STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING _____ B. WING _____	07/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APERION CARE FORT WAYNE	5700 WILKIE DR FORT WAYNE, IN 46804

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident representatives were notified of changes concerning 4 of 4 residents reviewed. (Resident D, Resident F, Resident G, and Resident H) Findings include: 1. The Record review for Resident D began on 7-29-2020 at 2:00 p.m. [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set) assessment for Resident D was dated 6-5-2020. Resident D's BIMS (Brief Interview for Mental Status) score was 9/15, which indicated the resident was mildly cognitively impaired. A confidential interview with Resident D's family on 7-28-2020 at 1:19 p.m., indicated the family member was the POA (Power of Attorney). The POA indicated the facility did not notify her regarding the admission paperwork, or for the room move for Resident D. The resident was moved from the Harmony (Behavioral) unit to a regular room with a roommate. The family indicated they tried to communicate with the facility regarding the room change, but there was no follow up from the facility on anything. A review of the progress notes indicated there was no documentation regarding a room move for Resident D. The resident's record lacked notification of the resident's representative. A copy of the clinical census for Resident D was provided by Medical Records on 7-30-2020 at 11:30 a.m., and indicated the resident was moved on 5-29-2020 from room [ROOM NUMBER] on the Harmony unit to West unit room [ROOM NUMBER]A. A progress note dated 6-20-2020 at 3:43 p.m., indicated the resident had been getting irritated with his new roommate, management was aware and working on a solution. 2. The clinical record of Resident F was reviewed on 7/29/2020 at 1:00 p.m. [DIAGNOSES REDACTED]. The MDS (Minimum Data Set) Assessments were completed on the following dates: An Admission MDS Assessment, dated 3/30/2020 was completed and accepted by CMS. The Admission Assessment indicated Resident F's BIMS (Brief Interview for Mental Status) Score was 01, which indicated severe cognitive impairment. A Discharge Return Anticipated MDS Assessment, dated 5/19/2020, was completed and accepted by CMS. The Admission Record for Resident F indicated, a family member was listed as the Responsible Party, POA for Financial, POA for Care and was also the Resident's Emergency Contact. Review of Resident F's Hospital History and Physical (H&P) with an admission date of [DATE], indicated Resident F presented to the ER (emergency room) via EMS (Emergency Medical Services/Ambulance) from the nursing home. Resident F had a fever and cough. The H&P also indicated Resident F had severe Alzheimer's dementia. The H&P indicated the resident was admitted to in-patient care with a COVID-19 virus infection, mild [MEDICAL CONDITION] (low oxygen levels in the body) and fever. Review of Resident F's May 2020 Progress Notes indicated, on 5/19/20 at 15:37 (3:37 p.m.), the resident had a COVID 19 nasal/pharyngeal swab collected and was sent to the lab. The progress notes were lacking documentation regarding notification of Resident F's POA (Power of Attorney) to inform them of the order for the COVID-19 testing. A Progress Note dated on 5/19/20, indicated medications were administered. The next entry in Progress Notes was dated 5/27/20 regarding a physician's orders [REDACTED]. An IDT (Interdisciplinary Team) progress noted dated 5/28/20 at 12:57 p.m., indicated Resident F required isolation for droplet precautions related to the confirmed [DIAGNOSES REDACTED]. There was no documentation of Resident F's POA notification of positive COVID-19 diagnosis. The note did not indicate the resident's POA was notified the resident would be put into isolation precautions. Review of Resident F's Order Details indicated an order, dated 5/19/20 at 21:11 (9:11 p.m.), from the Nurse Practitioner whose order was to send Resident F to the hospital for evaluation and treatment. Resident F's records were lacking notification of the POA regarding the resident being transferred out to the hospital for evaluation and treatment. 3. The clinical records of Resident G were reviewed on 7//29/20 at 10:15 a.m. [DIAGNOSES REDACTED]. The Quarterly MDS assessment dated [DATE] indicated a BIMS Score of 12, which indicated moderate cognitive impairment. The Admission Records for Resident G indicated the resident was their own Responsible Party. A family member was also listed as a Responsible Party (Health Care Decision Maker) and as the resident's Emergency Contact 1. Review of Resident G's Census indicated on 5/16/20, Resident G was moved to a different room on the facility's 200 Hall, which was the facility's COVID Unit at that time. Review of Resident G's Progress Notes indicated the following: A nurses note on 5/14/2010 at 11:45 a.m., indicated a COVID-19 nasal/pharyngeal swab collection was completed and sent to the lab. The nurses notes were lacking documentation regarding notification of the POA relaated to a COVID-19 test being done for the resident. A Physician's progress note, dated 5/14/2020 at 16:49 (4:49 p.m.), indicated the resident was seen due to a concern of COVID-19 virus because the resident had spiked a fever of 100.7 degrees Fahrenheit (F) and had a harsh cough. The Physician's note reported a chest x-ray revealed infiltrates (associated with pneumonia) and the resident was started on an antibiotic. The resident's progress notes d documentd not indicate notification of the POA regarding symptoms, fever, or of a chest X-ray order. There was no notification documented in the notes of POA notification of X-ray results or the order for an antibiotic. A nurses note on 5/15/2020 at 20:41 (8:41 p.m.) indicated Resident G tested positive for COVID-19 and the NP ordered new medications for treatment. The progress notes lacked notification of Resident G's POA regarsding the positive COVID-19 test and new medications ordered. There was no documentation in the progress notes of POA notification when the resident was moved to the COVID Unit and placed on isolation precautions. 4. The clinical records of Resident H were reviewed on 7/29/20 at 11:30 a.m. [DIAGNOSES REDACTED]. The Admission MDS (Minimum Data Set) Assessment, dated 4/17/20, indicated the resident had a BIMS Score of 12, which indicated moderate cognitive impairment. The current Quarterly MDS, dated [DATE] indicated a BIMS Score of 11, which also indicated moderate cognitive impairment. Review of Resident H's progress notes indicated the following: A nurse's note dated 5/20/2020 at 11:05 a.m., indicated a COVID-19 nasal/pharyngeal swab collection was completed and sent to the lab. The nurses notes did not indicate notification of the POA related to COVID-19 test completion. A progress note dated 5/25/2020 at 10:14 a.m., indicated the resident was receiving treatment for [REDACTED]. The Physician's progress note, dated 5/26/2020 at 14:03 (2:03 p.m.) indicate Resident H's COVID-19 test results were positive and the resident was placed in isolation precautions. Resident H's progress notes did not indicate notification of the POA regrading the positive COVID -19 test results or ordered isolation precautions. An interview with the DON (Director of Nursing) on 7/30/20 at 2:10 p.m., indicated notifications to the residents' responsible parties were not documented in the residents' records. She also indicated Resident G and Resident H's BIMS scores were 12, they were their own person and they would be notified. Review of in-service education records, provided by the Administrator on 7/30/20 at 3:40 p.m., for Nurses', QMA's (Qualified Medication Aide) and CNA (Certified Nursing Assistant) on 4/2/2020, titled Nursing Education and Proper Documentation, indicated a Nurse's Notes for New Orders, included the family or responsible party should be notified and the notification documented. Review of current facility policy provided by the Administrator on 7/30/2020 at 2:25 p.m., titled, Physician-Family Notification-Change in Condition with a revision date of 11-13-2018, indicated, .To ensure that medical care problems are communicated to the attending physician or authorized designee and family/responsible party in a timely, efficient and effective manner. Responsibility: Licensed Nursing

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) Personnel/Social Services .The facility will inform the resident, consult with resident's physical or authorized designee such as Nurse practitioner; and if known, notify the resident's legal representative or an interested family member when there is: .(B) A significant change in the resident's physical, mental, or psychosocial status (i.e , a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); .(C) A need to alter treatment significantly (i.e , a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); .or commence a new form of treatment to deal with a problem (e.g., the use of any medical procedure, or therapy that has not been used on that resident before.) (D) A decision to transfer or discharge the resident from the facility This Federal tag relates to Complaint IN 867. 3.5-5(a)(2) 3.1-5(b)
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure an allegation of abuse was reported for 1 of 4 residents reviewed.(Resident J) Findings include: On 7/28/2020 at 10:20 a.m., the record of Resident J was reviewed. [DIAGNOSES REDACTED]. The Admission record, dated 7/2020, listed the resident as the responsible party for a contact. The quarterly Minimum Data Set (MDS) assessment dated [DATE], included but was not limited to, the following: BIMS (Brief Interview for Mental Status) was 13 (independent cognition); no acute change in mental status; following symptoms were present for 12-14 days (nearly every day) of the assessment period: little interest or pleasure in doing things, feeling down or depressed or hopeless, trouble falling or staying asleep or sleeping too much, feeling tired or having little energy, feeling bad about yourself, trouble concentrating on things, moving or speaking slowly or the opposite - being so fidgety or restless moving around a lot more than usual; potential indicators of [MEDICAL CONDITION] none of the above; presence and frequency of behavior symptoms was documented and behavior not exhibited; personal hygiene documented as one person physical assist required and resident did participate in assessment. On 7/27/2020 at 11:45 a.m., the Harmony Unit (locked behavior unit) was observed. Resident J was observed sitting in a wheelchair at the nurses station. Resident J indicated they are sexually and physically molesting me here. Resident J also began talking about her medications. On 7/27/2020 at 12:10 p.m., the Administrator was made aware of the allegation of sexual and physical abuse Resident J had made on 7/27/2020 at 11:45 a.m. The Administrator indicated the resident was care planned for making false accusations. The Administrator indicated the facility investigated all allegations. At 2:20 p.m., She indicated the investigation of Resident J's allegation was in process On 7/27/2020 at 2:30 p.m., the Director of Nursing (DON) provided a copy of the note she had documented on 7/27/2020. The note included she was informed Resident J was making an allegation of sexual assault on July 25, 2020. The DON verified the care plan was noted to have the problem of, behavior of making false allegations about staff and other residents. Resident also had the [DIAGNOSES REDACTED]. The note indicatd the investigation was ongoing. On 7/28/2020 at 12:45 p.m., the Administrator provided a copy of an untimed note she had documented on 7-27-2020 . The note indicated to continue to investigate resident allegation she was raped over the weekend on Saturday night. She accused 2 female staff members (one which did not work Saturday night) and a nurse which also was not working Saturday night. The note indicated Resident J was care planned for making up stories about staff and made up stories about staff of color. The note indicated the resident did not like black people, tells them they are beneath her and makes accusations about nasty things they do because of their color. the note indicated the facility would continue to follow up accusations found to be unfounded. On 7/29/2020 at 2:10 p.m. the Administrator was interviewed. She indicated they began the investigation of Resident J's allegation of sexual abuse reported on 7/27/2020. She indicated Resident J had accused Nurse 4 of holding her down while CNA 9 and CNA 6 assaulted her. The Administrator indicated CNA 9 was not even working that night and had not been employed at facility for a few months. The Administrator indicated she did not report this allegation of abuse to ISDH because it was almost like a daily occurrence with Resident J. The Administrator indicated the resident alleges she's been raped or abused or molested multiple times a week. On 7/29/2020 at 3:15 p.m. the Administrator was interviewed. She indicated they did not report this incident to the State Agency as the resident made sexual abuse allegations daily. She indicated of the 2 nurses and 3 CNAs worked some or all of the shift in question on 7/25/2020. The facility had no statement from Nurse 5, CNA 7 nor CNA 8 but the facility did haave statements from CNA 6 and Nurse 4. She indicated she understood the allegation occurred later in the evening and thought Nurse 4 had already left for the evening prior to the time of the allegation. On 7/30/2020 at 12:00 p.m., the Administrator was interviewed. She indicated she was made aware of Resident J's allegation of abuse after 12:00 p.m. on 7/27/2020 by the Indiana State Department of Health (ISDH) surveyor. When the Administrator was queered regarding investigation progress and completion, no information was provided. She indicated the resident accused others all the time of abusing her. She indicated this incident should not have been reported to the state as the resident makes these allegations all the time about being sexually abused. She indicated this allegation was no different than the others the resident made. The Administrator indicated the allegations were a normal behavior for her. She indicated the resident's allegations were always sexual in nature. On 7/30/2020 at 1:59 p.m., the Administrator provided a current copy of the facility policy and procedure, dated 11/28/2016 titled Abuse Prevention and Reporting - Indiana. The following was included: Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation will result in an investigation. Investigation should be documented and a copy of the investigation should be kept with the report to ISDH. Upon learning of the report, the administrator or a designee shall initiate an incident investigation. All alleged violations involving abuse, are reported immediately but not later than 2 hours after the allegation is made or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The facility will follow the ISDH (Indiana State Department of Health) Incident Report Policy criteria. On 7/30/2020 at 11:00 a.m.,. the ISDH Incident Reporting Policy, dated 7/15/2015, was reviewed. The policy included, but was not limited to, the following: Purpose to provide guidance on the type of the incidents to be reported; timeline for reporting and the information to be included in the report. The facility must ensure that all alleged violations involving mistreatment or abuse, are reported immediately to the administrator of the facility. Note: Alleged violation in the above regulation is defined as a situation or occurrence (incident) that is observed or reported but has not yet been investigated. Types of incidents reportable under Federal and State Rules include but are not limited to, the following: any sexual contact involving a resident who lacks the ability to give consent because of cognitive impairment. The results of the investigation must be reported to the administrator or designee within 5 working days of the incident. The facility must ensure all alleged violations involving mistreatment or abuse, are reported immediately to the administrator of the facility. Incident reporting and timeframe: An incident identified as mistreatment or abuse, must be reported immediately after providing care and protection for the resident and determining the incident meets the reporting criteria. Follow up report must be submitted within 5 working days after the initial report. This Federal tag relates to Complaint IN 140. 3.1-28(e)
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure an allegation of abuse was thoroughly investigated for 2 of 4 residents reviewed for abuse. Resident J, Resident E Findings include: 1. On 7/28/2020 at 10:20 a.m., the record of Resident J was reviewed. [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE], included but was not limited to, the following: BIMS (Brief Interview for Mental Status) was 13 (independent cognition); no acute change in mental status; following symptoms were present for 12-14 days (nearly every day) of the assessment period: little interest or pleasure in doing things, feeling down or depressed or hopeless, trouble falling or staying asleep or sleeping too much, feeling tired or having little energy, feeling bad about yourself, trouble concentrating on things, moving or speaking slowly or the opposite - being so fidgety or restless moving around a lot more than usual; potential indicators of [MEDICAL CONDITION] none of the above; presence and frequency of behavior symptoms was documented and behavior not exhibited; personal hygiene documented as one person physical assist required and resident did participate in assessment. On 7/27/2020 at 11:45 a.m., the Harmony Unit (locked behavior unit) was observed. Resident J was observed sitting in a wheelchair at the nurses station. Resident J indicated they are sexually and physically molesting me here. Resident J also began talking about her medication, [MEDICATION NAME]. On 7/27/2020 at 12:10 p.m., the Administrator (Adm) was made aware of the allegation of sexual and physical abuse Resident J had made on 7/27/2020 at 11:45 a.m. The Adm

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) indicated the resident is care planned for making false accusations. The Adm indicated the facility investigates all allegations. On 7/27/2020 at 2:20 p.m., the Adm was interviewed. She indicated the investigation of Resident J's allegation is in process. On 7/27/2020 at 2:30 p.m., the Director of Nursing (DON) provided a copy of the note she had documented on 7/27/2020. The note included the following: Writer was informed this morning .(name of Resident J) was making an allegation of sexual assault on July 25, 2020. Writer immediately contacted the certified nurse's aids (CNA 6 and CNA 9) and the nurse (Nurse 4) that were mentioned in the allegation and had them write statements as to their whereabouts and events of Saturday. Writer also verified .care plan is noted to have the behavior of making false allegations about staff and other residents. Resident also has the [DIAGNOSES REDACTED]. On 7/28/2020 at 11:00 a.m., the resident was interviewed. The resident did not provide any mention of the allegation of sexual abuse she mentioned on 7/27/2020 at 11:45 a.m. On 7/28/2020 at 12:45 p.m., the Adm provided a copy of the following note she had documented on 7-27-2020 (no time). Continue to investigate resident stating .she was raped over the weekend on Saturday night. She accused 2 female staff members (one which did not work Saturday night) and a nurse which also was not working Saturday night. (Name of Resident J) is care planned for making up stories about staff and makes up stories about staff of color. She does not like black people. She tells them they are beneath her and makes accusations about nasty things they do because of their color. Will continue to follow up accusations found to be unfounded . On 7/28/2020 at 2:45 p.m. the Director of Nursing (DON) was interviewed. She indicated yesterday, after she was made aware of the allegation the resident made, she went to talk to the resident. She indicated the resident did not mention anything about the allegation of abuse to the DON. She indicated she looked at the resident and did not see any indicators of trauma and/or bruising to the resident's extremities, what she could visualize with the resident dressed. She indicated the resident refused to be examined so she was unable to perform any additional assessment. The DON indicated she did not document this conversation with the resident and/or this exam. The DON indicated the resident has behaviors daily and the staff may not always document these. The DON identified behaviors the facility monitors for the resident include the resident telling staff they do not belong here, tells staff they can live on their own, resident tries to cast demons out, and has a history of refusing medications and/or pocketing medications. On 7/29/2020 at 2:10 p.m. the ADM was interviewed. She indicated they began the investigation of Resident J's allegation of sexual abuse on was reported 7/27/2020. She indicated Resident J had accused Nurse 4 of holding her down while CNA 9 and CA 6. The ADM indicated CNA 9 was not even working that night and had not been employed at facility for a few months. The ADM indicated she did not report this allegation of abuse to ISDH because it is almost like a daily occurrence with (name of Resident J). The ADM indicated the resident alleges she's been raped or abused or molested multiple times a week. On 7/29/2020 at 3:15 p.m. the ADM was interviewed. She indicated they did not report this incident to the State Agency as resident makes sexual abuse allegations daily. She indicated of the 2 nurses and 3 CNAs who worked some of all of the shift on 7/25/2020, they currently had no statement from Nurse 5, CNA 7 and CNA 8 but they do from CNA 6 and Nurse 4. She indicated she understood the allegation to be it occurred later in the evening and thought Nurse 4 had already left for the evening. On 7/29/2020 at 3:21 p.m. the DON was interviewed. She indicated she did document a note on 7/29/2020, regarding the sexual abuse allegation from Resident J, which she was made aware of on 7/27/2020. At this time, she provided a copy of the hand written note (not included in the electronic medical record) which indicated the following: Dated 7/27/2020: Writer .up to see (name of Resident J) Monday, 7/29/2020 (sic). Writer asked resident what she needed to talk about. Resident wanted to talk about .put back on [MEDICATION NAME] .Resident began to talk about all legal names .No bruises or marks were noted on residents arms. Resident refused detailed skin assessment. Resident was sitting at nurses station in w/c (wheelchair) talking with other residents .seemed to be in a good mood . On 7/30/2020 at 11:15 a.m. the DON was interviewed. She indicated she should have documented her assessment and interview of the resident in the resident's nurses notes, behavior notes and/or behavior log. She indicated the allegation of abuse should have been investigated as soon as the facility had been made aware of it. The DON indicated she had been made aware on Monday, 7/27/2020. She indicated she talked to the resident early afternoon on Monday 7/27/2020. She indicated all the staff working on 7/25/2020 in the evening should have been interviewed. She indicted CNA 8 had already left prior to the time the alleged event took place. She indicated there were 2 alert and oriented and interviewable residents who reside on the behavior unit and she didn't think to interview them. The DON indicated the resident is speaks for herself as she has no POA and/or guardian. She indicted the resident was a incontinent and had her briefs checked and changed for bladder and bowel incontinence. The DON indicated she was unable to locate documentation the resident's peri area had been assessed. The DON indicated the following written statements from staff who had worked the evening shift on 7/25/2020, had been received on the following dates: Nurse 4 on 7/27/2020; CNA 6 on 7/27/2020; CNA 7 on 7/29/2020; CNA 8 on 7/30/2020; and Nurse 5 on 7/30/2020. The DON was queered regarding having interviewed the two residents on the Harmony unit (who had been identified by facility on 7/27/2020 at 8:40 a.m. as being alert, oriented and reliable for interview). She indicated I didn't think about that. On 7/30/2020 at 11:45 a.m., the Interim Social Service Director (ISSD) was interviewed. She indicated the following: The facility was made aware of incident on 7/27/2020 and the investigation began on 7/27/2020. She indicated the alleged incident allegedly occurred on 7/25/2020 on the evening shift. She indicated she followed up with the resident on 7/27/2020 and the resident sees the Nurse Practitioner 10. The ISSD indicated she interviewed the resident on 7/29/2020. She indicated the resident refuses her medications frequently really should have been on injectable medications. She indicated the resident had not mentioned this allegation since 7/27/2020. She indicated the resident indicated that Nurse 4 held her down while CNA 6 and CNA 9 (who had not worked here for at least 2 months) assaulted her. On 7/30/2020 at 12:00 p.m., the ADM was interviewed. She indicated she was made aware of the Resident J's allegation of abuse after 12:00 p.m. on 7/27/2020 by the Indiana State Department of Health (ISDH) surveyor. She indicated as of this time, Nurse 5, who was working that evening of 7/25/2020 had not been interviewed. The Adm indicated Nurse 5 who was working on 7/25/2020, should have probably been interviewed prior to today. When the ADM was queered regarding if the investigation was complete, no information was provided. The ADM indicated the DON assessed the resident on 7/27/2020 after she was made aware of the allegation. She indicated the resident accused others all the time of abusing her. She indicated this incident should not have been reported to the state as the resident makes these allegations all the time about being sexually abused. She indicated this allegation was no different than the others the resident made. The ADM indicated this is a normal behavior for her. She indicated the resident indicated Nurse 4 held her down while CNA 6 and CNA 9 (who has not worked at the facility for about 2 months) abused her. She indicated the resident's allegations were always sexual in nature. The Adm indicated they should have been more timely with their investigation, that they usually complete it within 48-72 hours. She indicated they were not notified of the allegation until Monday, 7/27/2020. On 7/30/2020 at 12:05 p.m., the Behavior logs from 6/29/2020 to 7/10/2020 were reviewed. Documentation on each day indicated none of the above observed (frequent crying, repeat movements, yelling/screaming, kicking/hitting, pushing, grabbing, pinching/scratching, biting, wandering, abusive language, threatening behavior, sexually inappropriate, rejection of care) for 26 entries. Documentation for 4 shifts had NA (not applicable) documented. One shift, on 7/5/2020, had documented the resident exhibited kicking/hitting and abusive language. Review of the nurses notes for the time period 6/29/2020 to 7/10/2020 indicated the resident had refused medications on the following dates: 7/3/2020, 7/4/2020, and 7/5/2020. The resident was documented as having been in the hospital from 7/10/2020 to 7/20/2020, for treatment due to fluid overload. No additional documentation was observed in the Behavior logs and/or the nurses notes for 6/29/2020 to 7/10/2020. On 7/30/2020 at 12:07 p.m., the Behavior logs from 7/20/2020 to 7/30/2020 2343 reviewed. Documentation on 16 of these entries indicated none of the above observed. The options were the same as listed on the behavior log from 6/29/2020 to 7/10/2020. Twice NA was documented and two separate days the behavior of yelling/screaming and biting was documented; one day had documented rejection of care and repeats movement; and 1 day had documented yelling/screaming and repeats movements. Review of the nurses notes for the time period 7/20/2020 to 7/30/2020 indicated Resident J returned to the facility on [DATE]. Nurses notes dated 7/21/2020 at 4:26 a.m. indicated alert and oriented to self only. Does not answer simple questions appropriately. Nurses notes 7/22/2020 at 3:30 a.m. indicated Uncooperative/resist care. Non-compliant with plan of care. Anxious, restless, socially inappropriate behavior. Yelling . Documentation indicated the resident refused medications on 7/22/2020 - 7/30/2020. Nurses notes 7/25/2020 at 12:49 p.m. and 7/26/2020 at 12:49 p.m. indicated Resident is alert, oriented to person, place, time and situation. No evidence of acute changes in mental status from resident's baseline . Documentation was lacking in the nurses notes of the resident having voiced allegations of sexual and/or physical abuse in nature. On 7/30/2020 at 12:20 p.m., Nurses notes, dated 7/27/2020 were reviewed. The first entry for 7/27/2020 was at 4:05 p.m. and the last entry for the day was at 9:30 p.m. The entry at 9:30 p.m. on 7/27/2020 indicated the following: Resident is alert. Oriented to person, place, time and situation. No evidence of acute changes in mental status from resident's baseline. Mood and behavior concern noted.

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) Uncooperative/resists care. Non-compliant with plan of care. Socially inappropriate behavior. Resident yelling at the nurses station saying everyone is lying to her. Documentation was lacking in the record of the resident's allegation of sexual and physical abuse she voiced on 7/27/2020 at 11:45 a.m. and the Adm was made aware of on 7/27/2020 at 12:10 p.m. On 7/30/2020 at 12:10 p.m. the Medical Records Clerk (MRC) provided copies of care plans which had the following focus: 7/20/2020 I have the following: verbal abuse and racist comments again people of color .I have also stated that everyone that work on this unit is abusive. Interventions included but were not limited to, the following: Intervene as needed to protect the rights and safety of resident and/or others; investigate the need for psychological support. On 7/30/2020 at 12:11 p.m., the MRC provided a copy of a care plan which addressed the focus of I have a behavior problem r/t accusing staff of saying things that are not true. I have a history of making false accusations against staff and residents statements about other residents dated 7/20/2020. Interventions included administer medications as ordered and staff will meet residents needs with two staff members at all times when working with resident. On 7/30/2020 at 12:12 p.m., the MRC provided a copy of the care plan, dated 7/20/2020, which addressed the problem of I will be non-compliant/resistive to care with: I refuse to allow nursing to perform skin assessments, I am non-compliant with care that staff offers me. I am non-compliant with medication administration. Interventions include: encourage resident to be compliant with care and educate resident/family/caregiver of possible negative outcomes r/t non-compliance. On 7/30/2020 at 12:13 p.m., the MRC provided a coy of the care plan, dated 7/20/2020, which addressed the problem of I have impaired cognitive function or impaired thought process r/t (related to) dementia, [MEDICAL CONDITION] and biopolar disorder. On 7/30/2020 at 12:14 p.m., the MRC provided a copy of the plan of care which addressed the problem of I have a behavior problem r/t (related to) accusing staff of saying things that are not true. I have a history of make false accusations against staff and residents statements about other residents, dated 7/20/2020. Interventions include to administer medications as ordered and staff will meet residents needs with two staff members at all times when working with resident. On 7/30/2020 at 12:15 p.m., the MRC provided a plan of care for the focus of I will be non-compliant/resistive to care with: allowing nursing to perform skin assessments and with care that staff offers to me. I am non-compliant with medication administration, dated 7/20/2020. On 7/31/2020 at 9:15 a.m., the Adm was interviewed. She indicated regarding Resident J (Resident J name) comes up with all kind of stories. The Adm was queered if Resident J was considered interviewable or not and the Adm indicated this was a behavior, making up stories, that Resident J had. The Adm indicated Resident J is not competent and the resident does not have a POA (power of attorney) as the resident will not give the facility a name of anyone. The Adm indicated there should be enough documentation to she in the care plan, the resident is incompetent and that is why they cannot keep a roommate in that room. The Adm indicated the facility could and will eventually get a POA and/or guardian for this resident but with COVID, things have just been so hectic. The Adm indicated the resident signed the paperwork when the resident was admitted to the facility. The Adm indicated the facility does investigate allegations of abuse but a lot of times with this resident, they are delusions. The Adm indicated the resident does not take her medication as prescribed as it is refused a lot. The Adm indicated when the resident sees someone new on the unit, (name of resident) tells them everything. The Adm indicated if it (allegation of abuse) had been someone else on the unit, we would have jumped on it hot and heavy but she claims abuse almost daily . On 7/30/2020 at 1:59 p.m., the Administrator provided a current copy of the facility policy and procedure, dated 11/28/2016 for Abuse Prevention and Reporting - Indiana. The following was included: Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. During the course of the investigation of an allegation of resident sexual abuse, the facility shall assess and make a determination of whether the sexual activity was consensual on the part of the resident. The facility will conduct an investigation and protect the resident from non-consensual sexual relations anytime the facility has reason to suspect the resident may not have the capacity to consent. Resident Assessment: staff will identify residents with an increased vulnerability for abuse, or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals and approaches, which would reduce the changes of abuse or mistreatment for [REDACTED]. Employees and volunteers are required to report any incident, allegation or suspicion of potential abuse, they observe, hear about or suspect to the administrator immediately. Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation will result in an investigation. Investigation should be documented and a copy of the investigation should be kept with the report to ISDH. Upon learning of the report, the administrator or a designee shall initiate an incident investigation. The appointed investigator will, at a minimum, attempt to interview the person who report the incident, anyone likely to have direct knowledge or the incident and the resident, if interviewable Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed to determine whether anyone has witnessed any prior abuse, neglect or mistreatment by the accused individual. The investigator will report the conclusions of the investigation in writing to the administrator or designee within 5 working days of the reported incident. All alleged violations involving abuse, are reported immediately but not later than 2 hours after the allegation is made or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The facility will follow the ISDH (Indiana State Department of Health) Incident Report Policy criteria. On 7/30/2020 at 11:00 a.m.,. the ISDH Incident Reporting Policy, dated 7/15/2015, was reviewed. The policy included, but was not limited to, the following: Purpose to provide guidance on the type of the incidents to be reported; timeline for reporting and the information to be included in the report. The facility must ensure that all alleged violations involving mistreatment or abuse, are reported immediately to the administrator of the facility. Note: Alleged violation in the above regulation is defined as a situation or occurrence (incident) that is observed or reported but has not yet been investigated. Types of incidents reportable under Federal and State Rules include but are not limited to, the following: any sexual contact involving a resident who lacks the ability to give consent because of cognitive impairment. The results of the investigation must be reported to the administrator or designee within 5 working days of the incident. The facility must ensure all alleged violations involving mistreatment or abuse, are reported immediately to the administrator of the facility. Incident reporting and timeframe: An incident identified as mistreatment or abuse, must be reported immediately after providing care and protection for the resident and determining the incident meets the reporting criteria. Follow up report must be submitted within 5 working days after the initial report. 2. The record for Resident E was reviewed on 7/28/20 at 9:00 A.M. [DIAGNOSES REDACTED]. A facility incident report dated 4/18/20, indicated Resident E alleged that a Certified Nursing Assistant (CNA) bent her fingers and turned her wheelchair causing the wheels to come up. The resident was assessed by a nurse and there was no redness, bruising, or open areas noted on resident. The CNA was immediately suspended pending the investigation of the alleged incident. A follow up indicated the facility was unable to substantiate abuse with the incident. There was no documentation indicating the allegation regarding Resident E on 4/18/20 was investigated by the facility. The Administrator was interviewed on 7/29/20 at 4:08 P.M. During the interview the Administrator indicated with an allegation of abuse the facility would start an investigation immediately. During the investigation, statements would be taken from the resident making the allegation, staff members, and other residents. Resident E was interviewable in this case, so she should have been interviewed. The facility would have documentation regarding an investigation. There was no documentation indicating the allegation regarding Resident E on 4/18/20 was investigated by the facility. The Director of Nursing Services was interviewed on 7/29/20 at 2:38 P.M. During the interview the DNS indicated if there is a resident to resident incident or abuse is suspected staff should report it immediately. If a CNA observes it they would report it to their charge nurse. It would then be reported to the Administrator and the DNS. The facility would do an investigation into what occurred. If a staff member is involved they may be suspended depending on the allegation. The facility would interview the staff member involved, interview the resident, and other residents may be interviewed if needed or if they witnessed anything. Staff would be asked to write statements about what occurred. A note would usually be documented in the computer about the event. Abuse can include verbal, physical, mental, emotional or sexual. The facility educates staff regarding abuse at meetings regularly. A policy, dated 1/22/2019, was provided by the A on 7/27/20 at 10:49 A.M., titled Abuse Prevention and Reporting- Indiana. The policy indicated .Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation. Investigation should be documented, and a copy of the investigation should be kept with the report to ISDH .Investigation Procedures: The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records

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	155446	A. BUILDING _____ B. WING _____	07/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APERION CARE FORT WAYNE	5700 WILKIE DR FORT WAYNE, IN 46804

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) or other documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed to determine whether any one has witnessed any prior abuse, neglect, exploitation, mistreatment or misappropriation of resident property by the accused individual. This Federal tag relates to Complaints IN 190, and IN 140. 3.1-28(d)
F 0622 **Level of harm -** Actual harm **Residents Affected -** Few	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide appropriate transfer for 1 of 2 residents reviewed. This resulted in anxiety and fear for the resident. (Resident B) Findings include: The record review for Resident B began on 7-27-2020 at 3:56 p.m. [DIAGNOSES REDACTED]. The MDS (Minimum Data Set) discharge with anticipated return dated 6-6-2020 for the 5-22-2020 discharge indicated a discharge status in box A2100 of Community. Resident B's BIMS (Brief Interview for Mental Status) was 15/15, which indicated the resident's mental status was cognitively intact. The May 2020 social service progress notes were reviewed. The notes on May 1, 2020 indicated no physical or verbal behaviors for any symptoms directed towards others, no behavioral symptoms directed toward self and no behaviors putting resident at risk for injury or illness. The current discharge plan indicated that Resident B had a discharge plan to move to an apartment but needed a waiver and an apartment to open. A Social Services progress note dated 5-12-2020, indicated Resident B played cards and smoked. Resident B was waiting for assisted living apartment to open after Covid-19 ended. A progress note written by Social Services dated 5-22-2020 at 6:54 p.m., indicated Resident B went to a single woman's shelter. The resident took all of her medications with her and several bags of personal clothes. She was dropped off and taken into the building at 6:25 p.m. A progress note dated 5-26-2020 at 6:47 p.m., indicated Resident B had verbal behavioral symptoms occurred 1 to 3 days as she yelled at staff. The summary indicated Resident B left to go to a shelter per staff due to non-compliance smoking in her bathroom. There was no documentation available for review to indicate Residnet B had been smoking in her room prior to her 5-22-2020 discharge. An interview with Resident B on 7-28-2020 at 11:00 a.m., indicated the Former Social Services Designee drove her to a shelter which had no sleeping facilities in the staff member's car . She indicated CNA 2 (Certified Nurse Aide) went with them. Resident B indicated she told CNA 2 that she did not smoke in her room and the Former Social Services said to her I did not say you did it. Resident B indicated she was asked about how this discharge to a shelter came about and she indicated they accused her of smoking in her room. She indicated one day, the Former Social Services came down to her room [ROOM NUMBER] times and told her, you need to get out. She indicated the Former Social Services indicated she was going to an assisted living, then told her she was going to a homeless shelter as the assisted living would not take her. She indicated the police came and asked her why she wanted to stay here where they did not want her here. Resident B indicated she had no where else to go. The police indicated she had to leave and that's when the Former Social Services drove her to the homeless shelter. An interview with Resident B's POA (Power of Attorney) on 7-28-2020 at 1:06 p.m., indicated the facility lead the POA to believe Resident B would be taken care of when discharged from the facility. The POA indicated she was aware of previous warnings regarding smoking. The facility discharged the resident without notifying her of the discharge, or why the resident was being discharged . The POA indicated she was never given a reason for the discharge and never given a chance to appeal it. An interview with the Administrator on 7-31-2020 at 10:05 a.m., indicated she was asked who was notified about the smoking incident and about Resident B going to a shelter. The Administrator indicated the Former Social Services notified her the resident had been smoking in her room and she could discharge Resident B to a homeless shelter. The Administrator indicated she was unable to provide any documentation of this, as she gave her notes to the Former Social Services for safe keeping and the Interim Social Services was unable to locate any of the documentation. The Administrator was asked if the resident was provided with a Notice of Transfer or Discharge and if she had the opportunity appeal the discharge or to contact the ombudsman. The Administrator indicated the resident should have been provided the Notice of Transfer or Discharge and with the opportunity to appeal and contact the Ombudsman. She indicated she was not aware that the homeless shelter did not provide a place to stay during the day, did not provide food and only provided a motel to stay for the night. She indicated if she would have know that, Resident B would not have been discharged there as it was not a safe discharge. A nurse progress note on 5-26-2020 at 7:41 p.m., indicated Resident B was readmitted to the facility and arrived to facility via a private vehicle per the POA. Resident B's personal fund statement dated May 2020 was provided by the Receptionist on 7-29- at 11:59 a.m. A review of the personal fund statement indicated Resident B had $17.05 in her account as of 5-20-2020, and no money had been withdrawn at the time of discharge on 5-22-2020. A copy of Discharge Instructions for Resident B dated 5-22-2020 at 4:05 p.m., was provided by Medical Records on 7-28-2020 at 3:20 p.m. The Discharge Instructions were not completely filled out. The only documentation on the form included the resident's weight, vital signs, oxygen saturation, pain level, and allergies [REDACTED]. The form was not signed by Resident B. An interview with Resident B on 7-28-2020 at 11:00 a.m., indicated Social Services drove her to a shelter on 5-22-2020 and dumped her there. An interview with Nurse 1 on 7-29-2020 at 10:22 a.m., indicated she saw Resident B leave with the Former Social Services person on 5-22-2020. She indicated the resident took her medications with her. Nurse 1 indicated she did not fill out any paperwork for a discharge.When a person discharged from the facility, the resident would get a discharge summary, a form which has their profile, medications listed, a bed hold form, and a transfer/discharge report. Nurse 1 indicated she had never had any reason to suspect Resident had smoked in the facility at any time. An interview with the Interim Social Services Designee (SSD) on 7-30-2020 at 9:42 a.m., indicated there were concerns regarding the lack of records for Resident B. This included discharge planning and documentation. The Interim SSD indicated she had been going through the Social Services office and had not found any documentation or notes regarding any paperwork given to Resident B at the time of her discharge. The Interim SSD was made aware Resident B's records lacked a physician order [REDACTED].To provide safe departure from the facility .To provide for continuity of care and treatment .Equipment .Clinical Record .Discharge Notice, Transfer form (other than death) .Wheelchair .Discharge Against Medical Advice Form (as applicable) .Procedure 1. Explain discharge procedure to resident and family. Provide additional health education or medication instruction information for resident or family as indicated in lay terms. Review and adhere to current federal regulations as found in Resident Rights and Transfer and Discharge Policies. 2. An attending physician order [REDACTED]. Initiate measures for follow-care as indicated (Social Services, Home Health Care, ect.) 3. Inform all departments of anticipated and actual discharge . 7. Complete Transfer Form accurately and completely including vital signs. Ensure that resident's current physical and psycho/social assessment, medications and current treatment is completely described and available to the receiving facility upon transfer. Assure required 'notices' (DNR, Will, POA) are sent with the resident. Note time of leaving 10. Thoroughly assess resident prior to discharge/transfer. 11. Document discharge summary. Include notes on specific instructions given (medications dressings, ect.) to resident and responsible parties in lay terminology This Federal tag relates to Complaint IN 757. 3.1-12(a)(3)
F 0623 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Notice of Discharge or Transfer was provided to 2 of 2 residents reviewed. (Resident B and Resident F) Findings include: 1. The Record Review for Resident B began on 7-27-2020 at 3:56 p.m. [DIAGNOSES REDACTED]. The MDS (Minimum Data Set) discharge with anticipated return assessment was dated 6-6-2020 for a 5-22-2020 discharge. The discharge status in box A2100 was marked Community. Resident B's BIMS (Brief Interview for Mental Status) was 15/15, which indicated the resident's mental status was cognitively intact. A progress note dated 5-22-2020 at 6:54 p.m., indicated Resident B was discharged to a single woman's shelter. The resident took all of her medications and several bags of personal clothes on discharge. She was dropped off and taken into the building at 6:25 p.m. An interview with Resident B on 7-28-2020 at 11:00 a.m., indicated the Former Social Services drove her in her

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F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) personal car to a shelter on 5-22-2020 and dumped her there. An interview with Nurse 1 on 7-29-2020 at 10:22 a.m., indicated she saw Resident B leave with the Former Social Services on 5-22-2020. She indicated the resident took her medications with her. Nurse 1 indicated she did not fill out any paperwork for a discharge. She also indicated for a person discharging from the facility, the resident would get a discharge summary, a form which has their profile, medications listed ect, the bed hold, and transfer/discharge report. Nurse 1 indicated she was not aware of the state form Notice of Discharge or Transfer. An interview with the Administrator on 7-31-2020 at 10:05 a.m., indicated she was asked who was notified about the smoking incident and about Resident B going to a shelter. The Administrator indicated the Former Social Services notified her and she could discharge Resident B to a homeless shelter. The Administrator indicated she was unable to provide any documentation of this, as she gave her notes to the Former Social Services for safe keeping and the Interim Social Services was unable to locate any of the documentation. The Administrator was asked if the resident was provided with a Notice of Transfer or Discharge and if she had the opportunity appeal the discharge or to contact the ombudsman. The Administrator indicated the resident should have been provided the Notice of Transfer or Discharge and with the opportunity to appeal and contact the Ombudsman. The Administrator indicated she was aware the discharge planning and the appropriate paperwork was not being done at the facility. The Administrator indicated we have tried to educate the nurses about what to do when a resident discharges and on the use of forms and documentation. She indicated the staff was still picking and choosing what forms to use and they haven't been making copies of the forms for the records. An interview with the Interim Social Services on 7-30-2020 at 9:42 a.m., indicated there were concerns for the lack of records for Resident B which included discharge planning and documentation. She indicated there were no notes found regarding any paperwork she may have given to Resident B at the time of her discharge on 5-22-2020. The Interim Social Services was made aware Resident B records lacked a physician order [REDACTED].before a facility transfers or discharges a resident, the facility must .notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand .record the reasons for the transfer or discharge in the resident's medical record .The timing of the notice .generally this notice must be provided at least 30 days prior to the transfer or discharge .facility initiated discharges only .does not include planned discharges or resident initiated discharges .exceptions to the 30-day requirement apply when the transfer or discharge is effected because .the resident's welfare is at risk and his or her needs cannot be met in the facility or the health and safety of others in the facility is endangered .in these cases, the notice must be provided as soon as practicable A copy of the Resident Rights was provided by Human Resources on 7-29-2020 at 12:10 p.m., and indicated, .the facility must provide you with written notice before you are to be transferred or discharged from the facility and include how you can appeal decisions to the Indiana State Department of Health 2. The clinical record of Resident F was review on 7/29/2020 at 1:00 p.m. [DIAGNOSES REDACTED]. A Discharge Return Anticipated MDS (Minimum Data Set) Assessment, dated 5/19/2020, was completed and accepted by CMS. An Entry Assessment, dated 5/27/2020 was completed and accepted by CMS. A Medicare 5 Day Assessment, dated 6/2/2020 was completed and accepted by CMS. The assessment indicated the resident had a BIMS Score of 01, which indicated severe cognitive impairment. Review of Resident F's Census indicated resident was on hospital unpaid leave from 5/19/2020 to 5/27/2020. Review of Resident F's Order Details indicated an order, dated 5/19/20 at 21:11(9:11 p.m.), from the Nurse Practitioner, Resident F was to be sent to the hospital for evaluation and treatment. Resident F's records did not indicate notification of the POA was completed regarding the resident being transferred out to the hospital for evaluation and treatment. Review of Resident F's assessments and progress notes for May 2020, did not indicate documentation for transfer to the hospital on [DATE]. The ADON (Assistant Director of Nursing) provided the order detail report on 7/30/20 at 10:30 a.m. The order was to send Resident F to the hospital for evaluation and treatment. Interview with the ADON indicated they were not able to provide transfer paper work completed when Resident F was transferred to the hospital. Interview with the Medical Records on 7/30/20 at 4:15 p.m. indicated she had provided all progress notes for May 2020, but there was no Transfer/Discharge form. Interview with the Administrator on 7/31/20 at 12:30 p.m., indicated no additional records were available for Resident F when they were transfered to the hospital. Review of facility's current, nondated, Discharge Checklist, which was provided by the AIT (Administrator-in-Training) on 7/31/2020 at 11:30 a.m. The Discharge Checklist indicated, .if discharging/transferring to hospital, complete the Einteract (sic) Transfer Form V4.1. It is in the assessment tab. Nurses note entered Needs to include: assessment of resident (vitals, ambulation, any c/o (complaint of) pain, how were they leaving?, orientation, Respiratory Assessment, Cardiac Assessment, GI Assessment, Skin Assessment, etc.) .Make copies of all papers to keep for file. Send original with resident This Federal tag relates to Complaint IN 757. 3.1-12(a)(6)(A)
F 0624 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Prepare residents for a safe transfer or discharge from the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure sufficient preparation and orientation prior to discharge was completed for 1 of 1 resident reviewed. (Resident B) Findings include: The Record Review for Resident B began on 7-27-2020 at 3:56 p.m. [DIAGNOSES REDACTED]. The MDS (Minimum Data Set) discharge with anticipated return assessment was completed on 6-6-2020 for the 5-22-2020 discharge. The discharge status in box A2100 was marked Community. Resident B's BIMS (Brief Interview for Mental Status) was 15/15, which indicated the resident's mental status was cognitively intact. A progress note written by the Former Social Services dated 5-22-2020 at 6:54 p.m., indicated Resident B went to a named single woman's shelter. The resident took all of her medications with her and several bags of personal clothes. She was dropped off and taken in the building at 6:25 p.m. Further review of Resident B's record indicated there was not a physician order [REDACTED]. An interview with Resident B on 7-28-2020 at 11:00 a.m., indicated the Former Social Services drove her in her car to a shelter and just dumped her there on 5-22-2020. She indicated the shelter did not have overnight accommodations, so they put her on a bus and took her to a motel. She indicated she had to be out of the motel by 7:00 a.m. the next day. She indicated she had no where to go during the day that she sat in the park, mostly cried and was petrified. She indicated she had no money, as the facility kept her money and she had no food or water. She indicated the shelter did give her crackers and a sandwich. Resident B was asked about how this discharge to a shelter came about and she indicated they accused her of smoking in her room. She indicated one day, the Former Social Services came down to her room [ROOM NUMBER] times and told her, you need to get out. She indicated the Former Social Services indicated she was going to an assisted living, then told her she was going to a homeless shelter as the assisted living would not take her. She indicated the police came and asked her why she wanted to stay here where they did not want her here. Resident B indicated she had no where else to go. The police indicated she had to leave and that's when the Former Social Services drove her to the homeless shelter. An interview with Resident B's POA (Power of Attorney) on 7-28-2020 at 1:06 p.m., indicated the facility led the POA to believe Resident B would be taken care of when discharged from the facility. The facility discharged the resident without notifying her of the discharge and without any money, food or water. The POA indicated Resident B was taken to a homeless shelter that only provided lodging for the night at a motel and no place for her during the day from 7:00 a.m. until check in at the shelter at 6:00 p.m. An interview with Nurse 1 on 7-29-2020 at 10:22 a.m., indicated she saw Resident B leave with the Former Social Services on 5-22-2020. She indicated the resident took her medications with her and Nurse 1 indicated she did not fill out any paperwork for a discharge. Nurse 1 indicated she was unaware the facility was considering discharging the resident. An interview with the Administrator on 7-29-2020 at 11:34 a.m., indicated Resident B was discharged because she was smoking in her room with another resident who was on oxygen. The Administrator indicated this should have been documented in the resident record. The Administrator was notified there was no documentation found about this incident or any other smoking incident regarding Resident B. The Administrator indicated that did not surprise her. The Administrator indicated Resident B was non-compliant with smoking and other issues which she could not remember. The Administrator indicated she assumed this shelter was like any other homeless shelter where you stayed there, had a bunk, worked there and were provided with food and water. The Administrator indicated she did not know the homeless shelter did not have a place for them to sleep and sent them off with a bus token for return after 7:00 a.m. the next day from a motel. The Administrator indicated she was not sure if the resident had eaten dinner prior to leaving the facility and did not know if the resident was provided any food and water to take with her from the facility, or money from her resident fund account. The Administrator indicated Resident B should have had a State Notice of Discharge or Transfer form, and discharge instructions with her including her medication list and would not expect her to get a bed hold since she was discharged to the community. The Administrator was asked if Resident B had been given written warnings for her non-compliance and she indicated she thought the Former Social Services was documenting this in the resident record. She indicated the Interim Social Worker was going through the Former Social Worker's office files now checking for

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

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F 0624 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) documentation. An interview with the Administrator on 7-31-2020 at 10:05 a.m., indicated she was not aware that the homeless shelter did not provide a place to stay during the day, did not provide food and only provided a motel to stay for the night. She indicated if she would have know that, Resident B would not have been discharged there as it was not a safe discharge. On 7-29-2020 at 1:02 p.m., APS was contacted. The Case Manager indicated she was sort of behind the scenes in the case with Resident B. The Case Manager indicated she was notified by Former Social Services that this resident had a safe discharge to a homeless shelter and the police were involved. Former Social Services indicated to the Case Manager the facility had been working with Resident B since August of 2019, she was non-compliant with safe smoking policies and continued to smoke in her room. The Case Manager indicated she questioned the Former Social Services, for a resident who had been at the facility for that long, how a discharged to a homeless shelter could be a safe discharge. The Case Manager indicated she was contacted by Resident B's POA as the resident was found wandering around in a park and was unable to manage on her own. The Case Manager indicated she advised the POA to take the resident to the hospital emergency room . The Case Manager indicated she was notified by the hospital emergency room they were working with the facility to have the resident return to the facility. A copy of the hospital emergency room report dated 5-26-2020 at 4:06 p.m., was provided by the Administrator on 7-29-2020 at 11:57 a.m. The report indicated the patient had been incorrectly removed from her care facility and dropped at a homeless shelter. The patient had been roaming the streets for 4 days without any place to go and this had exacerbated her chronic pain in her lower extremity. The patient indicated she had been having diarrhea for the last 36 hours. Lab work indicated a potassium level of 3.5 mmol/L (one thousandth of a mole in a liter, a measurement), normal range for potassium was 3.6 - 5.1 mmol/L. All other labs were within normal limits and her chest xray was normal. The notes indicated the resident was hydrated with fluids and would be discharged back to the long term care facility. A current, undated policy/procedure Discharge/Transfer of Resident was provided by the Administrator on 7-30-2020 at 8:15 a.m. The purpose: .To provide safe departure from the facility .To provide for continuity of care and treatment .Equipment .Clinical Record .Discharge Notice, Transfer form (other than death) .Wheelchair .Discharge Against Medical Advice Form (as applicable) .Procedure 1. Explain discharge procedure to resident and family. Provide additional health education or medication instruction information for resident or family as indicated in lay terms. Review and adhere to current federal regulations as found in Resident Rights and Transfer and Discharge Policies. 2. An attending physician order [REDACTED]. Initiate measures for follow-care as indicated (Social Services, Home Health Care, ect.) 3. Inform all departments of anticipated and actual discharge. 4. Should the resident's family or resident desire to leave without a physician's orders [REDACTED]. 7. Complete Transfer Form accurately and completely including vital sign. Ensure that resident's current physical and psycho/social assessment, medications and current treatment is completely described and available to the receiving facility upon transfer. Assure required 'notices' (DNR, Will, POA) are sent with the resident. Note time of leaving. 9. Notify family and receiving facility when being transferred to acute care facility. 10. Thoroughly assess resident prior to discharge/transfer. 11. Document discharge summary. Include notes on specific instructions given (medications dressings, ect.) to resident and responsible parties in lay terminology This Facility tag relates to Complaint IN 757. 3.1-12(a)(21)
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide a Bed Hold Policy Notification to the Resident's Representative for 1 of 1 resident. (Resident F) Findings include: The clinical record of Resident F 7/29/2020 at 1:00 p.m. [DIAGNOSES REDACTED]. A Discharge Return Anticipated MDS (Minimum Data Set) Assessment, dated 5/19/2020, was completed and accepted by CMS. An Entry Assessment, dated 5/27/2020 was completed and accepted by CMS. A Medicare 5 Day Assessment, dated 6/2/2020 was completed and accepted by CMS. The assessment indicated Resident F had a BIMS Score of 01, which indicated severe cognitive impairment. Review of Resident F's Census indicated the resident was on hospital unpaid leave from 5/19/2020 to 5/27/2020. Review of Resident F's Order Details indicated an order, dated 5/19/20 at 21:11 (9:11 p.m.), from the Nurse Practitioner to sent Resident F to the hospital for evaluation and treatment. Review of Resident F's records for May 2020, did not indicate documentation was completed regarding transfer to the hospital. The records did not indicate a Bed Hold Policy had been completed, nor if the Bed Hold Policy was provided in writing to the Resident's POA. The ADON (Assistant Director of Nursing) provided the order detail report on 7/30/20 at 10:30 a.m. The order indicated to send Resident F to the hospital for evaluation and treatment. Interview with the ADON indicated they were not able to provide the documented Notice of Bed Hold Policy for Resident F, nor record of the Bed Hold Policy being provided to the POA when Resident F was transferred to the hospital. Interview with the Administrator on 7/31/20 at 12:30 p.m., indicated no additional records were available for Resident F when they were transferred to the hospital. Review of facility's current, nondated, Discharge Checklist, provided by the AIT (Administrator-in-Training) on 7/31/2020 at 11:30 a.m., indicated, .Bed hold signed or verbal given.) .Make copies of all papers to keep for file. Send original with resident Review of facility's current, nondated, Notice of Discharge/Transfer and Bed Hold Policy, provided by the Administrator on 7/30/2020 at 3:40 a.m., indicated, .The regulation requires facilities to issue two notices related to bed-hold policies. The first notice could be given well in advance of any transfer, i.e., information provided in the admission packet .The second notice must be provided to the resident, and if applicable the resident's representative, at the time of transfer, or in cases of emergency transfer, within 24 hours Use paper copies .to be completed .obtain signature when possible on Bed Hold Notice .Keep a copy for proof of compliance and scan into file . This Facility tag relates to Complaint IN 867. 3.1-12(a)(25)(26)
F 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure discharge planning process was in place for 3 of 3 residents discharged from the facility. (Resident B, Resident C and Resident D) Findings include: 1. The Record Review for Resident B began on 7-27-2020 at 3:56 p.m. [DIAGNOSES REDACTED]. The MDS (Minimum Data Set) discharge with anticipated return assessment was dated 6-6-2020 for the 5-22-2020 discharge. The discharge status in box A2100 was marked Community. Resident B's BIMS (Brief Interview for Mental Status) was 15/15, which indicated the resident's mental status was cognitively intact. The discharge plan question for active discharge planning already occurring for the resident to return to the community was answered no and the question regarding a referral being made to the Local Contact Agency was answered no. The May 2020 social service progress notes were reviewed. The notes datedMay 1, 2020 indicated the current discharge plan was for the resident to move to an apartment but she needed a waiver and an apartment to open. A progress note dated 5-22-2020 at 6:54 p.m., indicated Resident B went to a woman's shelter. The resident took all of her medications with her and several bags of personal clothes. She was dropped off and taken into the building at 6:25 p.m. A copy of Resident B's care plans were obtained from Medical Records on 7-28-2020 at 4:18 p.m. There was not a care plan developed to indicate discharge planning was planned or initiated. An interview with Resident B on 7-28-2020 at 11:00 a.m., indicated the Former Social Services drove her in the staff member's personal car to a shelter which had no sleeping facilities. Resident B was asked how this discharge to a shelter came about and she indicated they accused her of smoking in her room. She indicated one day, the Former Social Services came down to her room [ROOM NUMBER] times and told her, you need to get out. She indicated the Former Social Services indicated she was going to an assisted living, then told her she was going to a homeless shelter as the assisted living would not take her. She indicated the police came and asked her why she wanted to stay here where they did not want her. Resident B indicated she had no where else to go. The police indicated she had to leave and that's when the Former Social Services drove her to the homeless shelter. An interview with Resident B's POA (Power of Attorney) on 7-28-2020 at 1:06 p.m., indicated the facility led the POA to believe Resident B would be taken care of when discharged from the facility. She indicateed the facility called the day of the discahrge and there was no planning for or ability to appeal the discharge. The facility discharged the resident without notifying her until after the resident had been discharged without any money, food or water. The POA indicated Resident B was taken to a homeless shelter that only provided lodging for the night and no place for her during the day from 7:00 a.m. until check in at the shelter at 6:00 p.m. An interview with Nurse 1 on 7-29-2020 at 10:22 a.m., indicated she saw Resident B leave with the Former Social Services on 5-22-2020. She indicated the resident took her medications with her and Nurse 1 indicated she did not fill out any paperwork for a discharge, nor was the staff aware of any plans for discharge. On 7-29-2020 9:26 a.m., the Case Manager at the homeless shelter was interviewed. She indicated the nursing home dropped off a woman named (Resident

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	155446	A. BUILDING _____ B. WING _____	07/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APERION CARE FORT WAYNE	5700 WILKIE DR FORT WAYNE, IN 46804

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

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F 0660 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 7) B's name) on 5-22-2020. On 7-30-2020 at 4:35 p.m., a letter was received from the Case Manager which indicated Resident B was brought to the homeless shelter on 5-22-2020 due to smoking in her room. The shelter was the intake site for an emergency women's program from mid-May to July 8th, 2020. The intake was 6:00 p.m. to 7:00 p.m. at the shelter and then they were transported to the local hotel where they could stay until 7:00 a.m. the next day. The letter indicated it was their responsibility to transport themselves back to the homeless shelter for intake the next evening and those checking into the homeless shelter should not arrive prior to 5:00 p.m. The letter indicated Resident B returned to the site on 5-23-2020 and 5-24-2020. The shelter had last seen Resident B on 5-24-2020. The letter indicated someone contacted the shelter to let them know Resident B was going to the emergency roiagnom on [DATE]. Additional information received from the homeless shelter on 8-3-2020 at 9:47 a.m., indicated the shelter was not open at all during the daytime hours for food or water and the hotel stay was strictly from 7pm-7am. The Case Manage indicated there was no prior contact with the nursing facility regarding Residnet B until she was dropped off at their door. An interview with the Administrator on 7-29-2020 at 11:34 a.m., indicated Resident B was discharged because she was smoking in her room with another resident who was on oxygen. The Administrator indicated this should have been documented in the resident record. The Administrator was notified there was not any documentation found about this incident or any other smoking incident regarding Resident B. The Administrator indicated Resident B should have had discharge planning prior to going to the shelter. The Administrator was asked if Resident B had been given warnings of impending discharge for her non-compliance. The Administrator indicated she thought the Former Social Services was documenting this in the resident record. She indicated the Interim Social Worker was going through the Former Social Worker's office files at that time. The Administrator provided what she had in her paper file on 7-20-2020 at 11:57 a.m. This included a copy of the progress notes with the note on 5-22-2020 that Resident B was dropped off at homeless shelter, a Nursing Home to Hospital Transfer Form and Discharge Instructions dated 5-22-2020, a copy of the [MEDICATION NAME] controlled substance record showing 4 [MEDICATION NAME] left on the card, the emergency room visit notes and a note that APS (Adult Protective Services) was notified. There were no notes to indicate a discharge plan had been begun or implemented prior to the date of discharge. On 7-29-2020 at 1:02 p.m., APS was contacted. The Case Manager indicated she was sort of behind the scenes in this case with Resident B. The Case Manager indicated she was notified by Former Social Services that this resident had a safe discharge to a homeless shelter and the police were involved. Former Social Services indicated to the Case Manager the facility had been working with Resident B since August of 2019, she was non-compliant and smoking in her room. The Case Manager indicated she questioned the Former Social Services, how discharge to a homeless shelter could be a safe discharge. The Case Manager indicated she was contacted by Resident B's POA later because the resident was wandering around in a park and was unable to manage on her own. The Case Manager indicated she advised the POA to take the resident to the hospital emergency room . The Case Manager indicated she was notified by the hospital emergency room they were working with the facility to have the resident return to the facility. The Case manager indicated she was unaware of any discharge planning until the day of Resident B's discharge. 2. The record review for Resident C began on 7-27-2020 at 2:11 p.m. [DIAGNOSES REDACTED]. The MDS admission assessment dated [DATE], indicated Resident C had a BIMS of 15/15, which indicated the resident was cognitively intact. The resident required an extensive assist of 1 person for bed mobility, transfers, walk in room, walk in corridor happened one time, locomotion on unit and dressing, toileting and personal hygiene. The resident required supervision of one person for the locomotion off unit and eating. The assessment indicated the resident had a [DEVICE] (gastrostomy tube, a way to feed a person liquids who could not eat by swallowing their food), surgical wounds, and was provided [MEDICAL CONDITION] care and oxygen. The box for active discharge planning for the resident to return to the community was marked no. A discharge MDS assessment with no anticipated return for Resident C was completed on 2-27-2020 and indicated the discharge was planned and no referrals were needed. A review of the progress notes indicated three entries on 1-13-2020 for Social Services, which included a social history, an assessment and a room move. The assessment indicated the resident planned to discharge to home, but there were no discharge plans at that time. The care plans for Resident C were reviewed and there was not a care plan developed or implemented that included discharge planning. A nurse progress note dated 2-23-2020 at 1:08 p.m., indicated Resident C's family came to take the resident out for a leave of absence to her home. Resident C and her family indicated she would be discharging to home on Monday, 2-24-2020. There were no further discharge notes in the resident's progress notes to indicate she was given instructions for discharge, there was a plan in place for safe discharge or when she left the facility. An interview with Medical Records on 7-28-2020 at 3:20 p.m., indicated neither the Notice of Discharge nor Transfer nor the bed hold policy was found in the Resident C's records or in her stacks of papers to be filed. A confidential interview with Resident C's family indicated when she was discharged , there were no medication orders to get her medications or a medication list with instructions on what dose or when to administer the medications. The family did not know how to go about getting the feeding for the [DEVICE] and the facility only sent home 4 cans of the feeding, which was less than a day's need. The family indicated they were not set up with any type of home health care referral for care, supplies for the [MEDICAL CONDITION] nor plans to ensure the transition from the facility to home went smoothly. The family indicated the Former Social Services promised all kinds of things to them, including a meeting to assist them to figure out the needs of the resident prior to discharge but the meeting did not take place, nor was there communication to try and set the meeting up. The family indicated Resident C came home with a paper which indicated she may discharge to home. 3. The Record review for Resident D began on 7-29-2020 at 2:00 p.m. [DIAGNOSES REDACTED]. An admission MDS assessment for Resident D was dated 6-5-2020. Resident D's BIMS was 9/15, which indicated the resident was mildly cognitively impaired. There were no discharge plans marked and the assessment indicated the resident planned to stay at the facility. The MDS discharge with return not anticipated assessment for Resident D dated 7-8-2020 indicated the residnet had a BIMS of 9/15. The discharge plan area indicated the residnet was returning to the community with no referral needed. A confidential interview with Resident D's family was completed on 7-28-2020 at 1:19 p.m The family member indicated they were the POA. The facility did not notify the receiving facility the resident's time of departure and there was no plan to coordinate care with the recieving facility. When the resident arrived at the new facility, there were no discharge instructions or summary provided to assist in the transition of care. A review of the social service note dated 6-10-2020 indicated a care plan meeting was planned on 6-25-2020 at 1:30 p.m. The note indicated the care plan invite was sent to the resident on 6-10-2020. There was no note the POA had been made aware or had been invited to the care plan meeting. A review of Resident D's care plans indicated, there was not a care plan developed or implemented to address discharge planning. A review of the progress notes indicated the NP made a visit on 7-7-2020. Her plan was to continue with the current psych plan of care. There were no further progress notes provided to indicate Resident D was discharged , where he was discharged to or any type of paperwork prepared or sent with him. A review of the physician orders [REDACTED]. to coordianate care with the recieving facility An interview with Nurse 1 on 7-29-2020 at 4:16 p.m., indicated when a person discharged from the facility, the resident would get a discharge summary, a form which has their profile, medications listed, the bed hold, and a transfer/discharge report sent to the recieving facility for a smooth transition. An interview with the Interim Social Services on 7-30-2020 at 9:42 a.m., indicated there were concerns regarding the lack of discharge planning for Resident B, Resident C and Resident D including documentation. The Interim Social Services indicated she had been going through the Former Social Services office, boxes of papers left in the office and there were no notes found regarding any paperwork she may have given to Resident B, Resident C or Resident D neither prior to nor at the time of their discharges. Resident C, who was admitted in January 2020 with a [MEDICAL CONDITION] and a feeding tube, the Interim Social Services indicated when this resident was discharged , she should have had the discharge paperwork sent home with them, along with a discharge summary, which would have included a medication list. She would have had a physician's orders [REDACTED]. Resident D, with a BIMS 9/15, the Interim Social Services indicated when residents were admitted for a short term rehab stay, discharge planning should begin within 1-2 weeks of admission with continued evaluation for the future discharge. She indicated for a resident being transferred to another facility, she would expect the following paperwork to be sent with the resident to the receiving facility; the face page, history and physical, temperatures for the last several weeks, physician's orders [REDACTED]. She indicated prior to resident discharge from the facility, the recieving facility should have been contacted to coordinate care for a smooth transition and at discharge notified the receiving facility that the resident was on his way. She indicated this facility should have sent the discharge paperwork with the resident. The Interim Social Services indicated she has been going through the current residents' records and trying to update those as she had not found the discharge planning care plans in the records. An interview with the Interim Social Services on 7-30-2020 at 11:10 a.m., indicated she searched the Former Social Services office and found no additional documentation of any discharge information for Resident C or Resident D. A current Social Services Director job

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F 0660 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 8) description dated 5-2-2017 was provided by Human Resources on 7-29-2020 at 12:10 p.m. This job description was signed by the Former Social Services on 8-12-2019 and indicated .The primary purpose of the Social Services Director is to assist in planning, organizing, implementing, evaluating and directing the overall operation of our facility's Social Services Department in accordance with federal, state, and local standards, guidelines and regulations, our established policies and procedures, and as may be directed by the Administrator, to assure that the medically related emotional and social needs of the resident are met/maintained on an individual basis .The Essential Duties and Responsibilities . included but were not limited to, .coordinate the resident discharge planning process and make referrals for appropriate home care services prior to the resident's return to the community A copy of the Social Service: Job Specific Orientation for the Former Social Services was provided on 7-29-2020 at 12:10 p.m., and indicated the Former Social Services was oriented on 8-19-2019 on the following areas which included but were not limited to, .Social Service assessment and general documentation requirements .care plans .discharge planning and follow-up .post discharge follow-up A statement at the bottom of the Social Service Job Specific Orientation page indicated .This employee has completed their orientation and has demonstrated reasonable command of each of the topics presented The PASS was circled. The areas were initialed by a supervisor's initials. A current, undated policy/procedure Discharge/Transfer of Resident was provided by the Administrator on 7-30-2020 at 8:15 a.m. The purpose: .To provide safe departure from the facility .To provide for continuity of care and treatment .Equipment .Clinical Record .Discharge Notice, Transfer form (other than death) .Wheelchair .Discharge Against Medical Advice Form (as applicable) .Procedure 2. An attending physician order [REDACTED]. Initiate measures for follow-care as indicated (Social Services, Home Health Care, ect.) This Federal tag relates to Complaints IN 898, IN 757, and IN 867. 3.1-12(a)(18)(19)
F 0661 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a discharge summary was completed for 3 of 3 residents reviewed. (Resident B, Resident C, and Resident D) Findings include: 1. The Record Review for Resident B began on 7-27-2020 at 3:56 p.m. [DIAGNOSES REDACTED]. The MDS (Minimum Data Set) discharge with anticipated return assessment was dated on 6-6-2020 for the 5-22-2020 discharge. The discharge status in box A2100 was marked Community. Resident B's BIMS (Brief Interview for Mental Status) was 15/15, which indicated the resident's mental status was cognitively intact. A progress note dated 5-22-2020 at 6:54 p.m., indicated Resident B went to a single woman's shelter. The resident took all of her medications with her and several bags of personal clothes. She was dropped off and taken in the building at 6:25 p.m. An interview with Nurse 1 on 7-29-2020 at 10:22 a.m., indicated she saw Resident B leave with the Former Social Services on 5-22-2020. She indicated the resident took her medications with her and Nurse 1 indicated she did not fill out any paperwork for a discharge. An interview with the Administrator on 7-29-2020 at 11:34 a.m., indicated the Interim Social Worker was going through the Former Social Worker's office files in search of the Discharge Summary. The Administrator provided what she had in her paper file. This included a copy of the progress notes with the note on 5-22-2020 that Resident B was dropped off at homeless shelter, a Nursing Home to Hospital Transfer Form and Discharge Instructions dated 5-22-2020, a copy of the [MEDICATION NAME] controlled substance record showing 4 [MEDICATION NAME] left on the card, the emergency room visit notes and a note that APS (Adult Protective Services) was notified. There was no Discharge Summary in the file. 2. The record review for Resident C began on 7-27-2020 at 2:11 p.m. [DIAGNOSES REDACTED]. The MDS admission assessment dated [DATE], indicated Resident C had a BIMS of 15/15, which indicated the resident was cognitively intact. The box for active discharge planning for the resident to return to the community was marked no. A discharge MDS assessment with no anticipated return for Resident C was completed on 2-27-2020 and indicated the discharge was planned and no referrals were needed. A review of the progress notes indicated three entries on 1-13-2020 for Social Services, which included a social history, an assessment and a room move. The assessment indicated the resident planned to discharge to home, but had no discharge plans at the time. A nurse progress note dated 2-23-2020 at 1:08 p.m., indicated Resident C's family came to take the resident out for a leave of absence to her home. Resident C and her family indicated she would be discharging to home on Monday, 2-24-2020. There were no further discharge notes in the resident's progress notes to indicate any discharge summary or when the resident had left the facility. An interview with Medical Records on 7-28-2020 at 3:20 p.m., indicated no Discharge Summary was found in Resident C's records, her files nor in her stacks of papers to be filed. 3. The Record review for Resident D began on 7-29-2020 at 2:00 p.m. [DIAGNOSES REDACTED]. An admission MDS assessment for Resident D was dated 6-5-2020. Resident D's BIMS was 9/15, which indicated the resident was mildly cognitively impaired. There were no discharge plans as the resident planned to stay at the facility. The MDS discharge with return not anticipated assessment for Resident D was dated 7-8-2020 and indicated a BIMS of 9/15. The discharge plan question was marked as returning to community and no referral needed. A confidential interview with Resident D's family was completed on 7-28-2020 at 1:19 p.m The family member indicated she was POA. The facility did not notify the receiving facility the resident's time of departure, and when the resident arrived at the new facility, there was not a discharge summary provided to assist in the transition of care. A review of Resident D's care plans indicated, there was not a care plan implemented regarding discharge. A review of the progress notes indicated the NP made a visit on 7-7-2020 and her plan was to continue with the current psych plan of care. There were no further progress notes provided to indicate Resident D was discharged , where he was discharged to or a Discharge Summary sent with him. A review of the physician orders [REDACTED]. An interview with Nurse 1 on 7-29-2020 at 4:16 p.m., indicated for a person discharging from the facility, the resident would get a discharge summary, a form which has their profile, medications listed, the bed hold, and a transfer/discharge report. An interview with the Interim Social Services on 7-30-2020 at 9:42 a.m., indicated there were concerns for the lack of records for Resident B, Resident C and Resident D which included discharge planning and documentation. The Interim Social Services indicated she had been going through the Former Social Services office, boxes of papers in the office, and there were no notes found regarding any Dischare Summary having been given to Resident B at the time of her discharge on 5-22-2020. The Interim Social Services was made aware Resident B's records dod not indicate a Discharge Summary with a medication list for the 5-22-2020 discharge had been completed. She indicated Resident C, who was admitted in January 2020 with a [MEDICAL CONDITION] and a feeding tube, when this resident was discharged , she should have had the discharge paperwork sent home with them, including a discharge summary, which would have included a medication list. She would have had a physician's orders [REDACTED].She indicated Resident D, with a BIMS 9/15, admitted for a short term rehab stay, discharge planning should have begun within 1-2 weeks after amission. She indicated for a resident being transferred to another facility, she would expect the following paperwork to be sent with the resident to the receiving facility, the face page, history and physical, temperatures for the last several weeks, physician's orders [REDACTED]. She indicated when the resident was discharged from this facility she would have notified the receiving facility that the resident was on their way. She indicated this facility should have sent the discharge paperwork with the resident. The Interim Social Services indicated she has been going through the current residents' records and trying to update those she could. An interview with the Interim Social Services on 7-30-2020 at 11:10 a.m., indicated she searched the Former Social Services office and found no additional documentation of any discharge information including discharge summaries for Resident C or Resident D. A current Social Services Director job description dated 5-2-2017 was provided by Human Resources on 7-29-2020 at 12:10 p.m. This job description was signed by the Former Social Services on 8-12-2019 and indicated .The primary purpose of the Social Services Director is to assist in planning, organizing, implementing, evaluating and directing the overall operation of our facility's Social Services Department in accordance with federal, state, and local standards, guidelines and regulations, our established policies and procedures, and as may be directed by the Administrator, to assure that the medically related emotional and social needs of the resident are met/maintained on an individual basis .The Essential Duties and Responsibilities . included but were not limited to, .coordinate the resident discharge planning process and make referrals for appropriate home care services prior to the resident's return to the community A copy of the Social Service: Job Specific Orientation for the Former Social Services was provided on 7-29-2020 at 12:10 p.m., and indicated the Former Social Services was oriented on 8-19-2019 on the following areas which included but were not limited to, .Social Service assessment and general documentation requirements .care plans .discharge planning and follow-up .post discharge follow-up A statement at the bottom of the Social Service Job Specific Orientation page indicated .This employee has completed their orientation and has demonstrated reasonable command of each of the topics presented The PASS was circled. The areas were initialed by a supervisor's initials. A current, undated policy/procedure

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F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 9) Discharge/Transfer of Resident was provided by the Administrator on 7-30-2020 at 8:15 a.m. The purpose: .To provide safe departure from the facility .To provide for continuity of care and treatment .Equipment .Clinical Record .Discharge Notice, Transfer form (other than death) .Wheelchair .Discharge Against Medical Advice Form (as applicable) .Procedure 1. Explain discharge procedure to resident and family. Provide additional health education or medication instruction information for resident or family as indicated in lay terms. Review and adhere to current federal regulations as found in Resident Rights and Transfer and Discharge Policies. 11. Document discharge summary. Include notes on specific instructions given (medications dressings, ect.) to resident and responsible parties in lay terminology A undated, current copy of a Discharge Checklist was located in the facility inservice education binder on 7-31-2020 at 11:30 a.m. The inservice date, 4-2-2020, was listed on the sign in sheets for the facility nursing staff . The Discharge Checklist included an area to check off for the .Discharge summary completed--including all meds (medications) added to summary This Federal tag relates to Complaints IN 898, IN 757, and IN 867.
F 0745 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medically-related social services were provided for 3 of 3 residents reviewd for safe discharge. This resulted in fear, anxiety, and a lack of coordination of medical supplies and care residents after discharge. (Resident B, Resident C, and Resident D) Findings include: 1. The Record Review for Resident B began on 7-27-2020 at 3:56 p.m. [DIAGNOSES REDACTED]. The MDS (Minimum Data Set) discharge with anticipated return assessment was dated 6-6-2020 for the 5-22-2020 discharge. The discharge status in box A2100 was marked Community. Resident B's BIMS (Brief Interview for Mental Status) was 15/15, which indicated the resident's mental status was cognitively intact. The PHQ-9 (Patient Health Questionnaire for Depression) score was 21. A score greater than 20 indicated [MEDICAL CONDITION]. In section E, Behavior, the potential indicators for [MEDICAL CONDITION] was marked, B for delusions. No other behaviors were marked. The discharge plan for active discharge planning area indicated resident return to the community was no and the question regarding a referral being made to the Local Contact Agency was answered no. The MDS entry tracking record was dated 6-6-2020 for a re-admission date of [DATE]. Resident B was marked as entering from the community. The May 2020 social service progress notes were reviewed. The notes dated May 1, 2020 indicated no physical or verbal behaviors for any symptom directed towards others, no behavioral symptoms directed toward self and no behaviors putting resident at risk for injury or illness. The current discharge plan indicated that Resident B had a discharge plan to move to an apartment but needed a waiver and an apartment to open. A Social Services progress note dated 5-12-2020, indicated Resident B played cards and smoked. Resident B was waiting for assisted living apartment to open after Covid-19 ended. A Social Services progress note dated 5-22-2020 at 6:54 p.m., indicated Resident B went to a single woman's shelter. The resident took all of her medications with her and several bags of personal clothes. She was dropped off and taken into the building at 6:25 p.m. A Social Services progress note dated 5-26-2020 at 6:47 p.m., indicated Resident B was marked yes for verbal behavioral symptoms that occurred 1 to 3 days as she yelled at staff. In the summary, the Social Worker indicated Resident B left the facility to go to a shelter per staff due to non-compliance smoking in her bathroom. A nurse progress note on 5-26-2020 at 7:41 p.m., indicated Resident B was readmitted to the facility and arrived to facility via a private vehicle per the POA. A social service progress note dated 5-29-2020, indicated Resident B had hazardous behavior with smoking products. Resident B's personal fund statement for May 2020 was provided by the Receptionist on 7-29- at 11:59 a.m. A review of the personal fund statement indicated Resident B had $17.05 in the account as of 5-20-2020, and no money had been withdrawn at the time of discharge on 5-22-2020. A copy of the Discharge Instructions for Resident B dated 5-22-2020 at 4:05 p.m., and was provided by Medical Records on 7-28-2020 at 3:20 p.m. The Discharge Instructions were not completely filled out. The only documentation included the resident's weight, vital signs, oxygen saturation, pain level, and allergies [REDACTED]. The form was not signed by Resident B. Further review of Resident B's record indicated there was not a physician order [REDACTED]. A Smoking Safety Risk Assessment for Resident B was completed on 5-26-2020. Potential for safe smoking problem following the facility Smoking Policy had been initiated. An Abuse/Neglect Screening for Resident B was completed on 6-1-2020. indicated the resident was at The screening indicated the resident was at high risk for self abuse or neglect. A Screening Assessment for Evaluation of Self Harm/Suicide for Resident B dated 6-1-2020, indicated a score of 8. A score of 6 - 10 indicated a moderate risk for self harm/suicide and in the comment section, the notes indicated resident was at high risk for self harm, wiithout further explanation. An interview with Resident B on 7-28-2020 at 11:00 a.m., indicated the Former Social Services drove her in the staff person's personal car to a shelter which had no sleeping facilities. She indicated CNA 2 (Certified Nurse Aide) went with them. Resident B indicated she told CNA 2 that she did not smoke in her room and the Former Social Services replyed with I did not say you did it. Resident B indicated the facility just dumped her at the shelter who then put her on a bus and took her to a motel. She indicated she had to be out of the motel by 7:00 a.m. the next day. She indicated she had no where to go during the day, that she went to the park, mostly cried and was petrified. She indicated she had no money, as the facility kept her money. She indicated the shelter gave her crackers and a sandwich. Resident B indicated she was asked about how the discharge to a shelter came about and she indicated they accused her of smoking in her room. She indicated one day, the Former Social Services came down to her room [ROOM NUMBER] times and told her, you need to get out. She indicated the Former Social Services indicated she was going to an assisted living, then told her she was going to a homeless shelter as the assisted living would not take her. She indicated the police came and asked her why she wanted to stay here where they did not want her. Resident B indicated she had no where else to go. The police indicated she had to leave and that's when the Former Social Services drove her to the homeless shelter. An interview with Resident B's POA (Power of Attorney) on 7-28-2020 at 1:06 p.m., indicated the facility led the POA to believe Resident B would be taken care of when discharged from the facility. The POA indicated she was aware of previous warnings regarding smoking. The facility discharged the resident without notifying her of the discharge, without any money, food or water. The POA indicated Resident B was taken to a homeless shelter that only provided lodging for the night and no place for her during the day from 7:00 a.m. until check in at the shelter at 6:00 p.m. An interview with Nurse 1 on 7-29-2020 at 10:22 a.m., indicated she saw Resident B leave with the Former Social Services on 5-22-2020 and she was not sure why. Nurse 1 indicated the resident took her medications with her and Nurse 1 indicated she did not prepare any paperwork for a discharge. She indicated the resident had been compliant with smoking since returning to the facility. An interview with CNA 2 (Certified Nurse Aide) on 7-29-2020 at 10:48 a.m., indicated on 5-22-2020, she was pulled off the behavioral unit and asked to go with the Former Social Services to take Resident B in the staff member's car. CNA 2 indicated she did not know what happened and why she was being asked to go in the car with Former Social Services. She indicated she went to Resident B's room and the police were there. She indicated the Former Social Services was observed to be yelling at Resident B and her room was in shambles with clothing and items strewn about. CNA 2 indicated the resident's bags were packed and Resident B gave CNA 2 her jewelry. CNA 2 indicated she inventoried the jewelry, placed it in a sealed bag and gave to the Administrator. CNA 2 indicated she rode in the back seat with Resident B and when they arrived at the homeless shelter, Former Social Services went inside. CNA 2 indicated when Former Social Services came out, Resident B asked her why she was doing this and Former Social Services yelled at her that she was non-compliant. On 7-29-2020 9:26 a.m., the Case Manager at the homeless shelter was interviewed. She indicated the nursing home dropped of a woman (Resident B). They tried to give her Resident B's medical records, but the Case Manager indicated she could not take them. She indicated this shelter was for single women who came for intake between 6:00 p.m. and 7:00 p.m. She indicated a bus would transport the women to a motel for the night and they had to be out by 7:00 a.m. in the morning. The Case Manager indicated the bus did not run on Sundays, but she could not remember if the bus ran on Saturdays during the pandemic. On 7-30-2020 at 4:35 p.m., a letter was received from the Case Manager which indicated Resident B was brought to the homeless shelter on 5-22-2020 due to reported smoking in her room. The shelter was the intake site for an emergency women's program from mid-May to July 8th, 2020. The intake was 6:00 p.m. to 7:00 p.m. and then they were transported to the local hotel where they could stay until 7:00 a.m. the next day. The letter indicated it was their responsibility to transport themselves back to the named homeless shelter for intake the next evening. The letter indicated those checking into the homeless shelter should not arrive prior to 5:00 p.m. The letter indicated Resident B returned to the site on 5-23-2020 and 5-24-2020. Resident B was last seen at the shelter on 5-24-2020. The letter indicated someone contacted the shelter to let them know Resident B was going to the emergency roiagnom on [DATE]. Additional information

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	155446	A. BUILDING _____ B. WING _____	07/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APERION CARE FORT WAYNE	5700 WILKIE DR FORT WAYNE, IN 46804

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F 0745 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 10) received from the homeless shelter indicated the shelter was not open at all during the daytime hours for food or water. They were strictly the intake site from 6-7pm. The hotel stay was strictly from 7pm-7am. On 7-29-2020 at 9:46 a.m., the local Police Department was contacted for a copy of the police report. A copy of the police report was provided on 7-29-2020 at 10:32 a.m. The report indicated on May 22nd, 2020 at approximately 1725 hours (5:25 p.m.) the police responded to the facility inreference an unwanted party. The officers spoke to the Former Social Worker who advised that they currently had a patient, Resident B, who had been discharged due to smoking in the room. The Former Social Worker advised that they had attempted to have Resident B exit the facility and had provided her with a new place to stay located at another address in the same city. The officer advised that they would not transport individuals and the Former Social Worker advised she would be willing to transport Resident B. The officer spoke to the resident and indicated she could no longer stay at the facility. He explained where her new living situation would be if she were willing and the Former Social Worker would be willing to transport her. Resident B indicated she did not think it was fair she had to leave the facility, however stated she would be willing to be transported by the Former Social Worker to the shelter. The note indicated Resident B gathered some of her belongings and made a plan to get the rest of her belongings at a later date. The Former Social worker transported to Resident B to the homeless shelter. An interview with the Administrator on 7-29-2020 at 11:34 a.m., indicated Resident B was discharged because she was smoking in her room with another resident who was on oxygen. The Administrator indicated this should have been documented in the resident's record. The Administrator was notified there was no documentation found in the record regarding this incident or any other smoking incident involving Resident B. The Administrator indicated that did not surprise her. The Administrator indicated Resident B was non-compliant with smoking and other issues which she cannot remember. She indicated the Former Social Services notified the POA of the situation regarding Resident B's smoking in her room with another resident who was on oxygen. The POA was on board with a homeless shelter the Former Social Services had found to take Resident B. The Administrator indicated Resident B was agreeable to go. The Administrator was asked about the police call on 5-22-2020 to assist with Resident B's discharge. She indicated she couldn't remember why the police were called. She indicated 3 days later, she was notified Resident B was in the hospital emergency room . The Administrator indicated Resident B's POA had contacted the Corporate Supervisor and the hospital social worker had also contacted the facility about taking the resident back. The Administrator indicated she was in the facility when the Former Social Services transported Resident B to the homeless shelter. The Administrator indicated she assumed this was like any other homeless shelter where you stayed there, had a bunk, worked there and were provided with food and water. The Administrator indicated she did not know the homeless shelter did not have a place for them to sleep, sent them off with in a bus to a mote,l and had a bus token for return after 7:00 a.m. the next day. The Administrator indicated she was not sure when Resident B left the facility what items were in her possession. She indicated she was not sure if the resident had eaten dinner prior to leaving the facility and did not know if the resident was provided any food and water to take with her from the facility, or money from her resident fund account. The Administrator indicated Resident B should have had a State Notice of Discharge or Transfer form, and discharge instructions with her including her medication list and would not expect her to get a bed hold since she was discharged to the community. The Administrator was asked if Resident B had been given written warnings for her smoking non-compliance.She indicated she thought the Former Social Services was documenting this in the resident record. She indicated the Interim Social Worker was going through the Former Social Worker's office files to find the missing documentation. The Administrator provided what she had in her paper file. This included a copy of the progress notes with the note on 5-22-2020 that Resident B was dropped off at homeless shelter, a Nursing Home to Hospital Transfer Form which was dated for a previous hospitalization , Discharge Instructions dated 5-22-2020, a copy of the [MEDICATION NAME] controlled substance record showing 4 [MEDICATION NAME] left on the card, the emergency room visit notes and a note that APS (Adult Protective Services) had been notified. On 7-29-2020 at 1:02 p.m., APS was contacted. The Case Manager indicated she was sort of behind the scenes in this case with Resident B. The Case Manager indicated she was notified by Former Social Services that this resident had a safe discharge to a homeless shelter and the police were involved. The APS Case Manager indicated the Former Social Services indicated the facility had been working with Resident B since August of 2019 regarding her non-compliance with smoking safely and in her room. The Case Manager indicated she questioned the Former Social Services, how could being discharged to a homeless shelter be a safe discharge, given the previous length of stay of Resident B. The Case Manager indicated she was contacted by Resident B's POA as the resident was found wandering around in a park and was unable to manage on her own. The Case Manager indicated she advised the POA to take the resident to the hospital emergency room . The Case Manager indicated she was notified by the hospital emergency room they were working with the facility to have the resident return to the facility. On 7-28-2020 at 4:15 p.m., Resident B was re-interviewed and was asked about what she did each day and what she had to eat each day after being dropped off at the homeless shelter. She indicated she could not remember if she ate supper prior to leaving the facility on 5-22-2020 around 6:00 p.m. She indicated she was just dropped off at the shelter with no food, no water and no money. She indicated she had 4 pain pills and she had what was left of her other medications and a day's worth of clothing. She indicated the shelter provided the transportation to the motel on 5-22-2020.The next morning her POA's family got her some breakfast through a fast food drive through. She indicated on Saturday and Sunday, there was not a bus to take her back to the homeless shelter and indicated it was too far for her to walk. She can't remember about having anything to eat except for the breakfast. She indicated she was very scared as she did not know this town. She indicated on Monday morning she took the bus back to the homeless shelter and they let her sit in the grass in front and provided her ice water, a sack lunch and a bathroom. She remembered spending one day on the weekend in a park, but could not remember where. She indicated she was dragging around her prescriptions and a couple of females at the motel asked her if she had prescriptions. She indicated she was afraid they were going to attack her, so she told them no. Resident B indicated on Tuesday, 5-26-2020, the POA took her to the hospital emergency room . She indicated she went back to the facility on Tuesday evening (5-26-2020). An interview with the Administrator on 7-31-2020 at 10:05 a.m., indicated the Former Social Services indicated to her that she could discharge Resident B related to unsafe smoking to a homeless shelter. The Administrator indicated the POA and the Nurse Practitioner were aware and in agreement with the discharge. The Administrator indicated she was unable to provide any documentation of this, as she gave her notes to the Former Social Services for safe keeping and the Interim Social Services was unable to locate any of the documentation. The Administrator indicated she was not aware that the homeless shelter did not provide a place to stay or food during the day and only provided a motel to stay for the night. She indicated if she would have know that, Resident B would not have been discharged there as it was not a safe discharge. The Administrator was asked if the resident was provided with a Notice of Discharge or Transfer and if she had the opportunity to contact the state or the ombudsman regarding the discharge. The Administrator indicated the resident should have been provided the Notice of Discharge or Transfer and had the opportunity to contact the state or the Ombudsman. The Administrator indicated she was aware discharge planning and the appropriate paperwork was not being done at the facility. The Administrator indicated the facility had tried to educate the nurses about what to do when a resident discharged as well as the use of forms and documentation. She indicated the staff were still picking and choosing what forms to use and they hadn't been making copies of the forms for the records. The Administrator indicated the Former Social Services was placed on suspension as she was not doing her job with following through with discharge planning and documentation. Then, two days later the Former Social Services resigned. 2. The record review for Resident C began on 7-27-2020 at 2:11 p.m. The resident was admitted on [DATE] and billing stopped on 2-24-2020. [DIAGNOSES REDACTED]. The admission MDS assessment dated [DATE], indicated Resident C had a BIMS of 15/15, which indicated the resident was cognitively intact. The PHQ-9 score was 14, which indicated the resident had minor depression. There were no behaviors marked. The resident required an extensive assist of 1 person for bed mobility, transfers, walk in room, walk in corridor happened one time, locomotion on unit and dressing, toileting and personal hygiene. The resident required supervision of one person for the locomotion off unit and eating. There was no impairment of the upper or lower extremities and the resident used a walker and wheelchair. The resident was 66 inches tall, 294 pounds and was marked as having a [DEVICE] (gastrostomy tube, a way to feed a person liquids who could not eat by swallowing their food). The resident had surgical wounds marked and was getting [MEDICAL CONDITION] care and oxygen. A discharge MDS assessment with no anticipated return for Resident C was completed on 2-27-2020 and indicated the discharge was planned. The resident had a BIMS of 14/15 and had no behaviors marked. The resident needed limited assist with bed mobility, transfers, walking in room/corridor, locomotion on/off unit, toileting, dressing, and personal hygiene. For eating, the resident required an extensive assist. The [DEVICE] was checked no. The resident had Physical and Occupational Therapy services which ended on 2-24-2020. The resident had Speech Therapy services which ended on 2-18-2020. The MDS assessment indicated a discharge plan was made and

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F 0745 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 11) no referrals were needed. A review of physician orders [REDACTED]. A review of the Social Services progress notes indicated three entries on 1-13-2020. The notes included a social history, an assessment and a room move. The assessment indicated the resident planned to discharge to home, but had no discharge plans at this time. No further documentation by the Former Social Services regarding any discharge planning was found in the progress notes. The care plans for Resident C were reviewed. There were no a care plans regarding discharge planning, the gastrostomy tube, and the care plan for regular diet was updated on 3-10-2020, after the resident discharged on [DATE]. A nurse progress note dated 2-23-2020 at 1:08 p.m., indicated Resident C's family came to take the resident out for a leave of absence to her home. Resident C and her family indicated she would be discharging to home on Monday 2-24-2020. There were no further discharge notes in the resident's record to indicate she was discharged or when she left. A Discharge Summary for Resident C with an effective date of 2-24-2020 at 10:52 a.m., was completed. The Discharge Summary, indicated vitals were completed on 2-24-2020 in the morning for the blood pressure, pulse, respirations and pain level. The last weight was documented on 2-7-2020 and the last temperature was taken on 2-23-2020. The resident's allergies [REDACTED]. The section to be completed by Social Services indicated the resident had a walker and no services or referrals were needed. None of the medications, the dosage amounts or times to be given were entered on the discharge form. The diet orders indicated Resident C was fed by gastrostomy tube feeding with no amounts or how often the feedings should be done. The Activities of Daily living were entered as the resident was independent and used a walker. The education Resident C received was marked as medication administration, blood pressure monitoring, oxygen therapy, aerosol/nebulizer, [MEDICAL CONDITION] care, wound care/dressing changes, tube feeding administration and care of site. Two wounds were listed with instructions for care. There was no indication the resident received a copy of these instructions. An interview with Medical Records on 7-28-2020 at 3:20 p.m., indicated neither the Notice of Discharge or Transfer or the bed hold policy was found in the Resident C's file or in her stacks of papers to be filed. A confidential interview with Resident C's family indicated when she was discharged , there were no medication orders to get her medications nor instructions telling her when to administer the medications. The family did not know how to go about getting the feeding for the [DEVICE] as the resident did not take anything by mouth. The facility only sent home 4 cans of the feeding, which was less than one day's supply. The family indicated they were not set up with any type of home health referral for care, supplies for the [MEDICAL CONDITION], nor support to ensure the transition from the facility to home went smoothly. The family indicated the Former Social Services promised all kinds of things to them, including a meeting to assist them to figure out the needs of the resident prior to discharge. No meeting had been attempted and none of it was done. The family indicated the resident came home with a paper which indicated may discharge to home. 3. The Record review for Resident D began on 7-29-2020 at 2:00 p.m. [DIAGNOSES REDACTED]. An admission MDS assessment for Resident D dated 6-5-2020, indicated Resident D's BIMS was 9/15, which indicated the resident was mildly, cognitively impaired. The PHQ-9 score was 16 which indicated the resident had moderately severe depression. There were no behaviors marked. Resident D required a limited assist of 1 person for bed mobility, eating, toilet use and personal hygiene. The resident required supervision with set up help only for walk in room/corridor and locomotion on/off unit. The resident required supervision of one staff for transfers and dressing. Resident D had no limitations on his upper or lower extremities and no mobility devices marked. The resident and family or significant other participated in the assessment and there were no discharge plans as the resident planned to stay at the facility. The MDS discharge with return not anticipated assessment for Resident D was dated 7-8-2020 and indicated a BIMS of 9/15. The resident needed limited assist for bed mobility, transfers, locomotion on/off unit, dressing, eating, toilet use and personal hygiene. The walk in room/corridor occurred only once or twice. The resident was marked for taking antipsychotics and an antidepressant. The discharge plan question was marked as returning to community with no referral needed. A confidential interview with Resident D's family was done on 7-28-2020 at 1:19 p.m The family member indicated she was the POA. She indicated the facility did not notify her regarding admission paperwork. The facility had Resident D sign a form for a full code when the resident was a DNR (Do Not Resuscitate). The facility did not notify her of a room move from the Harmony (Behavioral) unit to a regular room with a roommate. The family indicated they tried to communicate withthe facility regarding this, but there was no follow up from the facility on anything. The family indicated the current facility did not notify the receiving facility the time of departure, and when the resident arrived, there was not a discharge summary provided to assist in the transition of care. A review of a social service evaluation in the progress notes indicated on 6-1-2020, the Former Social Services documented Resident D was a full code. A copy of Resident D's Post form was provided by Medical Records on 7-29-2020 at 3:23 p.m. Resident D's Post form dated 5-29-2020 indicated the resident had signed the form and dated it with a date of 3-23-2020. The physician signed and dated the Post form on 3-27-2020. The history and physical dated 5-13-2020 for Resident D from the transferring hospital indicated the patient was a Do Not Resuscitate per Indiana Post Form. A review of the social service note dated 6-10-2020 by the Former Social Services indicated a care plan meeting was to be held on 6-25-2020 at 1:30 p.m. The note indicated the care plan invite was sent to the resident on 6-10-2020. A review of progress notes indicated there was no entry regarding a room move for Resident D and no notification of the resident's representative was documented. A copy of the clinical census for Resident D was provided by Medical Records on 7-30-2020 at 11:30 a.m., and indicated the resident was moved on 5-29-2020 from room [ROOM NUMBER] in the Harmony unit to the West unit room [ROOM NUMBER]A. There were no further social services notes to indicate the resident was followed up for any issues regarding the room move. A review of Resident D's care plans indicated, there was not a care plan addressing discharge planning developed. A review of the progress notes indicated the NP made a visit on 7-7-2020 and her plan was to continue with the current psych plan of care. There were no further progress notes provided to indicate Resident D was discharged , where he was discharged to or whether any type of paperwork prepared or sent with him. A review of the physician orders [REDACTED]. An interview with Medical Records on 7-29-2020 at 3:37 p.m., indicated there was not a Bed Hold, a Notice of Discharge or Transfer form, or discharge instructions in the records. An interview with Nurse 1 on 7-29-2020 at 4:16 p.m., indicated when a person discharged from the facility, the resident would get a discharge summary, a form which has their profile, medications listed, the bed hold, and transfer/discharge report. She indicated she did not know what the state form Notice of Transfer or Discharge was. An interview with the Administrator on 7-29-2020 at 4:32 p.m., indicated the facility social services program would be described in the social worker's job description. An interview with the Interim Social Services on 7-30-2020 at 9:42 a.m., indicated there were concerns regarding the lack of records for Resident B, Resident C and Resident D, which included discharge planning and documentation. The Interim Social Services indicated she had been going through the Former Social Services office, boxes of papers, and had not found any notes or documentation to back up any of the accusations/warnings given to Resident B. She indicated there were no notes found regarding any paperwork she may have given to Resident B at the time of her discharge on 5-22-2020. The Interim Social Services was made aware Resident B's records lacked a physician order [REDACTED]. She would have had a physician's orders [REDACTED].Resident D, with a BIMS 9/15, the Interim Social Services would not have him sign a Post form to designate the Advanced Directives he had chosen, due to the resident's BIMS score of 9. She indicated in theory, when a resident was admitted to the facility during Covid-19 and with limited family visitation, social services should have contacted the resident representative to get information and social history. She indicated for residents that were admitted for short term rehab stays, discharge planning should have begun within 1-2 weeksof admission with ongoing evaluation for the future. She indicated when a resident was being transferred to another facility, she would expect the following paperwork to be sent with the resident to the receiving facility, face page, history and physical, temperatures for the last several weeks, physician's orders [REDACTED]. She indicated when the resident was discharged from this facility she would have notified the receiving facility that the resident was on his way. She indicated thi
F 0803 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** Based on observation, interview and record review, the facility failed to ensure menus were followed as programmed for 1 of 1 meal observations observed on 1 of 3 units in the facility. Findings include: On 7/27/2020 at 8:40 a.m., the Director of Nursing (DON) provided a list of current residents identified as alert, oriented and reliable for interview. None of the residents on the locked, dementia unit were identified as being alert, oriented and reliable for interview. On 7/27/2020 at 11:55 a.m., the meal service was observed on the locked, dementia unit. Styrofoam plates were observed to have a clear plastic sheet covering over the plate, with food on the plate visible. The meal included the following: meatloaf, potatoes

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F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 12) with gravy, corn and a bowl of pudding. An individual portion of margarine was observed on each plate but no roll and/or bread was observed to have been served on each plate. At this time, 6 of 6 residents had been served in the dining room. These residents appeared to have food on their plate equivalent to a regular diet. No bread was observed on any of these 6 plates at this time. No bread was observed to have been available on the unit for service at this time. The remaining 10 of 10 plates on the tray cart, were observed with no bread on the plates. On 7/30/2020 at 1:45 p.m., the Dietary Manager was interviewed. The Dietary Manager indicated the menu should be followed. On 7/28/2020 at 3:00 p.m., the Dietary Manager provided a current copy of the facility policy and procedure for Menu Planning and Requirements dated 2020. The policy and procedure included, but was not limited to, the following: Menus are planned to provide nourishing, palatable .that meet the nutritional needs of residents served .in accordance with the .Recommended Dietary Allowances . On 7/28/2020 at 3:00 p.m., a copy of the tray card for the noon meal on 7/27/2020 was observed. The tray card indicated a regular diet and indicated the dinner roll/margarine to be included on the menu. On 7/29/2020 at 3:00 p.m., the Dietary Manager provided a copy of the menu for the noon meal on 7/27/2020. The noon meal was to have included the following: meatloaf, potatoes, corn, banana pudding and dinner roll/margarine. This Federal tag relates to Complaint IN 140 3.1-20(i)(1) 3.1-20(i)(4)
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** Based on observation, interview and record review, the facility failed to ensure food was served at a palatable temperature for 1 of 1 meals observed. (Resident K, and Resident L) Findings include: 1. On 7/27/2020 at 12:05 p.m., Resident L was interviewed. The resident indicated they ate in their room and when they received the meal tray, the food was cold. This resident indicated the cold food temperatures varied from meal to meal, no particular meal was always cold. On 7/27/2020 at 12:11 p.m., Certified Nursing Assistant (CNA) 3 was observed to removed the Styrofoam containers (attached lid over a Styrofoam plate) from the insulated dietary cart. CNA 3 was then observed to place the Styrofoam containers on an open 3 tiered metal cart. She was observed to push the metal cart down the 200 hall to serve the meals. CNA 3 was interviewed and indicated the reason she took the Styrofoam containers out of the insulated dietary cart and put on the metal cart was so the meals would stay warmer. On 7/27/2020 at 12:20 p.m., CNA 3 was observed to prepare to pass the last tray in the 200 hall. At this time, the meal temperatures were checked. The temperature of the main entree casserole was checked with an Indiana State Department of Health (ISDH) thermometer. CNA 3 verified the temperature of the casserole to be 127.2 Fahrenheit (F). On 7/28/2020 at 10:40 a.m., Resident K was interviewed. The resident indicated they ate in their room and when they received their try, the food was cold. Indicated they have been getting their meals on Styrofoam plates for awhile but was unable to identify how long this had been. On 7/29/2020 at 2:56 p.m., Resident Council Minutes were reviewed. Documentation indicted the Resident Council was conducted on a 1 to 1 basis due to Covid Restrictions. The minutes included resident names and comments for the areas of care interviewed. The March 7, 2020 minutes indicated food cold. Resident Council Minutes from 4/7/2020 indicated dietary needs work. The Resident Council Minutes, dated 4/13/2020, indicated dietary was lousy and not good. A comment dated 4/14/2020 indicated dietary was awful, turning food down everyday. A comment dated 6/10/2020 indicated dietary was lousy. On 7/30/2020 at 1:45 p.m., the Dietary Manager was interviewed. She indicated at the point of food being served to the residents, the minimum temperature of food should be 135 degrees F. She was made aware of the food temperatures which were obtained during the lunch meal observation on 7/27/2020. She indicated the reason the food temperatures on the meals served to the residents were low was because the hot plate warmer was broken. She indicated because of this, the meals were served on Styrofoam paper products. 2. Observation of lunch meal tray delivered to the Activity Room on 7/28/2020 at 12:20 p.m., the meal tray had a triple-compartment foam food container, which contained the following: a prepackaged 4 oz container of apple sauce and 1 single serving butter cup. Dietary Staff 10 entered the activity room with a thermometer and alcohol prep pads. At 12:24 p.m., the food container was opened to check the temperature of the food. He was observed to clean the thermometer before checking the temperature of the food. The rice casserole's temperature measured 116 degrees Fahrenheit (F). He cleaned the thermometer with the alcohol prep pad between the two foods checked. The broccoli's temperature measured 86 degrees F. An interview with Dietary Staff 10 indicated the food was dished up about 5 minutes before the last resident meal tray. He indicated the cooking temperature should be 160 degrees F. Review of the current facility policy, provided by the Dietary manager on 7/28/2020 at 3:00 p.m., titled, Monitoring Food Temperatures for Meal Service) indicated, .Food temperatures will be monitored to prevent food borne illness and ensure foods are served at palatable temperatures .d. If the serving/holding temperature of a hot food item is not at 135 degrees F or higher (check you state specific regulations: some states require 140 degrees F minimum hot holding temperature) when checked prior to meal services, the item will be reheated to at least 165 degrees F for a minimum of 15 seconds. The item may be reheated only once and must be discarded or consumed within two hours g. Meals that are served on room trays may be periodically checked at the point of service for palatable food temperatures. Food temperatures of hot foods on room trays at the point of service are preferred to be at 120 degrees F or greater to promote palatability for the resident. Any complaint regarding food temperatures by residents will be documented on the Food Temperature Log. Complaints will be investigated by conducting a test tray for that meal to determine if foods are remaining above 120 degrees F This Federal tag relates to Complaint IN 140. 3.1-21(a)(2)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure preventative infection control measures were implemented for 16 randomly observed employees and/or visitors and 1 vendor observed to draw blood on 2 of 2 residents. This had the potential to affect 85 of 85 residents residing in the facility. Findings include: 1. On 7/27/2020 at 5:50 a.m., the facility was entered. Signs on on the front entrance gave the directive for off hours, to enter through the employee entrance. Employee 1 was observed to enter the facility through the employee entrance. She was observed to go directly to the front desk, which was unattended. Various papers were observed on the front desk, with a thermometer available. An Employee Screening Log was observed with the following observed on the form: Screening must be completed prior to entering Resident Care Area .Perform hand hygiene and apply face mask prior to enter care area and perform hand hygiene before exiting facility . The form indicated Prior to start of shift, Date, shift, Dept (department), temp (temperature), any new symptoms .any recent exposure .screener initials; End of Shift -Prior to leaving . Temp, any new symptoms ., were you provided adequate PPE (personal protective equipment) during your shift, screener initials . On 7/27/2020 at 5:52 a.m., Employee 1 was interviewed. Employee 1 indicated staff were to take their own temperature and write it on the log after signing in and completing the questions on the form. On 7/27/2020 at 5:53 a.m., Employee 2, Employee 3 and Employee 4 were observed to enter the building through the employee entrance. They were observed to walk directly past the desk without signing in, did not perform temperature check and/or did not sanitize their hands. All 3 employees were observed to walk down the main entrance and into the resident care area. On 7/27/2020 at 5:56 a.m., Employee 2, Employee 3 and Employee 4 were observed to return to the front desk from the interior of the facility. They were observed to sign in using the pen at the desk. All 3 Employees were observed to take their own temps. They were not observed to sanitizing the thermometer before, after and between uses of various employees. Employee 5 was observed to approach the front desk from the employee entrance. She used the same thermometer without cleaning before and after use. These 4 staff had been observed to use the same pen and thermometer without cleansing between uses. These 4 employees were not observed to sanitize their hands before or after entering the registration and patient care area. No hand sanitizer was observed at the desk. Employee 6 was observed to pick up the thermometer without sanitizing it, place the thermometer on the inside of the left wrist, and take their temperature. On 7/27/2020 at 6:00 a.m., Nurse 7 requested the ISDH surveyor to take their temperature. LPN 7 was requested to take the temperature. LPN 7 was observed to pick up the thermometer, LPN 7 indicated Hmmm, I haven't used this one yet., then wothout sanitizing the thermometer, began to take the surveyor temperature. The surveyor reqiested the thermometer be sanitized prior to a temperature being taken. The thermometer was observed on the receptionist counter since 5:50 a.m. 7/27/2020. LPN 7 indicated currently there were no residents in the facility who were Covid positive. LPN 7 indicated Employee 2, 3 and 4 all worked on differing units throughout the facility. On 7/27/2020 at 6:30 a.m., Employee 8 and Employee 9 were observed to approach the front desk from the employee entrance. They were observed to check their temperature by touching their head with the thermometer. The thermometer was not observed to be cleaned prior to and after use. Employee 8 and Employee 9 were not observed to sanitize hands while at the front desk and prior to entering the patient care area. On 7/27/2020 at 6:33 a.m., Employee 10 was observed to approached the front desk from the interior of the facility. Employee 10 looked at the paper log and indicated I can't find where I signed in I know I did it. Employee 10

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	155446	A. BUILDING _____ B. WING _____	07/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APERION CARE FORT WAYNE	5700 WILKIE DR FORT WAYNE, IN 46804

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

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 13) was them observed to walked out of the facility through the employee entrance without checking their temperature, signing out, answering the end of shift questions and performing hand hygiene prior to leaving the facility. Employee 11 was observed to approach the front desk from the employee entrance and was observed to check their temperature without cleaning the thermometer before or after use. Employee 11 was not observed to perform hand hygiene prior to entering the patient care area of the facility. On 7/27/2020 at 6:33 a.m. Employee 12 was observed to enter the front desk area from the employee entrance. They were observed to walk directly by the front desk, did not sign in, did not take their temperature and did not perform hand hygiene prior to entering the patient care area of the facility. On 7/27/2020 at 6:34 a.m., Employee 13 and Employee 14 were observed to approach the front desk from the interior of the facility. Both were observed to take their temperature and document on the log. They were not observed to sanitize the thermometer prior to and/or after use. They were not observed to perform hand hygiene prior to leaving the registration area and exiting the building through the employee exit. On 7/27/2020 at 6:40 a.m., the Employee Screening Log was reviewed. Employee 13 and Employee 14 had signed in and out on 7/27/2020 after the ISDH staff had signed in at 5:52 a.m. Employee 13 and Employee 14 documented they worked third shift on 7/27/2020. On 7/27/2020 at 8:00 a.m., the Administrator was interviewed. She indicated the facility had the first case of COVID in the facility on May 14th. She indicated they thought a staff member was the one who brought the infection into the facility, per contact tracing. The Administrator indicated the facility had been COVID free for 1 month. On 7/28/2020 at 3:40 p.m., the Administrator was interviewed. She had reviewed the nursing schedule as worked on 7/25, 7/26, and 7/27/2020 and compared this to the Employee Screening Log located at the front reception desk. After review, the Administrator indicated the following clinical staff members did not complete or document the required screening process for COVID at the front receiption desk: On 7/25/2020 6 staff members, on 7/26/2020 10 staff members and on 7/27/2020 16 staff members. 2. On 7/27/2020 at 7:30 a.m., Resident K was observed in her room in her wheelchair (wc). A Vendor with scrubs on was observed to enter the resident's room. She was observed to have a satchel type bag with her. She put the satchel bag on a chair in the resident's room. She was observed to put gloves on. She was not observed to perform hand hygiene after entry into the resident's room. She was observed to take the vials out of her bag and put them on the bed. The Visitor was observed to draw at least 3 vials of blood. She was observed to then take her paper, put it on the resident's bed and label the vials of blood she had drawn with the same gloves she had used to draw the blood. She then took the pen, and without cleaning it, put it back in her pocket. She was observed to have taken the used tourniquet from the resident's arm and put it back in her bag. After removing her gloves, she picked up her paper and clipboard from the resident's bed. She was observed to them leave the room without performing any hand hygiene after glove removal and/or prior to leaving the room. On 7/20/2020 at 7:38 a.m., the Vendor was interviewed. She indicated she worked for a Health Association. At 7:40 a.m., the Vendor was observed to walk down the hall, put her clipboard on a cart in the hall and documented on her clipboard. She was then observed to walk into Resident M's room. The Vendor was observed to enter the resident's room and put her bag on a chair. She was then observed to take gloves out of her bag and without hand hygiene, put the gloves on. She then pulled a loose, tourniquet out of her bag. She pulled out 2 vials, went over to the resident and indicated she was going to draw blood. As she began to put the tourniquet on the resident, the ISDH surveyor stopped the vendor and interviewed her. She indicted the tourniquet she had pulled out of her bag was not previously used. She indicated she knew this because she only had 3 or 4 in her bag and she dug this one out of the bottom of her bag. She was interviewed regarding sanitizing her hands after removing her gloves after caring for Resident K and prior to applying gloves for this resident. She indicated she had sanitized her hands. She was asked where the sanitizer was she had used for hand hygiene. She looked in her bag and indicated Oh, I guess I didn't. I must have left it in my car. She was asked to remove her gloves and sanitize her hands prior to applying the gloves and drawing Resident M's blood. On 7/27/2020 at 9:30 a.m., the Director of Nursing (DON) was interviewed. She indicated she was the Infection Control Preventionist for the facility. She indicated hand sanitizer was on the desk for use, where staff and visitors were to sign in and be screened. She indicated staff were to sanitize their hands prior to going to the units and well as complete the screening procedure, sign in, answer the questions and check their temperature. Everyone was to wear a mask. She indicated staff was to perform the same procedure before their shift started and prior to exiting the building at the end of their shift. She indicated this included hand hygiene prior to leaving the facility at the end of their shift. The thermoteer was to be cleaned between usage. She was made aware of the observation of a staff member taking their temperature on their wrist. The DON indicated the thermomter was to be used on the forehead and was not for use on the wrist. On 7/27/2020 at 10:45 a.m., an anonymous staff member was interviewed. They indicated they take their temperature upon arrival to the facility, sign in and answer the questions prior to the start of the shift. They indicated they do clean the thermomter before and after each use. They indicated the alcohol wipes were kept at the desk where the sign in sheet and the thermometer was. On 7/27/2020 at 10:50 a.m., Anymoumous Staff was interviewed. They indicated when they arrived for work, they take their temp, sign in and answer the questions. They indicated they do not clean the thermomteter prior to or after usage. They indicated when they take their temperature, they held the thermometer up to their head but does not touch their head. On 7/29/2020 at 12:52 p.m., the Assistant Director of Nursing (ADON) provided a current copy of the undated, facility policy and procdure for Standard Precautions. The policy included but was not limited to, the following: Standard Precautions would be observed in order to prevent contact with blood or other potentially infectious materials. All blood or other potentially infecitous materials woould be considered infectious regardless of the perceived health status of the source individual. Hand hygiene was recognized as the most important way to prevent the transmission of infection. All employees were to wash hands after every unprotected contact with blood or other potentially infectious materials and after removing gloves. On 7/29/2020 at 12:53 p.m, the ADON provided a current undated copy of the facility policy and procedure for Procedure for Handwashing which included but was not limited to, the following: When to wash hands at a minimum: when reporting to work and before going home; before and after each resident contact. When to use alcohol hand sanitizer: after contact with resident's intact skin, after contact with inanimate objects (including medical equipment), before donning sterile gloves, before entering the resident's room and before exiting the resident's room. On 7/29/2020 at 2:05 p.m., the Receptionist provided a current copy of the manufactuers instructions for the thermometer the facility used. The product information was undated but included the following information: designed to measure human body temperature; aim the probe of the thermometer at the center of the forehead and maintain a distance of less than 1.18 inches (3 centimeters) away. Do not touch the forehead directly. Special reminders included: the thermometer was designed to take temperature readings from the center of the forehead. Do not take measurements from other parts of the body. On 7/30/2020 at 2:05 p.m., the DON was interviewed. She indicated the Receptionist, monitored visitors and staff for compliance with the screening process, taking temperature, signing in and out as well as cleaning the thermometer and hand hygiene. She indicated when the Receptionist was not working, the Healthcare Administrator in Training monitored compliance. The DON indicated when the Receptionist was not working, the front doors were kept locked and there was a sign directing outsiders to call into the facility. The DON indicated the staff were verbally made aware of the checking in and checking out procedure by her. She indicated she did not have documentation as to who she inserviced and when. She indicated either herself and/or the nurses monitor for compliance with the checking in and checking out procedure. 3. On 7/27/2020 at 9:15 a.m., upon entering the facility's main entrance, 5 signs posted on the outside of the glass entry door were observed. One of the signs indicated the following: ANYONE ENTERING THE BUILDING YOU MUST HAVE YOUR TEMPERATURE TAKEN. Before you start your shift and when you are done with your shift. You must record both readings each day you work! Thank you for helping keep everyone safe On 7/27/20 at 9:19 a.m., observation of the signs hanging on the front desk, indicated the following: Temperatures over 99.0 degrees Fahrenheit (F) have to be reported to the DON (Director of Nursing.) The sign further indicated, for all temperatures over 99.0 degrees, the staff would be asked to get a COVID-19 test done before returning to work. If negative, the staff would have to show proof before returning to work. A fax number was listed on the sign and indicated to fax the test results for COVID-19. The sign further indicated if the COVID-19 test was positive, the staff would have to quarantine for 14 days and be retested with a negative result to return back to work. There was not a sign to direct everyone to stop and be screened at the receptionists desk when entering the facility. On 7/27/2020 at 9:20 a.m., when entering the facility, the receptionist desk was observed at the main entrance. The Receptionist was standing up at the desk. After introduction to the Receptionist, she escorted ISDH (Indiana State Department of Health) Surveyor to the Activity Room. The Receptionist failed to provide COVID-19 Screening and temperature monitoring when entering the facility for the ISDH Surveyor. On 7/27/2020 at 9:24 a.m., Interview with the DON, indicated everyone who entereds the building was to be wearing a mask. The staff were to stop at the front desk and check their

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 14) temperatures. If their temperatures were above 99.0 degrees F the staff were to report to the DON or ADON (Assistant Director of Nursing). She indicated visitors, Hospice and Lab staff were to be screened when entering the building at the front desk. She indicated temperatures should be taken and recorded on the screening log and the screening questions answered on the screening log. She indicated the Receptionist would do the screening when she was working or whoever was working at the front desk. She further indicated the staff do self-screening if a nurse was there. The DON indicated the staff were to have their temperatures taken before starting work and at the end of their shift. She also indicated the thermometer should be cleaned with alcohol prep pads between each use. On 7/27/20 at 9:37 a.m., an interview with the facility's Receptionist, indicated screening should be done on everyone who entered the facility. The Receptionist indicated hand sanitizer should be used prior to screening and hand sanitizer was provided in the wall dispenser by the entry door. Also observed was a pump bottle of hand sanitizer on the countertop of the front desk. She indicated the screening log should be completed by staff and visitor or vendor. She indicated there were 2 separate screening logs and they were filed since screening began. The ISDH Surveyors asked the Receptionist to be screened. On 7/27/20 at 9:50 a.m., an interview with the facility's Receptionist indicated she does the screening when she is working at the front desk. She indicated she must have been busy when ISDH Surveyors entered the building and forgot to screen them. On 7/27/20 at 9:51 p.m., the Administrator indicated the Unit Nurses were responsible to come and sign off the screening logs after the logs were reviewed. Review of the Employee Screening Log, provided by the Receptionist on 7/27/20 at 9:58 a.m., indicated Screening must be completed prior to entering resident care area. The form indicated when answering, yes to any question, the employee should not work and should notify their supervisor immediately. Employeesereas instructed to perform hand hygiene and apply a face mask prior to entering the care area and perform hand hygiene before exiting facility. The Screening Log was to be completed prior to starting shift and at the end of the shift, prior to leaving the facility. Prior to starting a shift, the staff was to record the following: Name, Date, Shift, Department, Temperature, and answer questions, yes or no for the following: Any new symptoms or temperature greater than 100 degrees F. The list of symptoms included the following: cough, sore throat, new loss of smell or taste, headache, chills, muscle pain, nausea, vomiting or diarrhea. A second question indicated to answer, yes or no for any recent exposure or close contact with a COVID positive person outside of the facility. A space was provided for the screener's initials. Screening at the end of the shift, prior to leaving the facility was to be recorded on the screening log was temperature, any new symptoms or temperature greater than 100 degrees F. The list of symptoms included the following: cough, sore throat, new loss of smell or taste, headache, chills, muscle pain, nausea, vomiting or diarrhea. The log also asked staff if they were provided adequate PPE (Personal Protective Equipment) during their shift. If they answered no, they were to list what was needed. The Employee Screening Log ended with the Screener's initials. The Employee Screening Log had a signature line for the staff who reviewed the screening log, their title and the date the log was reviewed. Review of the Visitor/Vendor Screening Log, provided by the Receptionist on 7/27/2020 at 9:58 p.m., indicated all visitors and vendors were required to be screened upon entry, to use hand sanitizer upon entering and exiting the facility. They were to wear a mask at all times while in the facility. The form indicated if the person was running a fever or had any symptoms such as a cough, shortness of breath, sore throat, they would not be allowed in the facility. The screening also informed the visitor or vendor to only go to the resident's room and not to go into other areas, not to touch, hug or shake hands with anyone during the visit, to wash hands or use hand sanitizer before leaving resident room and when exiting the building. The screening form also instructed the visitor or vendor to self monitor for symptoms for 14 days after visiting the facility. The visitor or vendor were to complete the screening log which included, name, date, time, temperature. Answer yes or no to questions, if any recent fever greater than 100 degrees F, cough, new shortness of breath, sore throat, chills, muscle pain, headache, new loss of smell or taste? Also a question if any prolonged contact with a person with confirmed ore suspected COVID-19? A vendor only question, of Yes (to prolonged contact with a confirmed or suspected COVID-19 person) where they wearing the appropriate PPE? The screening log for visitors and vendors ended with the Screener's initials. The Visitor/ Vendor Screening Log had a signature line for the staff who reviewed the screening log, their title and date the log was reviewed. On 7/30/2020 at 1:55 p.m. a sign was observed posted beside the employee entry door, which stated, ALL STAFF YOU MUST HAVE SOMEONE MEET YOU AT THE FRONT DESK AND HAVE SOMEONE VERIFY YOUR TEMPERATURE. Review of facility's education provided by the AIT (Administrator-In-Training) on 7-31-2020 at 11:30 a.m., titled, COVID-19 for Long Term Care, by Illinois Department of Public Health, dated 4/27/2020 indicated, SCREENING: STAFF SHOULD BE SCREENED PRIOR TO SHIFT AND AT END OF SHIFT; ONE ENTRANCE ONLY; SOMEONE ASSISGNED TO SCREEN STAFF AND VISITORS AT ENTRANCE-NO SELF-SCREENING; INFORMATION TO BE ENTERED ON LOG SHEET BY SCREENER. STAFF SHOULD LINE UP 6 FEET APART TO BE SCREENED AT DOOR. ONCE SCREENED PERFORM HAND HYGIENE WITH ALCOHOL GEL BEFORE ENTERING RESIDENT AREA. SCREENING FOR SYMPTONS-STAFF AND RESIDENTS: Monitor for and Report Any of the Following Symptoms: Elevated temp (100.0 F or Greater)-FEVER MAY NOT ALWAYS BE PRESENT!! .Cough .Muscle Aches .Fatigue .Shortness of Breath .Sore Throat .Loss of smell/taste .Nausea/GI Upset, Diarrhea .Chills .Headache Review of the current facility policy,titled, Infection Surveillance, Tracking and QA (Quality Assurance) Reporting, with a revision date of 2-14-18, was provided by the Administrator on 7/30/20 at 4:05 p.m., indicated, .Purpose: To identify, monitor, track and report infections and monitor adherence to infection control practices .Track resident and staff outbreaks and complete outbreak line-list report/investigation. 4. Review of 3 employees, hired in 2020, for education for infection control and the COVID-19 Virus. Education documentation was lacking for COVID-19 Virus for the 3 employees in-service records. On 7/31/2020 at 12:50 p.m. the Administrator indicated they were not able to provide documentation for the 3 requested employee's education records for COVID-19 Virus. She indicated she did not have access to online education records. Review of the current facility policy,titled, Infection Surveillance, Tracking and QA (Quality Assurance) Reporting, with a revision date of 2-14-18, was provided by the Administrator on 7/30/20 at 4:05 p.m., indicated, .Purpose: To identify, monitor, track and report infections and monitor adherence to infection control practices .Infection Tracking includes but is not limited to: .Track and ensure training/education is conducted upon hire regarding departmental infection control practices, as well as when trends and noted during observation and tracing. Individual department heads are responsible for scheduling and ensuring in-services are conducted as identified . 5. Upon entrance to the facility on [DATE] at 8:50 a.m., there were multiple papers taped on the front door of the facility and at the front desk. After entering through the front door and waiting for the Receptionist to finish with staff at the front desk, the Receptionist directed this surveyor to the Activity room. Screening for the Covid-19 virus symptoms was not completed. On 7-27-2020 at 9:48 a.m., after the Receptionist was interviewed by another surveyor regarding who was to be screened when entering the building, the Receptionist then screened this surveyor for temperature and with screening questions. This Federal tag relates to Complaint IN 757 and IN 927. 3.1-18(a)