STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155349	A. BUILDING _____ B. WING _____	**07/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SAINT ANNE HOME	**1900 RANDALLIA DR FORT WAYNE, IN 46805**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0744 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop care and behavior approaches to prevent and treat adjustment difficulties following admission to the facility for 1 of 2 residents reviewed (Resident C). Findings include: On 7/22/20 at 1:41 P.M., Resident C's record was reviewed. [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set) assessment, dated 5/18/20, indicated the resident had a BIMS (Brief Interview Mental Status) score of 5 which signified he had severely impaired cognition. He displayed no behaviors and had not wandered or rejected care. He had 1 day, during the assessment, where he felt down, depressed, or hopeless. Resident C was independent with toileting, ambulation, and bathing and required supervision with his personal hygiene. He was occasionally incontinent of bowel and bladder. A CAA (Care Area Assessment) indicated the resident had dementia and was prescribed a cognition enhancing medication. He had severely impaired decision making abilities. Care Plans indicated the following: -Focus: The resident had a [DIAGNOSES REDACTED]. Interventions included, but were not limited to: maintain a consistent routine, prevent excessive stimulation, promote self care and independence, and utilize dementia protocol. -Focus: The resident displayed severe impairment with decision making skills. Goal: He would be assisted with simple decisions and his needs anticipated by staff as required through the next 90 days. Interventions included, but were not limited to: ask only simple questions, repeat as needed and display items when asked to make decisions (i.e., holding up a glass of juice or water). -Focus: The resident's thought process was altered (he had signs/symptoms of confusion) and he often thought other's were stealing from him. Goal: He would understand and function at his highest level through the next 90 days. Interventions included, but were not limited to: observe for confused behavior patterns, re-orient gently as needed, and review any medication/behaviors with the physician as needed. -Focus: Resident C demonstrated signs/symptoms of depression and received [MEDICATION NAME] (anti-depressant). Goal: He would be free of signs/symptoms of depression through the next 90 days. Interventions included, but were not limited to, administer anti-depressant medication as ordered, approach calmly and allow to vent feelings, monitor for side effects of anti-depressant medication, and monitor for signs/symptoms of depression. The Care Plans did not indicate the resident was born in another country and how his culture would affect his care. The plans did not address specific behaviors or culturally related interventions. Resident C experienced declines in his mood and behaviors, increased incontinence of bowel and bladder, and addition of anti-psychotic medications to his drug regimen since admission to the facility. Progress Notes from 5/11/20 - 6/8/20 indicated the following: -5/11/20 at 5:58 p.m., an admission evaluation indicated the resident had resided in the facility's assisted living (AL) area prior to admission. Resident C was confused with mild cognitive impairment. He had some agitation which was not a recent change. The resident was continent of bladder but had some bowel incontinence that was not new. -5/12/20 at 2:07 p.m., an elopement evaluation indicated the resident had no risk for elopement though he did wander. -5/13/20 at 9:46 a.m., the resident refused all care offered by the CNA (Certified Nurse Assistant) and refused to have his dirty clothes removed from the room. -5/13/20 at 4:21 p.m., the Social Worker indicated the resident had moved to the facility on ,[DATE] and had previously lived in the AL. The resident was born in another country but had moved to the area in the 1950's. -5/14/20 at 8:48 a.m., resident kept making multiple attempts toward the beauty shop. He requested that his beard be trimmed. Staff attempted to redirect him multiple times but he would become agitated and yell at staff. -5/15/20 at 2:44 p.m., resident was heading down the hall toward rehab. He was redirected back toward the unit without issue. -5/15/20 at 2:46 p.m., an elopement evaluation was completed and indicated the resident was at risk for elopement as he had a history of [REDACTED]. -5/15/20 at 3:36 p.m., resident hadn't eaten breakfast or lunch. When asked, he stated he was on a starvation diet. -5/24/20 at 12:36 a.m., resident refused supper and had stated 2 meals a day is enough for me. -5/27/20 at 1:25 p.m., the RD (Registered Dietician) indicated she had been notified by staff that the resident had been refusing his evening meals. Resident C indicated that he was from (country) and only ate 2 meals per day and did not eat after 6:00 p.m. -6/2/20 at 10:38 a.m., the resident came to the front desk and indicated he was fasting and would not be eating on this day. He stated if he were made to eat, he would just have it come right back out and signaled he would have a bowel movement. He then refused both breakfast and lunch. At 2:41 p.m., the nurse had been looking for the resident and he was found sitting outside in the courtyard by the beauty shop. He was outside enjoying the weather but staff were concerned about him wandering to his old apartment after done sitting outside. The resident refused to come in and stated he could sit outside if he wanted as long as he wasn't harming anything. The nurse told him that staff would come and check on him every 15 minutes until he came back in which he was okay with. On 6/8/20 at unknown time, a physician progress notes [REDACTED]. He was oriented. He had been experiencing some anxiety with making adjustments (move to facility from AL) but continued to improve. He was positive for agitation which was noted primarily by nursing staff who reported this had been improving. The resident had [MEDICAL CONDITION] with behavior disturbance which involved anxiety with recent changes although the resident seemed to be adapting. He was to continue taking the [MEDICATION NAME] to help control depression and anxiety symptoms. The progress note did not indicate the resident had been recently assessed as an elopement risk, that he had refused care, or that he was only eating 2 meals per day. Progress Notes from 6/8/20 through 6/19/20 indicated the following: -6/11/20 at 1:36 a.m., the resident refused to allow staff to provide any care at night and barricaded his door at times. -6/18/20 at 2:31 p.m., resident approached the nurse and started speaking about a man that lived upstairs and was stealing from him. He shared an elaborate story which he had repeated numerous times over the last week to staff. Staff had been unable to determine any correlation between the story and events that had occurred recently. At 3:14 p.m., Resident C refused housekeeping services numerous times to assist with cleaning his room. He closed the door on the housekeeper. He was observed to have newspaper thrown all around his room along with dishes, napkins and a foul odor was noted. He reported my roommate cleans my room, not you. -6/19/20 at 12:00 p.m., the resident was incontinent of a large loose BM (bowel movement). He sat down in chairs in the hallway and would not get up. When staff attempted to talk with him, he became argumentative and would not let staff help. After several minutes of speaking with him, he finally stood up and went back to his room to allow staff to help him clean up. At 1:51 p.m., the resident was seen by the NP (Nurse Practitioner) for medication review due to increased delusions and refusal of care. On 6/19/20, at unknown time, an NP progress note indicated the resident had been seen due to increase in behaviors with severe paranoia and resistance to care which were difficult to redirect. He was also noted with some hoarding like behaviors in his new room. The resident had recently relocated from AL. Staff reported increased confusion and resistance to care. He was having increased incontinence of both bladder and bowel then refusing assistance with personal hygiene. When he had bowel incontinence, he would refuse to eat to stop it. He was agitated and yelled at staff and other residents. A UTI (urinary tract infection) had been ruled out prior to his room move and he'd had no medication changes. Review of systems showed he was positive for activity and appetite change; positive for diarrhea; positive for

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

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F 0744 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) agitation, behavioral problems, confusion and sleep disturbance. He was nervous/anxious and hyperactive. During his physical exam, he was oriented to person, place, and time. He was agitated at time of the visit. He was talking about his taxes and hiring a lawyer so he could sue everyone around here. He was upset with the lock on his door and wanted the door to latch tighter and said he could just kick door with his foot and bust in. He talked about staff and stated Everyone around here, these Americans are all fat and lazy. A CNA was observed trying to assist the resident to change his clothes after an incontinent episode-the resident yelled at staff and said it was not a problem and they were lying to him. Assessment: Senile dementia with paranoia and behavioral disturbance. The NP consulted with the facility psychiatric NP and new orders were given for an anti-psychotic medication. The resident was to be given [MEDICATION NAME] 25 mg (milligrams) by mouth every day (morning) and [MEDICATION NAME] 50 mg by mouth at bedtime. Staff were to monitor his behaviors and document on every shift. The dose would need to be monitored and increased if his behaviors persisted. If the behaviors persisted, the NP would also consider discontinuing the cognitive enhancing medication due to side effects. For the residents full incontinence of bowel-his routine [MEDICATION NAME] for constipation was to be changed to as needed and his constipation monitored and fluids encouraged. The plan was to obtain lab work the following day and update providers in 1 week-medications would be re-evaluated at that time. If concerns remained, the psychiatric NP would be consulted. Progress Notes, dated 6/20/20 through 6/29/20, indicated the following: -6/20/20 at 6:44 p.m., the nurse went in to give the resident his evening medications. The room was very warm and the window open. He was lying in bed but sat up and greeted the nurse appropriately. He asked for a list of his medications and wanted to know what the pills were for or he wouldn't take them. He then expressed concern about having no shelves in his bathroom and stated If I don't get shelves, I will call the police. He was assured that the maintenance department would be notified and shelving provided. -6/21/20 at 2:27 a.m., resident had used the bathroom out by the nurses station several times that evening. He refused dinner and care offered by staff. He spent much of the evening ambulating around the unit but made no attempts to leave. -6/23/20 at 12:58 p.m., resident approached the nurse and asked to speak with someone in charge because a man, upstairs, was a thief, had been taking his things, and nothing had been done about it. If this couldn't be taken care of, he was going to the proper authorities. At 1:34 p.m., resident wanted to know why people weren't allowed upstairs. He was upset at the answer and stated to the nurse, I'm a citizen of this country. I have papers! Write down your name-your full name and your phone number. -6/24/20 at 3:22 p.m., the resident stated yesterday, I saw 2 people like me on 2nd floor. I can't remember their names. I need to go to the 2nd floor. The nurse attempted to tell him those people had returned to the first floor but he stated angrily I don't need a lecture. -6/25/20 at 11:25 a.m., resident stated that his good American friend told him he should go somewhere else to get more care. At 1:27 p.m., he went to the front desk and withdrew money from his account and told staff he didn't feel well and was probably going to the hospital. At 4:30 p.m., Resident C was found by staff heading towards the rehab. unit through the beauty shop hallway. Staff were unable to redirect him back through the doors and he went out to the inner courtyard area to sit. Staff were unable to redirect the resident. He later came back and went to his room without complaint. -6/26/20 at 12:44 p.m., the resident was argumentative with care and conversation. The CNA reported he had been voiding in his room not in the toilet. -6/28/20 at 9:40 p.m., the nurse went into the residents room to give him his evening medications and found the resident had piles of trash and food throughout his room. The nurse tried to clean up some but the resident refused and stated he knew where everything was because he had put it there. He did allow some of the dirty dishes to be removed but nothing else. On 6/29/20, at unknown time, an NP progress note indicated the resident had been seen for a 60 day medication review and follow up on recent behaviors and medication changes. Nursing staff reported behaviors and difficult interactions persisted and it was difficult to redirect the resident. He remained confused and argumentative with care. The resident was alert and oriented with his long term memory but struggled with short term memory. He was on a regular diet and fed himself but was inconsistent with his dietary intake. Staff reported he was having trouble with incontinent loose bowels, believed it was related to his diet and would stop eating, believing that fasting would resolve the problem. Review of systems/physical exam indicated the resident continued with diarrhea and urinating in trash cans instead of the toilet in his bathroom. He was positive for agitation, behavioral problems, confusion, sleep disturbance, nervous/anxious, hyperactive, [MEDICAL CONDITION] and paranoia. He was quick to anger and became agitated, difficult to redirect, increasingly more incontinent and resistant to assistance with getting cleaned up. Assessment: Senile dementia with paranoia with behavioral disturbance. Would increase the [MEDICATION NAME] to 50 mg by mouth daily and 100 mg by mouth at bedtime. Continue with anti-depressant for Reactive depression. Plan: Continue to work with resident on confusion, paranoia and resistance to care-noting some improvement with [MEDICATION NAME] but not completely resolved. Progress Notes, from 6/29/20 through 7/22/20, indicated the following: -6/30/20 at 10:30 p.m., resident was up walking in hallway. He stated that the man who stole all of his things from his room was having an auction tomorrow to sell his stuff. -7/2/20 at 10:17 a.m., Resident C stopped a housekeeper and asked her into his room and closed the door behind her. He stated all of you women who work here, who sit on your asses and get fat, need to leave me alone and stay out of my room. If you people don't leave me alone, I will get my lawyer friend and leave this place. All of you girls are mean to me because of of my tanned skin. The housekeeper assured the resident she would share his concern and left the room without incident. At 10:42 a.m., he was observed to get into the laundry cart parked outside his room where he was sorting through and gathering his own items. He yelled at the laundry staff member who was hanging items in in closet and stated he didn't want his things on hanger. He was demanding and pointing with an angry tone. -7/4/20 at 2:30 a.m., resident had been found in the rehab hallway fully dressed and telling staff that his belongings had been stolen. He reported that someone had been tapping at his window. Staff checked his room and noted piles of linens, newspapers, and items all over the floor. The staff member asked if they could help clean up but the resident asked staff to leave and shut the door. He stated that's what they all say then I have nothing. -7/5/20 at 1:46 a.m., resident refused care and was accusatory to staff. He paced at times and was observed putting newspaper in the back of his underwear and under his feet in his sandals. At 11:55 a.m., Resident C went to the nurses station and reported a man had come into his room and stole his baby pictures and were selling them in the store in the basement. Attempts made to re-orient him were unsuccessful and he refused to eat lunch. -7/6/20 at 1:26 a.m., resident was up and down much of the shift. He paced between the first floor and rehab nurses stations. He did voice one time that men were stealing his belongings but was easily redirected with distracting conversations. -7/14/20 at 12:55 p.m., resident had spent most of the day in his room. He continued to refuse to allow housekeeping staff into his room to clean and make the bed. -7/17/20 at 8:44 p.m., resident had been out of his room and walked around the nursing lounge taking items off the tables and shelves and had placed them in his walker. He was observed to take several items from the trash and placed them in a bag hanging from his walker. He refused to be re-directed and told staff to mind their own business and go with God. -7/18/20 at 2:46 p.m., resident was in his room throughout the day. He had his window and door open. He had trash and clothing all over the room and refused to allow staff to pick up his room. At 8:21 p.m., he was found out in the courtyard with his pants partially off and belt on the ground across the yard. He had been incontinent of stool which was all over the sidewalk. He was noted seated on a bench near the door but then moved to an umbrella table chair. Staff instructed him to stay put and not move but he stated I'd like to see you try to enforce that and moved to a 3rd seat soiling the seats as he moved. He then took newspapers, wiped off his shoes and placed them in the bushes. He refused to allow staff to clean him up and refused to move. After an hour, he finally allowed a male caregiver to assist him into the shower room and took a bath. His room was observed to have several trays and lots of trash on the floor and bathroom and he had 3 floor fans. He became angry and belligerent when staff attempted to touch anything in the room. He refused to be assessed by the nurse. -7/19/20 at 7:41 p.m., the resident became unresponsive for 1 minute while at the nurses station after supper. New orders were received to offer fluids every 2 hours and have the NP see in the morning. (There was no documentation found to indicate the resident had been seen by the NP on 7/20/20) -7/21/20 at 10:56 a.m., the nurse went into the resident's room to give him his medications where he was found with his blanket all cut into pieces. He had a piece of the blanket between his buttocks and no other clothing on from his waist on down. Resident C went on a rant about men coming into his room and taking his checkbook. He stated he was moving to another room. -7/22/20 at 3:06 p.m., the social worker indicated housekeeping had spoken with her about the resident not allowing staff to come in and clean his room. At 3:10 p.m., the resident came to the social workers office and stated he needed to get out of his room because everything is wrong. She went with him to his room where he removed 2 pairs of pants from the closet and stated they weren't his and didn't know how they got there. The pants had the resident's name in them but he stated he didn't know how his name got in them and that he didn't wear pants that dark. He asked the social worker to remove them from his room which she did. He was observed to have soiled pants laying on the floor of his room which he agreed to the social worker removing. On 7/22/20 at 2:14 P.M., the Social Worker was interviewed. During the interview, she

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F 0744 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) indicated Resident C had moved from the AL to the nursing facility because he required more care assistance than provided in AL. She indicated he was followed in the behavior management meetings which met once per month but didn't have documentation of what was discussed in the meetings. When questioned about the blanket found cut up in his room on 7/21/20, the resident's escalating anger, and safety concerns, she indicated prior to his move to the facility, all sharp items such as scissors had been removed and was not sure how he had cut up the blanket in his room. She indicated he collected and carried items in the bag hanging from his walker. She indicated if staff tried to intervene with his behaviors, he would become very belligerent and would yell at staff. When asked, she indicated the facility did offer psychological counseling for residents but since the Covid shutdown, they hadn't been able to have the counselor in the building. On 7/22/20 at 2:45 P.M., the Executive Director (ED) was interviewed. During the interview, she was asked about the resident's elopement risk and she indicated he was not at risk for elopement and couldn't get out of the courtyard. She indicated he was not at risk of hurting himself or others despite his expressed anger, refusals of care and housekeeping services, and recent cutting up of a blanket. She shared that the resident used the extra newspapers in his room for his sandals to absorb sweat and that she believed he had cut up his blanket to use as towels. He had a long history of hoarding and collecting items. She indicated he had been a janitor for [AGE] years and it was his habit to go through garbage and collect items. Resident C was from another country and in his culture, women were not respected and it was only the men who made decisions and had their voices heard. When questioned about the resident's escalating behaviors following admission to the facility, she indicated they were just a result of the resident's difficulty adjusting and he was trying to get used to women caring for him and handling his possessions. She indicated she had no issues with the resident because he understood she was the head boss and he respected that. On 7/22/20 at 3:03 P.M., Resident C was observed in his room with the ED present. The room was very warm and humid and the resident's window open. When asked, he told the ED he wasn't warm and the temperature was comfortable to him. He was observed dressed in slacks, shirt, and sweater. His speech was clear and he was respectful to the ED when conversing and commented that she was the head boss. There were several newspapers, paper items, and other trinkets throughout the room and covering his bed, however, the floor was clear of obstacles and the items presented no safety issue. He appeared to collect various items that sat on shelves, on his dresser, bedside table, bedside chair, floor near the wall by his 2nd bedside chair and across his bed. On 7/22/20 at 3:10 P.M., CNA 3 was interviewed. During the interview, she indicated she regularly cared for the resident. Resident C refused care often and required much coaxing at times however, she never felt threatened or scared of the resident. She indicated the resident preferred male caregivers. On 7/22/20 at 4:45 P.M., the ED, NP, DON, and Consultant DON who was present via Facetime were interviewed. The Consultant DON indicated that Resident C's behaviors were due to cultural factors. She stated she, herself, was born in the same country as the resident and he was acting according to their cultural values. She agreed that the care plans did not reflect these cultural factors or approaches to manage the differences in the 2 cultures. The NP indicated the resident was having difficulty adjusting and related behaviors therefore she had consulted with the facility's psychiatric NP who suggested use of the anti-psychotic medication. The ED indicated the resident's behaviors were reviewed daily during their stand up meetings but those meetings and discussions were not part of the resident's medical record. When questioned about placement on the memory care unit for safety, she indicated prior to admission, the IDT (Interdisciplinary Team) had discussed placement onto the secured memory care unit but had determined that he was not appropriate for the unit. On 7/22/20 at 4:51 P.M., the ED provided a current copy of the facility policy titled Behavioral Health Services which stated the following: (facility name) will provide residents with the necessary behavioral health care and services to achieve or maintain the highest possible physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care .2. b) the facility will ensure that a resident who does display or has not been diagnosed with [REDACTED].Changes in mood/behaviors not already identified in the resident care plan or increase in frequency, intensity or duration of mood/behaviors will be referred to the appropriate social worker .There will be a discussion and investigation into the issues: a depression screen by social worker, mood/behavior of the resident, staff interventions/approaches, acute medical problems, precipitating factors, resident's history, recent medication or life changes, review of labs .after all of the above has been discussed, a plan of action will be initiated .Based on the staff's ability or inability to easily alter the mood/behavior symptoms with the assistance of the physician, the team may decide to place resident into the Mood/Behavior Program .Interventions will be revised as needed This Federal tag relates to Complaint IN 489. 3.1-37