this concern cannot be substantiated at this time. On 2/11/25 at 1:35 p.m., observation of Resident B in her room sitting in a wheelchair preparing to go play bingo. The resident indicated she had given the prior Social Service Assistant (SSA) her bank card to pick up a few items for her, but then she got her bank statement showing purchases had been made to door dash as well as other places she would not have bought items from while in the facility. The resident indicated she had trusted the SSA, but now the SSA would not answer her phone calls to answer questions. Resident B's record was reviewed on 2/11/25 at			

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	10:28 a.m. Diagnoses on Resident B's profile included, but not limited to, dementia with psychotic disturbance (condition in which cognitive decline characteristic of dementia is accompanied by psychotic symptoms such as hallucinations and delusions). An annual and state optional MDS (Minimum Data Set) assessments, completed 1/16/2025, assessed the resident as having highly impaired hearing, but had the ability to make herself understood and to understand others. The resident needing limited assistance of one person physical assist for bed mobility, and limited assistance of two plus persons physical assist for transfers, and toilet use. A brief interview for mental status (BIMS) score of 15 out of 15 indicated the resident was cognitively intact. The resident indicated it was somewhat important to her to take care of her personal belongings or things, have her family or a close friend involved in discussion about her care, and to have a place to lock her things to keep them safe. A care plan indicated Resident B presented with a diagnosis of dementia and was at risk for memory loss, disorientation, impaired decision making and reduced or poor judgement and insight. The goal was for the resident to be able to communicate basic needs and accept verbal cues and reminders as needed for optimal psychosocial wellbeing. Interventions included ask yes/no questions to determine the resident's needs. Assist resident with tasks segmentation by simplifying tasks into steps. Offer demonstration/teach back as needed to ensure understanding. Reduce any distractions- turn off TV, radio, close the door etc. The resident understood consistent, simple, directive sentences. Provide the resident with necessary cues- stop and return if agitated. Cue,			

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	reorient and supervise as needed. The resident record lacked documentation of resident/resident representative concerns of the SSA having taken the resident's debit card and misappropriated money without the resident's permission, physician notification, or facility efforts in investigating the resident's concerns of misappropriation of funds had occurred. In-service Training Reports, dated 12/18/24, and 12/19/24, subject staff handling resident cash/cards, indicated 77 signatures of staff having signed from all departments, as having received the education. Educational statement indicated, "Staff of [the facility name] should not take cash money, debit cards, gift cards, or credit cards from any resident or family member of [the facility name]. If a resident or family member requests that any staff member access any of their cash, debit cards, gift cards, or credit cards staff member should decline and inform member of [the facility name] Leadership". During an interview on 2/14/25 at 11:01 a.m., a family member indicated she had been informed by Resident B around September or October 2024 that she had concerns about her debit card being used for purchases without her knowledge. Resident B had indicated that the SSA who had been shopping for her had quit without telling anyone, did not return the resident's debit card, and had taken all the evidence of the resident's records with her. The facility was made aware, along with the local police and the Ombudsman. Resident B had indicated when she received her October bank statement, she was missing over $4000. The resident indicated there were charges such as door dash, bath and body works, withdrawals from automated teller machines			

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	(ATMs), local and not so local big-box stores, on-line purchases for animal treats, etc. she could not have made herself. The resident had indicated during this time the SSA and Activity Director had also told her she needed to spend down some of her money so she would receive a monthly supplement, and the SSA had purchased the resident some clothing with her debit card, but at the time the resident thought the clothing was a gift from the SSA. Resident B's bank statements indicated, a. On 3/18/24 1 debit card transaction amounted to $46.60. b. On 4/15/24 5 debit card transactions amounted to $129.00. c. On 5/20/24 2 debit card transactions amounted to $64.09. d. There was no June 2024 statement available. e. On 7/15/24 no debit card transactions. f. On 8/19/24 30 debit card transactions amounted to $3,970.78. g. On 9/16/24 37 debit card transactions amounted to $3978.41. h. On 10/21/24 29 debit card transactions amounted to $1378.71. i. On 11/18/24 3 debit card transactions amounted to $23.53. j. On 12/09/24 5 debit card transactions amounted to $325.84. k. On 1/17/25 5 debit card transactions amounted to $322.69. Resident B's bank statements indicated, on 7/15/24 an ending balance of $9539.98, on 8/19/24 an ending balance of$5496.68, on 9/16/24 an ending balance of $1066.24, and an ending balance on 10/21/24 of $496.46. On 2/20/25 at 4:35 p.m., the BOM provided a			

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	general note, dated 10/28/24 at 3:25 p.m., The note indicated that the resident came in with her bank statement and wanted to dispute charges on the card. She did say the SSA did have the card so the resident could call the SSA, and she would bring her what she wanted to buy. Several charges did not make sense as the resident had not ever used door dash and especially one for $51.50 for a pizza restaurant, and 2 charges to a big box store on the same day at different locations. They called the bank together and gave them a list of the charges she did not authorize, and they said she would need to go to the bank location to get a new card. The BOM gave Resident B the option of putting the debit card in her financial file as only the BOM and ADM had access to her office as the door was locked when she was out of it, and that they would do a sign in and sign out when the card left the file. The BOM sent an e-mail to transportation for transport. On 2/20/25 at 4:35 p.m., the BOM provided a general note, dated 10/29/24 at 3:32 p.m. The note indicated that the resident brought her debit card into her office and the BOM placed it in a clasped envelope with the resident's name on it. During an interview on 2/11/25 at 2:40 p.m., the BOM indicated in October 2024, Resident B had come to her and asked that they call the bank together as Resident B's bank statement was showing charges she did not make. The bank asked if anyone had access to her bank card, and Resident B indicated the SSA so she could make purchases for the resident. When the request was made to deactivate the debit card, the teller informed them the resident would need to present to the bank in person and they would make her a new card, and the resident would need to sign for any disputed charges on her bank statement.			

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	Resident B was taken to the bank by facility transportation. The SSA had quit without notice in September keeping the resident's debit card, it was not returned until the end of October. A police officer had visited the facility in December and gotten statements and paperwork. The BOM indicated she had assisted the resident, and upon viewing the bank statements, many charges did not look like what the resident would have purchased living in the facility. But again, the facility had not had access to the residents outside bank statements until the resident decided to share with them. In October the BOM asked the resident to lock the debit card up in her office and came up with a sign in and sign out of the card log. A confidential interview conducted during the survey indicated in December 2024 police had been seen entering the facility and line staff indicated the police were in the facility to question the SSA for stealing Resident B's debit card and taking her money. The resident had indicated that the SSA used her debit card to purchase items she had not approved. During an interview on 2/13/25 at 3:15 p.m., Resident B indicated, she had given her debit card to the SSA to buy small purchases such as almond milk, lunch meat, and bread. To her knowledge the SSA had never brought her back a receipt for anything she purchased. In September and October 2024 the resident noticed large purchases to locations like door dash, big box stores, on-line animal treats, donut shops, and ATMs which were not places she would have been to personally, used, or approved. The resident indicated everyone knew it was the SSA that had used the card inappropriately. The police had been notified and she was currently waiting			

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	to hear back from the police and the bank to see if she would get to recover any of her money. The old debit card was cancelled and a new debit card obtained which was currently being locked up in the BOM office. The resident indicated to her knowledge she did not think the facility investigated the SSA's involvement in her debit card being used without her permission. There had been a brief discussion with the Administrator (ADM) who asked her how she knew it was the SSA that had used her card inappropriately, this led her to believe the facility had not taken her concerns about the SSA seriously. The resident indicated she just did not understand, the SSA had claimed to be her friend, so how could she do something like this? A Social Service Assistant job description, signed by the SSA on 2/27/24, indicated, "Work with the interdisciplinary team and administration to promote and protect resident rights and the psychological well-being of each resident. Prevent and address resident abuse as mandated by law and professional licensure ..." An Abuse Prevention Proficiency Test with the SSA's name, was dated as having been completed on 2/28/24. A typed resignation letter from the SSA, dated 8/23/24, indicated, please accept this as my formal resignation from the facility, my last day will be on the 15th day of September. The letter was not signed. During review of the SSA employee file, observation of a termination request, dated 10/29/24. The request indicated termination date 9/23/24, voluntary, termination reason: another position, last day worked 9/22/24.			

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	A Corrective Action Memo, dated and signed by the HR Director on 10/29/24, indicated the SSA had turned in her resignation on 8/23/24, with her last date to work on 9/15/24. On 9/11/24 she had rescinded her notice stating she was staying. On 9/23/24 the SSA did not show for work and would not reply to the ADM. The SSA was terminated. A typed witness statement, dated 10/28/24, and signed by the ADM indicated that the Social Service Director (SSD) and ADM had met with Resident B on this date as Resident B disclosed to the BOM, that she had provided her debit card to the former SSA so that the former SSA could purchase items on Resident B's behalf. Resident B was adamant that she wanted the SSA to have her debit card to help her make purchases as she requested. Resident B stated that she trusted the SSA implicitly. A typed witness statement, dated 10/28/24, and signed by the BOM, indicated Resident B had come in with her bank statement and wanted to dispute charges on her card. Several charges did not make sense as Resident B had not ever used door dash and esp. one for $51.50 at a pizza restaurant or 2 big box stores charge the same day at different locations. BOM and Resident B called the bank together and gave them a list of the charges she did not authorize, and they said she would need to come to the bank branch location to get a new card. The BOM gave Resident B the option of putting her new card in her financial file as only the BOM and ADM had access to her office and the door was locked when she was out of it and that they would do a sign in sign out when the card left the file. The BOM sent an email to transportation for transport.			

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	A typed witness statement, dated 10/31/24, unsigned, indicated, on 10/31/24 SSD contacted SSA via phone. SSA confirmed she did have Resident B's debit card for a time. SSA stated she returned the card the previous evening (10/30/24). The concerns for unknown charges were discussed with SSA. The potential for the card to have been lost or misplaced were discussed. SSA denied there to be any concern for unknown charges. SSA stated she always had the card in her possession, prior to returning it. A typed witness statement, dated 12/17/24, signed by the ADM and SSD, indicated there had been a meeting between Resident B, the ADM, and SSD regarding bank account concerns, following up with Resident B regarding bank account charges for October that she had disputed. Resident B discussed her concerns with her sister, and they have concluded that SSA, who Resident B allowed to have her debit card, must have made charges that Resident B did not authorize. Resident B trusted SSA and gave SSA permission to hold her debit card so she could purchase on Resident B's behalf. Resident B admitted that she had not reviewed her bank statements for several months. She also admitted that she did not think that SSA did anything wrong with her bank statement. Resident B was unaware that there was cyber theft and how banking information can be gathered without having any cards, etc. During an interview on 2/20/25 at 9:59 a.m., the ADM indicated she found out in October 2024 that Resident B had given her debit card to the SSA to use to help with shopping for the resident. The BOM had not seen Resident B's bank statements until October when the resident had asked her for help with her debit card. The SSD had contacted the SSA in October about			

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	suspicious charges, and the SSA had denied knowledge of the suspicious charges. The SSA had possession of Resident B's debit card for 38 days after she left employment with the facility. The debit card had been deactivated after being returned to the facility on 10/30/24, and the unusual charges that had been occurring for the past 3 months had stopped appearing on the bank statements. The resident record also lacked documentation of a staff member having possession of the resident personal debit card. During an interview on 2/20/25 at 3:50 p.m., the Regional Director of Operations indicated there was no facility policy about staff having possession of resident money or cards, just the best practice for staff not having possession of resident money or cards. During an interview on 2/20/25 at 3:50 p.m., the ADM indicated the first change in how staff handled resident monies happened in October 2024 with a debit card signing in and out process with Resident B. The facility went a step further in December and implemented a facility-wide process where a staff member or a resident had to sign for money or a card being taken out of the business office, accounting for how much was spent by presenting a receipt and giving back unused change. In December 2024 the facility presented in-servicing to staff on the new in-house practices. The ADM indicated, there was no documentation in Resident B's record from nursing staff or social services of the sister's report of questionable debit card charges or the police showing up to investigate. The ADM indicated, Resident B did not give the BOM bank statements until January 2025. On 2/20/25 at 11:09 a.m., the ADM provided an			

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	Abuse Prevention and Prohibition Program policy, dated 8/2020, and indicated the policy was the one currently being used by the facility. The policy indicated, "Purpose: To ensure the Facility establishes, operationalizes, and maintains and Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements ..." On 2/20/25 at 3:33 p.m., the Regional Nurse Consultant provided a Theft/Loss Prevention policy, dated 8/2020, and indicated the policy was the one currently being used by the facility. The policy indicated, "Purpose: To assist resident in safeguarding their person property ...E. The Administrator notified local law enforcement within any state applicable time period of an incident involving theft of resident property with a value of one hundred dollars [$100] or more ...III. The Administrator or designee investigates all reports of stolen items and documents the investigation on Grievance Forms ...When an alleged or suspected case of misappropriation of resident property is reported, the Administrator, or designee, notifies the following persons or agencies within twenty-four [24] hours of such incident: i. Department of Public Health/aging; ii. Ombudsman, iii. Resident's Representative; iv. Adult Protective Services; and v. Law Enforcement Officials ..." This deficient practice was corrected by 12/19/24 prior to the start of the survey and was therefore Past Noncompliance. The facility implemented a systemic plan that included a safe audit for			

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	resident bank cards, gift cards, and cash, staff education regarding abuse and misappropriation of property, a system for locking up bank cards, gift cards, and cash and signing in and out with the BOM (Business Office Manager) or ADM and providing receipts as proof of monies spent, and ongoing monitoring by Quality Assurance and Performance Improvement (QAPI). This citation relates to Complaint IN00449428. 3.1-28(a)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations Based on interview, and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for 1 of 3 residents reviewed for misappropriation (Residents B). Findings includes: During an interview on 2/14/25 at 11:01a.m., a family member indicated she had been informed by Resident B around September or October 2024 that she had concerns about her debit card being used for purchases without her knowledge. Resident B had indicated that the SSA who had been shopping for her had quit without telling anyone, did not return the resident's debit card, and had taken all the evidence of the resident's records with her. The facility was made aware, along with the local police and the Ombudsman. Resident B had indicated when she received her October bank statement, she was missing over $4000. The resident indicated there were charges such as door dash, bath and body works,	F 0609	1--What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Administrator and nursing staff have been educated on the abuse reporting policy and procedures. 2--How are other residents having the potential to be affected by the same deficient practice be identifies and what corrective action(s) will be taken? Administrator and nursing staff have been educated on the abuse reporting policy and procedures. 3--What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur?	03/14/2025

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	withdrawals from automated teller machines (ATMs), local and not so local big-box stores, on-line purchases for animal treats, etc. she could not have made herself. The resident had indicated during this time the SSA and Activity Director had also told her she needed to spend down some of her money so she would receive a monthly supplement, and the SSA had purchased the resident some clothing with her debit card, but at the time the resident thought the clothing was a gift from the SSA. On 2/11/25 at 1:35 p.m., observation of Resident B in her room sitting in a wheelchair preparing to go play bingo. The resident indicated she had given the prior Social Service Assistant (SSA) her bank card to pick up a few items for her, but then she got her bank statement showing purchases had been made to door dash as well as other places she would not have bought items while in the facility. The resident indicated she had trusted the SSA, but now the SSA would not answer her phone calls to answer questions. During an interview on 2/13/25 at 3:15 p.m., Resident B indicated, she had given her debit card to the SSA to buy small purchases such as almond milk, lunch meat, and bread. To her knowledge the SSA had never brought her back a receipt for anything she purchased. In September and October 2024 the resident noticed large purchases to locations like door dash, big box stores, on-line animal treats, donut shops, and ATMs which were not places she would have been to personally, used, or approved. The resident indicated everyone knew it was the SSA that had used the card inappropriately. The police had been notified and she was currently waiting to hear back from the police and the bank to see if she would get to recover any of her money. The		Any potential reportable situation will be reviewed with Nursing or Operational regional staff to ensure they are appropriate and reported timely. 4--How will the corrective actions be monitored to ensure the deficient practice will not reoccur? Audit results will be reviewed and reported to the IDT in QAPI. Determination of ongoing monitoring will be completed within the QAPI process.	

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	old debit card was cancelled and a new debit card obtained which was currently being locked up in the BOM office. The resident indicated to her knowledge she did not think the facility investigated the SSA's involvement in her debit card being used without her permission. There had been a brief discussion with the Administrator (ADM) who asked her how she knew it was the SSA that had used her card inappropriately, this led her to believe the facility had not taken her concerns about the SSA seriously. The resident indicated she just did not understand, the SSA had claimed to be her friend, so how could she do something like this? Resident B's record was reviewed on 2/11/25 at 10:28 a.m. Diagnoses on Resident B's profile included, but not limited to, dementia with psychotic disturbance (condition in which cognitive decline characteristic of dementia is accompanied by psychotic symptoms such as hallucinations and delusions). An annual and state optional MDS (Minimum Data Set) assessments, completed 1/16/2025, assessed the resident as having highly impaired hearing, but had the ability to make herself understood and to understand others. The resident needing limited assistance of one person physical assist for bed mobility, and limited assistance of two+ persons physical assist for transfers, and toilet use. A brief interview for mental status (BIMS) score 15/15 indicated cognitively intact. The resident indicated it was somewhat important to her to take care of her personal belongings or things, have her family or a close friend involved in discussion about her care, and to have a place to lock her things to keep them safe.			

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	A care plan indicated Resident B presented with a diagnosis of dementia and was at risk for memory loss, disorientation, impaired decision making and reduced or poor judgement and insight. The goal was for the resident to be able to communicate basic needs and accept verbal cues and reminders as needed for optimal psychosocial wellbeing. Interventions included ask yes/no questions to determine the resident's needs. Assist resident with tasks segmentation by simplifying tasks into steps. Offer demonstration/teach back as needed to ensure understanding. Reduce any distractions- turn off TV, radio, close the door etc. The resident understood consistent, simple, directive sentences. Provide the resident with necessary cues- stop and return if agitated. Cue, reorient and supervise as needed. Resident B's bank statements indicated, on 7/15/24 ending balance $9539.98, 8/19/24 ending balance $5496.68, 9/16/24 ending balance $1066.24, and ending balance on 10/21/24 was $496.46. The resident record lacked documentation of resident/resident representative concerns of the SSA having taken the resident's debit card and misappropriated money without the resident's permission, physician notification, or facility efforts in investigating the resident's concerns of misappropriation of funds had occurred. On 2/20/25 at 4:35 p.m., the BOM provided a general note, dated 10/28/24 at 3:25 p.m., The note indicated that the resident came in with her bank statement and wanted to dispute charges on the card. She did say the SSA did have the card so the resident could call the SSA, and she would bring her what she wanted to buy. Several charges did not make sense as the resident had not ever used door dash and especially one for			

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	$51.50 for a pizza restaurant, and 2 charges to a big box store on the same day at different locations. They called the bank together and gave them a list of the charges she did not authorize, and they said she would need to go to the bank location to get a new card. The BOM gave Resident B the option of putting the debit card in her financial file as only the BOM and ADM had access to her office as the door was locked when she was out of it, and that they would do a sign in and sign out when the card left the file. The BOM sent an e-mail to transportation for transport. On 2/20/25 at 4:35 p.m., the BOM provided a general note, dated 10/29/24 at 3:32 p.m. The note indicated that the resident brought her debit card into her office and the BOM placed it in a clasped envelope with the resident's name on it. During an interview on 2/11/25 at 2:40 p.m., the BOM indicated in October 2024, Resident B had come to her and asked that they call the bank together as Resident B's bank statement was showing charges she did not make. The bank asked if anyone had access to her bank card, and Resident B indicated the SSA so she could make purchases for the resident. When the request was made to deactivate the debit card, the teller informed them the resident would need to present to the bank in person and they would make her a new card, and the resident would need to sign for any disputed charges on her bank statement. Resident B was taken to the bank by facility transportation. The SSA had quit without notice in September keeping the resident's debit card, it was not returned until the end of October. A police officer had visited the facility in December and gotten statements and paperwork. The BOM indicated she had assisted the resident, and upon viewing the bank statements, many charges did			

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	not look like what the resident would have purchased living in the facility. But again, the facility had not had access to the residents outside bank statements until the resident decided to share with them. In October the BOM asked the resident to lock the debit card up in her office and came up with a sign in and sign out of the card log. A typed witness statement, dated 10/28/24, and signed by the ADM indicated that the Social Service Director (SSD) and ADM had met with Resident B on this date as Resident B disclosed to the BOM, that she had provided her debit card to the former SSA so that the former SSA could purchase items on Resident B's behalf. Resident B was adamant that she wanted the SSA to have her debit card to help her make purchases as she requested. Resident B stated that she trusted the SSA implicitly. A typed witness statement, dated 10/28/24, and signed by the BOM, indicated Resident B had come in with her bank statement and wanted to dispute charges on her card. Several charges did not make sense as Resident B had not ever used door dash and esp. one for $51.50 at a pizza restaurant or 2 big box stores charge the same day at different locations. BOM and Resident B called the bank together and gave them a list of the charges she did not authorize, and they said she would need to come to the bank branch location to get a new card. The BOM gave Resident B the option of putting her new card in her financial file as only the BOM and ADM had access to her office and the door was locked when she was out of it and that they would do a sign in sign out when the card left the file. The BOM sent an email to transportation for transport.			

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	A typed witness statement, dated 10/31/24, unsigned, indicated, on 10/31/24 SSD contacted SSA via phone. SSA confirmed she did have Resident B's debit card for a time. SSA stated she returned the card the previous evening (10/30/24). The concerns for unknown charges were discussed with SSA. The potential for the card to have been lost or misplaced were discussed. SSA denied there to be any concern for unknown charges. SSA stated she always had the card in her possession, prior to returning it. A confidential interview conducted during the survey indicated in December 2024 police had been seen entering the facility and line staff indicated the police were in the facility to question the SSA for stealing Resident B's debit card and taking her money. The resident had indicated that the SSA used her debit card to purchase items she had not approved. A typed witness statement, dated 12/17/24, signed by the ADM and SSD, indicated there had been a meeting between Resident B, the ADM, and SSD regarding bank account concerns, following up with Resident B regarding bank account charges for October that she had disputed. Resident B discussed her concerns with her sister, and they have concluded that SSA, who Resident B allowed to have her debit card, must have made charges that Resident B did not authorize. Resident B trusted SSA and gave SSA permission to hold her debit card so she could purchase on Resident B's behalf. Resident B admitted that she had not reviewed her bank statements for several months. She also admitted that she did not think that SSA did anything wrong with her bank statement. Resident B was unaware that there was cyber theft and how banking information can be gathered without having any cards, etc.			

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	A facility reported incident (FRI) report, dated 12/17/24 at 2:01 p.m., indicated the local police had entered the building at the request of Resident B's sister to investigate potential fraudulent charges on Resident B's account. The facility immediately opened an investigation into this concern along with a review of previous involvement in concerns with Resident B's bank account. On October 28, 2024, Resident B received her bank statement and noticed that there were charges on her account that she did not recognize. She went to the Business Office Manager (BOM) who helped her call the bank to make a report of possible fraudulent charges and deactivate her current debit card. The bank took care of this for Resident B and set her up with a new debit card. On October 28, 2024, Resident B received confirmation from the bank that she was reimbursed for the charges she was unaware of ($500.59) and would investigate the issue further. Resident B did not share at this time that she had any concerns with a former staff member having access to her debit card. BOM and Resident B agreed that going forward the debit card would be locked in the business office when Resident B was not using the card. The facility investigation was concluded on 12/18/24, this concern cannot be substantiated at this time. During an interview on 2/20/25 at 9:59 a.m., the ADM indicated she found out in October 2024 that Resident B had given her debit card to the SSA to use to help with shopping for the resident. The BOM had not seen Resident B's bank statements until October when the resident had asked her for help with her debit card. The SSD had contacted the SSA in October about suspicious charges, and the SSA had denied knowledge of the suspicious charges. The SSA			

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	had possession of Resident B's debit card for 38 days after she left employment with the facility. The debit card had been deactivated after being returned to the facility on 10/30/24, and the unusual charges that had been occurring for the past 3 months had stopped appearing on the bank statements. The ADM indicated she had not reported the misappropriation or done an investigation of the residents' concerns, or notified authorities in October, November, or December until the police came to the facility, as the bank was doing their own investigation. In December Resident B's sister had come to the facility with her concerns after calling the police, and the facility again had not conducted an on-going investigation and left the investigation to the police, therefore when doing the report to the Indiana Department of Health (IDOH) had concluded the allegations could not be substantiated at that time. The ADM indicated there were no grievance/concern forms filed on the resident's behalf regarding her concerns with misappropriation of her funds. The resident record also lacked documentation of a staff member having possession of the resident personal debit card. During an interview on 2/20/25 at 3:50 p.m., the Regional Director of Operations indicated there was no facility policy about staff having possession of resident money or cards, just the best practice for staff not having possession of resident money or cards. On 2/20/25 at 3:33 p.m., the Regional Nurse Consultant provided a Theft/Loss Prevention policy, dated 8/2020, and indicated the policy was the one currently being used by the facility. The policy indicated, "Purpose: To assist resident in safeguarding their person property ...E. The			

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	Administrator notified local law enforcement within any state applicable time period of an incident involving theft of resident property with a value of one hundred dollars [$100] or more ...III. The Administrator or designee investigates all reports of stolen items and documents the investigation on Grievance Forms ...When an alleged or suspected case of misappropriation of resident property is reported, the Administrator, or designee, notifies the following persons or agencies within twenty-four [24] hours of such incident: i. Department of Public Health/aging; ii. Ombudsman, iii. Resident's Representative; iv. Adult Protective Services; and v. Law Enforcement Officials ..." Cross reference F0602 and F0610. This citation relates to Complaint IN00449428. 3.1-28(a)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation Based on interview, and record review, the facility failed to thoroughly investigate an allegation of the misappropriation of property for 1 of 3 residents reviewed for misappropriation of property (Resident B). Findings include: During an interview on 2/20/25 at 9:59 a.m., the ADM indicated she found out in October 2024 that Resident B had given her debit card to the SSA to use to help with shopping for the resident. The BOM had not seen Resident B's bank statements until October when the resident had asked her for help with her debit card. The SSD	F 0610	1--What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Administrator and nursing staff have been educated on the abuse reporting policy and procedures. 2--How are other residents having the potential to be affected by the same deficient practice be identifies and what corrective action(s) will be taken?	03/14/2025

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	had contacted the SSA in October about suspicious charges, and the SSA had denied knowledge of the suspicious charges. The SSA had possession of Resident B's debit card for 38 days after she left employment with the facility. The debit card had been deactivated after being returned to the facility on 10/30/24, and the unusual charges that had been occurring for the past 3 months had stopped appearing on the bank statements. The ADM indicated she had not done an investigation of the residents' concerns, or notified authorities in October, November, or December until the police came to the facility, as the bank was doing their own investigation. In December Resident B's sister had come to the facility with her concerns after calling the police, and the facility again had not conducted an on-going investigation and left the investigation to the police, therefore when doing the report to the Indiana Department of Health (IDOH) had concluded the allegations could not be substantiated at that time. The ADM indicated there were no grievance/concern forms filed on the resident's behalf regarding her concerns with misappropriation of her funds. The resident record also lacked documentation of a staff member having possession of the resident personal debit card. On 2/11/25 at 1:35 p.m., observation of Resident B in her room sitting in a wheelchair preparing to go play bingo. The resident indicated she had given the prior Social Service Assistant (SSA) her bank card to pick up a few items for her, but then she got her bank statement showing purchases had been made to door dash as well as other places she would not have bought items while in the facility. The resident indicated she had trusted the SSA, but now the SSA would not answer her phone calls to answer questions.		Administrator and nursing staff have been educated on the abuse reporting policy and procedures. 3--What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? Any potential reportable situation will be reviewed with Nursing or Operational regional staff to ensure they are appropriate and reported timely. 4--How will the corrective actions be monitored to ensure the deficient practice will not reoccur? Audit results will be reviewed and reported to the IDT in QAPI. Determination of ongoing monitoring will be completed within the QAPI process.	

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	Resident B's record was reviewed on 2/11/25 at 10:28 a.m. Diagnoses on Resident B's profile included, but not limited to, dementia with psychotic disturbance (condition in which cognitive decline characteristic of dementia is accompanied by psychotic symptoms such as hallucinations and delusions). On 2/20/25 at 4:35 p.m., the BOM provided a general note, dated 10/28/24 at 3:25 p.m., The note indicated that the resident came in with her bank statement and wanted to dispute charges on the card. She did say the SSA did have the card so the resident could call the SSA, and she would bring her what she wanted to buy. Several charges did not make sense as the resident had not ever used door dash and especially one for $51.50 for a pizza restaurant, and 2 charges to a big box store on the same day at different locations. They called the bank together and gave them a list of the charges she did not authorize, and they said she would need to go to the bank location to get a new card. The BOM gave Resident B the option of putting the debit card in her financial file as only the BOM and ADM had access to her office as the door was locked when she was out of it, and that they would do a sign in and sign out when the card left the file. The BOM sent an e-mail to transportation for transport. On 2/20/25 at 4:35 p.m., the BOM provided a general note, dated 10/29/24 at 3:32 p.m. The note indicated that the resident brought her debit card into her office and the BOM placed it in a clasped envelope with the resident's name on it. An annual and state optional MDS (Minimum Data Set) assessments, completed 1/16/2025, assessed the resident as having highly impaired			

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	hearing, but had the ability to make herself understood and to understand others. The resident needing limited assistance of one person physical assist for bed mobility, and limited assistance of two+ persons physical assist for transfers, and toilet use. A brief interview for mental status (BIMS) score 15/15 indicated cognitively intact. The resident indicated it was somewhat important to her to take care of her personal belongings or things, have her family or a close friend involved in discussion about her care, and to have a place to lock her things to keep them safe. A care plan indicated Resident B presented with a diagnosis of dementia and was at risk for memory loss, disorientation, impaired decision making and reduced or poor judgement and insight. The goal was for the resident to be able to communicate basic needs and accept verbal cues and reminders as needed for optimal psychosocial wellbeing. Interventions included ask yes/no questions to determine the resident's needs. Assist resident with tasks segmentation by simplifying tasks into steps. Offer demonstration/teach back as needed to ensure understanding. Reduce any distractions- turn off TV, radio, close the door etc. The resident understood consistent, simple, directive sentences. Provide the resident with necessary cues- stop and return if agitated. Cue, reorient and supervise as needed. The resident record lacked documentation of resident/resident representative concerns of the SSA having taken the resident's debit card and misappropriated money without the resident's permission, physician notification, or facility efforts in investigating the resident's concerns of misappropriation of funds had occurred.			

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	During an interview on 2/14/25 at 11:01a.m., a family member indicated she had been informed by Resident B around September or October 2024 that she had concerns about her debit card being used for purchases without her knowledge. Resident B had indicated that the SSA who had been shopping for her had quit without telling anyone, did not return the resident's debit card, and had taken all the evidence of the resident's records with her. The facility was made aware, along with the local police and the Ombudsman. Resident B had indicated when she received her October bank statement, she was missing over $4000. The resident indicated there were charges such as door dash, bath and body works, withdrawals from automated teller machines (ATMs), local and not so local big-box stores, on-line purchases for animal treats, etc. she could not have made herself. The resident had indicated during this time the SSA and Activity Director had also told her she needed to spend down some of her money so she would receive a monthly supplement, and the SSA had purchased the resident some clothing with her debit card, but at the time the resident thought the clothing was a gift from the SSA. Resident B's bank statements indicated, on 7/15/24 ending balance $9539.98, 8/19/24 ending balance $5496.68, 9/16/24 ending balance $1066.24, and ending balance on 10/21/24 was $496.46. During an interview on 2/11/25 at 2:40 p.m., the BOM indicated in October 2024, Resident B had come to her and asked that they call the bank together as Resident B's bank statement was showing charges she did not make. The bank asked if anyone had access to her bank card, and Resident B indicated the SSA so she could make purchases for the resident. When the request was			

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	made to deactivate the debit card, the teller informed them the resident would need to present to the bank in person and they would make her a new card, and the resident would need to sign for any disputed charges on her bank statement. Resident B was taken to the bank by facility transportation. The SSA had quit without notice in September keeping the resident's debit card, it was not returned until the end of October. A police officer had visited the facility in December and gotten statements and paperwork. The BOM indicated she had assisted the resident, and upon viewing the bank statements, many charges did not look like what the resident would have purchased living in the facility. But again, the facility had not had access to the residents outside bank statements until the resident decided to share with them. In October the BOM asked the resident to lock the debit card up in her office and came up with a sign in and sign out of the card log. A confidential interview conducted during the survey indicated in December 2024 police had been seen entering the facility and line staff indicated the police were in the facility to question the SSA for stealing Resident B's debit card and taking her money. The resident had indicated that the SSA used her debit card to purchase items she had not approved. During an interview on 2/13/25 at 3:15 p.m., Resident B indicated, she had given her debit card to the SSA to buy small purchases such as almond milk, lunch meat, and bread. To her knowledge the SSA had never brought her back a receipt for anything she purchased. In September and October 2024 the resident noticed large purchases to locations like door dash, big box stores, on-line animal treats, donut shops, and			

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	ATMs which were not places she would have been to personally, used, or approved. The resident indicated everyone knew it was the SSA that had used the card inappropriately. The police had been notified and she was currently waiting to hear back from the police and the bank to see if she would get to recover any of her money. The old debit card was cancelled and a new debit card obtained which was currently being locked up in the BOM office. The resident indicated to her knowledge she did not think the facility investigated the SSA's involvement in her debit card being used without her permission. There had been a brief discussion with the Administrator (ADM) who asked her how she knew it was the SSA that had used her card inappropriately, this led her to believe the facility had not taken her concerns about the SSA seriously. The resident indicated she just did not understand, the SSA had claimed to be her friend, so how could she do something like this? During review of the SSA employee file, observation of a termination request, dated 10/29/24. The request indicated termination date 9/23/24, voluntary, termination reason: another position, last day worked 9/22/24. A Corrective Action Memo, dated and signed by the HR Director on 10/29/24, indicated the SSA had turned in her resignation on 8/23/24, with her last date to work on 9/15/24. On 9/11/24 she had rescinded her notice stating she was staying. On 9/23/24 the SSA did not show for work and would not reply to the ADM. The SSA was terminated. A typed witness statement, dated 10/28/24, and signed by the ADM indicated that the Social Service Director (SSD) and ADM had met with Resident B on this date as Resident B disclosed to			

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	the BOM, that she had provided her debit card to the former SSA so that the former SSA could purchase items on Resident B's behalf. Resident B was adamant that she wanted the SSA to have her debit card to help her make purchases as she requested. Resident B stated that she trusted the SSA implicitly. A typed witness statement, dated 10/28/24, and signed by the BOM, indicated Resident B had come in with her bank statement and wanted to dispute charges on her card. Several charges did not make sense as Resident B had not ever used door dash and esp. one for $51.50 at a pizza restaurant or 2 big box stores charge the same day at different locations. BOM and Resident B called the bank together and gave them a list of the charges she did not authorize, and they said she would need to come to the bank branch location to get a new card. The BOM gave Resident B the option of putting her new card in her financial file as only the BOM and ADM had access to her office and the door was locked when she was out of it and that they would do a sign in sign out when the card left the file. The BOM sent an email to transportation for transport. A typed witness statement, dated 10/31/24, unsigned, indicated, on 10/31/24 SSD contacted SSA via phone. SSA confirmed she did have Resident B's debit card for a time. SSA stated she returned the card the previous evening (10/30/24). The concerns for unknown charges were discussed with SSA. The potential for the card to have been lost or misplaced were discussed. SSA denied there to be any concern for unknown charges. SSA stated she always had the card in her possession, prior to returning it. A typed witness statement, dated 12/17/24, signed			

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	by the ADM and SSD, indicated there had been a meeting between Resident B, the ADM, and SSD regarding bank account concerns, following up with Resident B regarding bank account charges for October that she had disputed. Resident B discussed her concerns with her sister, and they have concluded that SSA, who Resident B allowed to have her debit card, must have made charges that Resident B did not authorize. Resident B trusted SSA and gave SSA permission to hold her debit card so she could purchase on Resident B's behalf. Resident B admitted that she had not reviewed her bank statements for several months. She also admitted that she did not think that SSA did anything wrong with her bank statement. Resident B was unaware that there was cyber theft and how banking information can be gathered without having any cards, etc. A facility reported incident (FRI) report, dated 12/17/24 at 2:01 p.m., indicated the local police had entered the building at the request of Resident B's sister to investigate potential fraudulent charges on Resident B's account. The facility immediately opened an investigation into this concern along with a review of previous involvement in concerns with Resident B's bank account. On October 28, 2024, Resident B received her bank statement and noticed that there were charges on her account that she did not recognize. She went to the Business Office Manager (BOM) who helped her call the bank to make a report of possible fraudulent charges and deactivate her current debit card. The bank took care of this for Resident B and set her up with a new debit card. On October 28, 2024, Resident B received confirmation from the bank that she was reimbursed for the charges she was unaware of ($500.59) and would investigate the issue further. Resident B did not share at this time that she had			

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	any concerns with a former staff member having access to her debit card. BOM and Resident B agreed that going forward the debit card would be locked in the business office when Resident B was not using the card. The facility investigation was concluded on 12/18/24, this concern cannot be substantiated at this time. On 2/20/25 at 3:33 p.m., the Regional Nurse Consultant provided a Theft/Loss Prevention policy, dated 8/2020, and indicated the policy was the one currently being used by the facility. The policy indicated, "Purpose: To assist resident in safeguarding their person property ...E. The Administrator notified local law enforcement within any state applicable time period of an incident involving theft of resident property with a value of one hundred dollars [$100] or more ...III. The Administrator or designee investigates all reports of stolen items and documents the investigation on Grievance Forms ...When an alleged or suspected case of misappropriation of resident property is reported, the Administrator, or designee, notifies the following persons or agencies within twenty-four [24] hours of such incident: i. Department of Public Health/aging; ii. Ombudsman, iii. Resident's Representative; iv. Adult Protective Services; and v. Law Enforcement Officials ..." Cross reference F0602 and F0609. This citation relates to Complaint IN00449428. 3.1-28(d) 3.1-28(e)			
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors			

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	Based on interview and record review, the facility failed to ensure a resident was free from significant medication errors related to administration of transdermal patches (a medication patch applied to the skin) for 1 of 1 resident reviewed for medication errors (Resident Q). Findings include: During an interview on 1/30/25 at 11:25 a.m., Resident Q's wife indicated that on 12/25/24 when she arrived to take Resident Q home, he had two Exalon patches (a medication patch applied to the skin for treatment of dementia). Resident Q was discharged form the hospital and admitted to the facility on 12/31/24 for rehab. On 1/1/25, when she went to visit him, she again discovered that he had two Exalon patches on, so she called the nurse down to witness. The Administrator (ADM), Director of Nursing Services (DNS), and the nurse all told her it was not a medication error to have two Exalon patches on. On 2/17/25 at 11:00 a.m., Resident Q's record was reviewed. His diagnoses included, but were not limited to, neurocognitive disorder with Lewy bodies (a progressive brain disorder that causes a decline in thinking and reasoning), dementia (a group of conditions that cause a person to lose the ability to think, remember, and reason), disorientation (feeling confused or lost, especially about time, place, or identity), and visual hallucinations (seeing things that aren't actually there). A physician's order, dated 12/23/24, indicated to administer Rivastigmine (Exalon) transdermal (applied to the skin) patch 24 hour (hr) 12.3 milligram (mg)/24 hour (hr). Apply one patch	F 0760	1--What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? This resident is discharged from the facility. 2--How are other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? DON/designee will audit new admissions to ensure that orders are transcribed correctly and proper tasks that are required for transdermal orders are in place. Nursing staff will be educated on proper transcription of orders and tasks that transdermal orders require. 3--What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? DON/Designee will audit transdermal patches daily X 4 weeks, weekly X 2 months and monthly X 3 months. 4--How will the corrective actions be monitored to ensure the deficient practice will not reoccur?	03/14/2025

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	transdermally in the morning for unspecified dementia, unspecified severity with agitation. Remove old patch before applying the new patch and remove per schedule. A physician's order, dated 12/31/24, indicated to administer Rivastigmine (Exalon) transdermal patch 24 hour 13.3 mg/24hr. Apply 1 application transdermally in the morning for dementia, remove old patch before applying. An emergency room report, dated 12/25/24 at 12:19 p.m., indicated that upon arrival, they found two patches/doses of Rivastigmine on him. A general progress note, dated 1/1/25 at 5:00 p.m., indicated the resident's wife was crying and hollered that she needed a nurse, when staff entered the room the wife was upset because the resident had two patches of rivastigmine, one dated and one not dated. Staff tried to reassure the wife that they would make sure to remind the nurse that the old patch needs to come off before a new one was applied. During an interview on 2/19/25 at 11:16 a.m., the Regional Nurse Consultant (RNC) indicated that the first time Resident Q was at the facility, the order for his Rivastigmine (Exalon) had included the task that the staff were required to sign off that indicated to take the patch off. The resident was admitted on 12/23/24 and discharged to the hospital on 12/25/24. He indicated they were not aware that the hospital record indicated he was found to have two Rivastigmine patches on when he got there. The second time he was at the facility, the order did not include the task that required staff to sign of that indicated to take the patch off. They were aware of the incident of two patches being found on Resident Q on 1/1/25, and a medication/treatment error report was		Audit results will be reviewed and reported to the IDT in QAPI. Determination of ongoing monitoring will be completed within the QAPI process.	

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	completed. On 2/19/25 at 11:30 a.m., the RNC provided two forms titled, "Medication/Treatment Unusual Occurrence Report (Medication/Treatment Error)", and indicated they were both related to the day they found two medication patches on Resident Q on 1/1/25. One form indicated it was reported on 1/2/25, the type of error was transcription error, and the description of what happened indicated, " ...failed to add supplementary documentation of removal of Rivastigmine patch upon application of new patch when order transcribed". The second form indicated it was reported on 1/2/25, the type of error was "other medication related error", and the description of what happened indicated, " ...failed to remove old Rivastigmine patch when applying new patch on 1/1/25". During an interview on 2/19/25 at 2:35 p.m., the Director of Nursing Services (DNS) indicated that Resident Q's wife came and notified them that the resident had two Rivastigmine (Exalon) patches on. When the resident was admitted on 12/31/24, a complete head to toe skin assessment was completed by the nurse. The DNS indicated that the skin assessment does not mention any patches on the skin, but that was not something they would document in the skin assessment. The RNC indicated that both of the patches were located on the residents back, but in different areas. During an interview on 2/20/25 at 1:48 p.m., the DNS indicated that during medication administration, staff were to verify that the order in the electronic chart matches the order on the label for the medication they were going to dispense and the pharmacy label on the medications included the entire order and			

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	instructions. She indicated that neither order from both of his stays included documentation of where the patches had been applied, and it was not their policy to document where they apply medication patches. On 2/19/25 at 11:30 a.m., the RNC provided an updated document and identified it as a current facility policy, titled, "Transdermal Drug Delivery System (Patch) Application". The policy indicated, " ...2. Read label three times before administering, check with MAR ...6. Select an appropriate site for application, note physicians order for placement. Observe site of previous application. Rotate sites of placement. If patches are continuous remove existing patch and cleanse site ...10. Document administration on MAR. Include site of administration to ensure rotation process ...." On 2/19/25 at 11:30 a.m., the RNC provided an updated document and identified it as the manufacturer guidelines for Rivastigmine (Exalon) patch dated 4/21/2000. The guidelines indicated 4/21/2000, indicated, " ...10. Overdosage ...it is recommended that in cases of asymptomatic overdose the patch should be immediately removed and no further patch should be applied for the next 24 hours ...overdosage with cholinesterase inhibitors can result in cholinergic crisis characterized by severe nausea, vomiting, salivation, sweating, bradycardia, hypotension, respiratory depression, collapse, and convulsions. Increasing muscle weakness is a possibility and may result in death if respiratory muscles are involved ...." This citation relates to Complaint IN00453464. 3.1-48(c)(2)			

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F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on observation, interview, and record review, the facility failed to ensure an admission inventory was completed, and failed to ensure discharge medications were counted and documented for 1 of 1 resident reviewed for medication disposition (Resident Q). Findings include: During an interview on 1/30/25 at 11:25 a.m., Resident Q's wife indicated that when she took him out of the facility on 1/1/25, they had at first refused to send them home with his medications, many of which they had brought from home, but the physician eventually ordered the medications to be released. The wife indicated she felt he was not being given the correct medication. On 2/17/25 at 11:00 a.m., Resident Q's record was reviewed. His diagnoses included, but were not limited to, neurocognitive disorder with Lewy bodies (a progressive brain disorder that causes a decline in thinking and reasoning), dementia (a group of conditions that cause a person to lose the ability to think, remember, and reason), disorientation (feeling confused or lost, especially about time, place, or identity), and visual hallucinations (seeing things that aren't actually there). Resident Q's medication list included Sertraline hydrochloride (HCL) (used to treat depression), Rivastigmine transdermal patch (a patch applied to the skin for treatment of dementia), melatonin (sleep aide), olanzapine (antipsychotic used to treat mental conditions), clonazepam (controlled substance used to treat anxiety, panic disorders,	F 0842	1--What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? This resident is discharged from the facility. 2--How are other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? DON/designee will audit all residents for Inventory sheets on admission. Don/Designee will provide nursing staff education on Inventory sheets upon admission and Drug reconciliation upon discharge. 3--What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? DON/Designee will audit daily X 4 weeks, weekly X 2 months and monthly X 3. 4--How will the corrective actions be monitored to ensure the deficient practice will not reoccur?	03/14/2025

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	155215	A. BUILDING 00 B. WING	02/20/2025

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	and seizures), acetaminophen (pain reliever/fever reducer), magnesium hydroxide suspension (laxative), and docusate sodium (stool softener). The record lacked documentation of an admission inventory list for admission date of 12/31/24. A scanned document, dated 1/1/25, titled, "control drug record", indicated that a total of 43 clonazepam 1 milligram (mg) pills were given to Resident Q's wife. The record was signed by staff and the resident's wife. The record lacked documentation for any of the other medications besides the clonazepam being counted or returned to the resident or his wife. During an interview with the Director of Nursing Services (DNS), she indicated that the resident was admitted on 12/31/24 and discharged against medical advice (AMA) on 1/1/25. When he was being discharged, the nurse contacted the provider who ordered his medications to be home with his wife. When they sent home the medications, they only had the family sign that they received the narcotics. She indicated he was signed out AMA, so there were different protocols. They did not complete an actual discharge summary or medication disposition list, the only count they had done was for narcotics. During an interview on 2/20/25 at 1:48 p.m., the DNS indicated they do not have an admission or discharge inventory list for Resident Q's second stay beginning on 12/31/24. During an interview on 2/20/25 at 4:19 p.m., the Regional Nurse Consultant (RNC), indicated that the staff should have filled out one of the medication disposition forms since the physician		Audit results will be reviewed and reported to the IDT in QAPI. Determination of ongoing monitoring will be completed within the QAPI process.	

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	ordered the medications to be sent home. On 2/20/25 at 2:17 p.m. the RNC provided a document titled, "Responsibility for Discharge Against Medical Advice," dated 1/1/25. The document was signed by Resident Q's wife and a witness on 1/1/25. On 2/20/25 at 4:19 p.m., the Regional Director of Operations (RDO) provided an undated document and identified it as a current facility policy titled, "Discharge Medications". The policy indicated, " ...If resident is leaving 'against medical advice' (AMA) the facility will adhere to their policy as it relates and all State and Federal Rules and Regulations. Procedure. 1. Medications are sent to the resident on discharge only upon the physician's order to do so ...4. Discharge medications are counted, or the volume of liquid estimated, and the following information is entered on the discharge medication documentation form ...Date ...prescription number if any ...name and strength of medication ...quantity or amount ...6. ...both the nurse releasing the medication and the person receiving the medication must sign the record acknowledging transmission of this information ...7. If medications were brought into the facility by a resident or responsible party and not returned or destroyed, the nurse returns, and documents return of the medications to the resident or responsible party along with other property or valuables upon discharge ...." This citation relates to Complaint IN00453464. 3.1-50(a)(2)			
F 9999				

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Bldg. 00	3.1-14 PERSONNEL (s) Professional staff must be licensed, certified, or registered in accordance with applicable state laws or rules. This state rule was not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure a valid license before a Qualified Medication Aide (QMA) provided medication and treatment services to residents for 1 of 7 QMAs reviewed for certifications (QMA 10). Findings included: A confidential concern during the survey indicated a QMA had been working without a renewed license from July 2024 to October 2024 and passing medications to residents. On 2/19/25 at 11:45 a.m. during an interview, the Human Resources (HR) Director, indicated she was responsible to assure all nurses license, QMA license and certified nursing assistant (CNA) license were renewed timely, and she kept a copy of their licenses as proof. The HR Director indicated that QMA's renewed their license every 2 years, and to her knowledge there had been no QMA's lagging in getting their license updated on time the prior year. On 2/19/25 at 2:53 p.m., during review of the 7 current QMA's listed on the schedule, the HR Director indicated QMA 10 had been hired on 3/29/24. The Background Screening Report, dated	F 9999	1--What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? Human Resources/Designee will do a full facility audit for all licensed staff to ensure all licenses are up to date and current. Upon hire Human Resources/Designee will perform an audit on staff licenses to ensure the license is up to date and current. This audit will be turned into the Administrator/Designee for review. 2--How will the corrective actions be monitored to ensure the deficient practice will not reoccur? Audit results will be reviewed and reported to the IDT in QAPI. Determination of ongoing monitoring will be completed within the QAPI process.	03/14/2025

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	3/29/24, indicated her credentials included a QMA license that would expire on 6/15/24. Nursing schedules provided by the Assistant Director of Nursing (ADON), dated 6/15/24 - 10/25/24, indicated documentation of QMA 10 having worked in a QMA capacity of passing medications to resident on 59 separate days. A Medication Aide Certification job description, signed by QMA 10 on 3/29/24, indicated position description, "Certified nursing assistant [CNA] responsible for administering daily medication to residents in accordance with accepted standards of practice, state and federal regulations and licensing requirements ..." During an interview on 2/20/25 at 11:14 a.m., the HR Director indicated, upon hire she had completed a background check on QMA 10 and found documentation her QMA license would expire on 6/15/24. She did not remember having a conversation with QMA 10 about her license expiring, having a plan to renew the license, or notifying management that QMA 10 was working in a QMA capacity with an expired license. The HR Director indicated she was responsible for keeping and tracking all nursing staff licenses, but she must have missed QMA 10's. During an interview on 2/20/25 at 11:37 a.m., QMA 10 indicated upon being hired her duties included completing the master schedule, daily scheduling of nursing staff, working as a CNA, and working as a QMA passing medications and doing treatments. QMA 10 indicated she was not aware of the expiration date of her QMA license, and had worked shifts in a QMA capacity after her license had expired. QMA 10 indicated she was used to getting a license renewal notice via e-mail			

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	from the licensing board, but had not received one last year and did not think to check her expiration date until October when she overheard nurses talking about renewing their license. Upon finding her license expired on the registry, she had gone to HR and gotten help to electronically apply for renewal of her license. QMA 10 indicated, ultimately it was her responsibility to have made sure her license was renewed timely. On 2/20/25 at 11:30 a.m. the Regional Director of Operations provided a Care Standards policy, dated 6/2020, and indicated the policy was the one currently being used by the facility. The policy indicated, "To ensure all residents receive necessary care and services that are evidence-based and in accordance with accepted professional clinical standards of practice ...III. The Administrator of designee maintains copies of current license and/or certification documentation for staff providing direct care to residents ..." This citation relates to Complaint IN00453723.			