STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155650	A. BUILDING 00 B. WING	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LINCOLNSHIRE HEALTH & REHABILITATION CENTER	8380 VIRGINIA ST MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00415074, IN00415577, IN00415694, IN00419693, IN00422944, and IN00423001. Complaint IN00415074 - Federal/State deficiencies related to the allegations are cited at F921. Complaint IN00415577 - Federal/State deficiencies related to the allegations are cited at F689, F921, and F9999. Complaint IN00415694 - No deficiencies related to the allegations are cited. Complaint IN00419693 - Federal/State deficiencies related to the allegations are cited at F727 and F732. Complaint IN00422944 - Federal/State deficiencies related to the allegations are cited at F727 and F732. Complaint IN00423001 - Federal/State deficiencies related to the allegations are cited at F727 and F732. Survey dates: December 4, 5 and 7, 2023 Facility number: 000577 Provider number: 155650 AIM number: 100266950 Census Bed Type: SNF/NF: 62 Total: 62 Census Payor Type:	F 0000	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rita Gatson	Administrator	12/15/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Medicare: 8 Medicaid: 44 Other: 10 Total: 62 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 12/11/23.			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure a resident who was being transferred in a bus to an appointment was secured appropriately in the bus to prevent the wheelchair from tipping over and also failed to ensure a Physician's Order and Care Planned intervention was in place to prevent falls, related to anti-roll back device was not located on a wheelchair for 2 of 3 residents reviewed for accidents. (Residents K and G) Findings include: 1. Resident K's record was reviewed on 12/5/23 at 1 p.m. The diagnoses included, but were not limited to, multiple sclerosis and convulsions. A Quarterly Minimum Data Set (MDS)	F 0689	F689 Free of Accident Hazards/Supervision/Devices The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or*	12/15/2023

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	assessment, dated 9/5/23, indicated a moderately impaired cognitive status, extensive assistance of two for transfers, and supervision for locomotion. A Care Plan, dated 5/25/23, indicated a risk for falls and a wheelchair was used for locomotion. The interventions included, anti-roll back device for the wheelchair and a non-slide pad (dycem) for the wheelchair seat. A Nurse's Note, dated 11/28/23 at 1:15 p.m., indicated the a call from the facility's Bus Driver indicated the resident had fallen while in the bus and had hit her head. She was driven to the hospital Emergency Room and was being evaluated and treated. A Nurse's Note, dated 11/28/23 at 6:35 p.m., indicated the ambulance transferred the resident back to the facility. She indicated she felt better, was alert and oriented to person, place and time, voiced no complaints, and denied pain and discomfort. A Fall Interdisciplinary Note, dated 12/4/23 at 7:16 a.m., indicated the resident was being transferred by the facility bus to a doctor's appointment and fell inside the bus. The Bus Driver indicated one of the straps that secured the wheelchair in the bus had broken and caused the wheelchair to tip over. The root cause of the fall indicated the Bus Driver needed more training on how to effectively secure the wheelchair residents in the bus and education had been provided for safety measures during transport. The investigation of the occurrence indicated the resident was interviewed on 11/28/23, and stated she had fallen while being transported to the hospital for a doctor's appointment. She had not		*executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The Bus Driver was re-educated on the correct way to strap a wheelchair on the bus with return demonstration. The IDT met to discuss fall interventions for Resident K and G; anti-rollbacks were resolved from the care plans. Dycem was added to the wheelchair for Resident K. **2) How the facility identified other residents:** All the residents have the potential to be affected by this alleged practice. **3) Measures put into place/ System changes:** Facility staff was re-educated on ensuring fall interventions are in place for all residents and a Physician Order is present if appropriate. An audit of fall interventions was completed for all residents to ensure interventions are in place and appropriate. The Bus Driver was re-educated on the correct way to strap a wheelchair	

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	felt the driver had strapped her wheelchair in properly and forgot to put the straps on her chair. While being transported, she felt her chair leaning. The Bus Driver left her on the floor of the bus because she had been in pain and drove immediately to the Emergency Room. An interview with the Bus Driver on 12/1/23, indicated he had assisted the resident onto the bus on 11/28/23 around 12:30 p.m. and was transferring her to a doctor's appointment. He strapped the wheelchair down with two straps on the right and one strap on the left. The straps were tight. The last corner of the transfer, he had heard a loud noise and observed the wheelchair on its side on the floor. He stopped the bus and checked the resident. She was not moved and had voiced she was in pain. He was close to the hospital and drove her to the Emergency Room. Staff at the Emergency Room came out and assessed and moved the resident to the inside of the hospital. He then notified the Nurse at the facility. The Emergency Room Notes, dated 11/28/23, indicated the resident was found lying on her right side on the floor. Her head was resting on the metal part of the ramp. She complained of head and neck pain. The CT scan of the cervical spine was negative for a fracture and the CT scan of head was negative for acute intracranial abnormality. A signed statement from the Maintenance Director from a sister facility indicated on 11/28/23, a full inspection of the bus was completed upon return to the facility. All devices and the straps and lap belt were functioning properly. The Bus Driver indicated the devices to strap down the wheelchair were strapped to the		on the bus with return demonstration. **4) How the corrective actions will be monitored:** The DON/Designee will audit/observe 5 residents weekly for 4 weeks and then bi-weekly thereafter ensure fall interventions are in place and appropriate along with physician order; as well as residents are strapped securely on the facility bus. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 12/15/2023**	

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	wheels and not to the frame of the wheelchair. On 12/1/23 when the Bus Driver returned to work, re-education was completed for the correct way to strap a wheelchair in the bus. A return demonstration was completed for safe transport. During an interview on 12/5/23 at 1:29 p.m., the Regional Vice President of Operations (VPO) indicated after the occurrence, the bus was inspected, there had been no broken straps. He was placed on suspension and had not worked again until re-training had been completed and the drug test was returned. During an interview with the Bus Driver on 12/7/23 at 8:08 a.m., he indicated he had worked a sister facility prior to working at this facility. He had occasionally driven the bus for that facility and the buses functioned the same. He had been trained by the Activity Director at the other facility how the wheelchair was to be strapped in the bus for a safe transport and that was how Resident K's wheelchair was strapped down. He had strapped the back straps on the wheelchair frame and front straps to the wheelchair frame. The straps were locked into place. When the chair tipped over, the front and back strap on the right side of the wheelchair had come off. When this happened he was about 300 feet from the Hospital, he had not moved the resident and took her to the Emergency Room and they come out to get her. He has been re-trained by the Maintenance Director from a sister facility and he showed him where to anchor the straps, which were in a different place on the wheelchair than he had been shown before, and to make sure the straps were tightened. An observation of a resident being secured in the bus on 12/7/23 at 9:28 a.m., indicated the			

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	wheelchair was locked, the back straps were hooked to the right and left bar on the frame on the back of the wheelchair and front right and left strap was hooked to the cross bar under the wheelchair. The straps were tightened and locked into place. The wheelchair was checked to ensure it would not move. He then place the safety belt on the resident and again checked to make sure the wheelchair was secured. An interview on 12/7/23 at 9:49 a.m. with the Maintenance Director of the sister facility, indicated the Bus Driver had attached the strap to the wheel and not the frame of the chair. He had been re-trained, and had completed a return demonstration. A facility policy, dated 9/1/20, titled, "Vehicle Safety", and received from the Regional Vice President of Operations, indicated the wheelchair's brakes were to be locked, the front straps were to be secured close to the seat surface and to ensure the straps were secure. The rear straps were to be secured close to the seat surface and were to be checked to ensure they were secured. 2. Resident G was observed on 12/4/23 at 7:39 a.m., 8:32 a.m., 9:03 a.m., and 12:26 p.m. sitting in the wheelchair. There was no anti-roll back device on the wheelchair. He was observed on 12/5/23 at 11:35 a.m. sitting in the wheelchair in the activity room coloring. There was no anti-roll back device on the wheelchair. The Director of Nursing indicated at the time of the observation, the anti-roll back device was not on his wheelchair. Resident G's record was reviewed on 12/5/23 at			

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	10:56 a.m. The diagnoses included, but were not limited to, dementia. A Quarterly MDS assessment, dated 11/11/23, indicated an severely impaired cognitive status, no behaviors, a wheelchair was used, was dependent for transfer, and had two or more falls without injuries. A Care Plan, dated 5/15/23, indicated a risk for falls. The interventions included an anti-roll back device was to be used. A Physician's Order, dated 5/9/23, indicated anti-roll backs were to be used on his wheelchair. This citation relates to Complaint IN00415577. 3.1-45(a)(2)			
F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on record review and interview, the facility failed to ensure a Registered Nurse (RN) was	F 0727	F727 RN 8 Hrs/7 days/Wk	12/15/2023

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	scheduled in the facility for at least 8 consecutive hours a day, 7 days a week. This had the potential to affect 64 of 64 residents who resided in the facility. Finding includes. Review of the nursing staffing schedules for November 2023 on 12/6/23 at 2 p.m., indicated there was no RN in the facility for eight consecutive hours on November 11, 2023. During an interview on 12/7/23 at 8:57 a.m., the Director of Nursing acknowledged the schedule for 11/11/23 indicated the RN who was scheduled had called off and there was no other RN in the building for eight consecutive hours. This citation related to Complaints IN00419693, IN00422944, and IN00423001. 3.1 -17(b)(3)		The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The schedule for upcoming days and future were reviewed by the scheduler and the DON to ensure an RN is scheduled for at least 8 hours each day. **2) How the facility identified other residents:** All the residents have the potential to be affected by this alleged practice. **3) Measures put into place/ System changes:** Facility staff was re-educated on ensuring an RN is scheduled for at	

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			least 8 hours each day. In the event an RN calls off, staff was re-educated to find RN coverage for that scheduled shift and if need be the DON will cover the shift only after completing her 8 hours for the day during the week and anytime on the weekend. **4) How the corrective actions will be monitored:** The DON/Designee will audit the nursing assignment schedules 4 times weekly for 4 weeks and then bi-weekly thereafter ensure an RN is scheduled at least 8 hours daily. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 12/15/2023**	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility			

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	must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on record review and interview, the facility failed to ensure the posted Nurse Staffing Information was up-to-date and current, related to	F 0732	F732 Posted Nurse Staffing Information	12/15/2023

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	call-offs, no shows, and replacements not updated every shift. This had the potential to affect all of the residents who resided in the facility for the month of November, 2023. Finding includes: The Nurse Staffing Information was reviewed with the nursing schedules for the month of November 2023 on 12/6/23 at 2 p.m., 19 of 30 days of posting were not up-to-date and current related to call offs and/or no shows. On 11/1/23, there were 2 LPN's on days and 2 LPN's on evenings and 7 CNA's/QMA's on days. The schedule indicated there was 1 LPN on days, 1 LPN on evenings, and 6 CNA's/QMA's on days. On 11/2/23, the posting indicated 2 LPN's on days, 3 LPN's on evenings, 8 CNA's/QMA's on days and 6 CNA's/QMA's on evenings. The schedule indicated there was 1 LPN on days, 2 LPN's on evenings, 6 CNA's on days, and 5 CNA's on evenings. On 11/6/23, the posting indicated 7 CNA's/QMA's on day shift. The schedule indicated there was 6. On 11/7/23, the posting indicated there was 1 LPN on evening shift. The schedule indicated there was no LPN on evening shift. On 11/10/23, the posting indicated there was 1 RN and 1 LPN on night shift. The schedule indicated there were 2 RN's and no LPN on the night shift. On 11/11/23, the posting indicated there was 1 RN on evening shift, 7 CNA's/QMA's on days and 7 CNA's/QMA's on evenings. The schedule indicated there was no RN on evening shift and 6		The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The Posted Nurse Staffing sheet was updated immediately with up-to-date and current information related to call offs, no shows and replacements. **2) How the facility identified other residents:** All the residents have the potential to be affected by this alleged practice. **3) Measures put into place/ System changes:** Facility staff was re-educated on ensuring that the Daily Posted	

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	CNA's/QMA's on the day and evening shift. On 11/12/23, the posting indicated there were 7 CNA's/QMA's on day shift, 6 CNA's/QMA's on evening shift, and 4 CNA's/QMA's on night shift. The schedule indicated there was 6 CNA's/QMA's on day shift, 5 on evening shift, and 3 on night shift. On 11/13/23, the posting indicated there were 8 CNA's/QMA's on day shift. The schedule indicated there were 7. On 11/14/23, the posting indicated there were 4 CNA's/QMA's on night shift. The schedule indicated there were 3. On 11/15/23, the posting indicated there were 2 LPN's and 6 CNA's/QMA's on day shift. The schedule indicated there was 1 LPN and 4 CNA's/QMA's on day shift. On 11/18/23, the posting indicated 2 LPN's on day shift and 4 CNA's/QMA's on night shift. The schedule indicated there was 1 LPN on day shift and 3 CNA's/QMA's on night shift. On 11/19/23, the posting indicated there were 7 CNA's/QMA's on day shift. The schedule indicated there were 6. On 11/20/23, the posting indicated there were 2 RN's on evening shift and 8 CNA's/QMA's on day shift. The schedule indicated there was 1 RN on evening shift and 6 CNA's/QMA's on days. On 11/21/23, the posting indicated there was 2 LPN's on evening shift. The schedule indicated there was 1 LPN.		Nurse Staffing sheet is posted daily, the actual hours worked column has been completed, and all information to be updated as needed related to call offs, no shows, and replacements every shift. **4) How the corrective actions will be monitored:** The Administrator/Designee will observe the Daily Posted Nurse Staffing sheet 3 times weekly for 4 weeks and the bi-weekly thereafter to ensure compliance with daily posting**,** the actual hours worked column has been completed, and all information has been updated as needed related to call offs, no shows, and replacements every shift. . **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 12/15/2023**	

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	155650	A. BUILDING 00 B. WING	12/07/2023

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	On 11/22/23, the posting indicated there were 7 CNA's/QMA's on the day shift. The schedule indicated there were 5. On 11/23/23, the posting indicated there were 2 LPN's on the evening shift, 6 CNA's/QMA's on the evening shift, and 4 CNA's/QMA's on the night shift. The schedule indicated there was 1 LPN on evenings, 4 CNA's/QMA's on evening shift, and 3 CNA's/QMA's on night shift. On 11/24/23, the posting indicated there were 2 LPN's on the evening shift, 2 LPN's on the night shift, 7 CNA's/QMA's on the evening shift and 4 CNA's/QMA's on the night shift. The schedule indicated there was 1 LPN on the evening shift, 5 CNA's/QMA's on the evening shift,and 3 CNA's/QMA's on the night shift. On 11/25/23, the posting indicated there was 2 LPN's on the day shift, 2 LPN's on the evening shift, 7 CNA's/QMA's on the evening shift and 4 CNA's/QMA's on the night shift. The schedule indicated there was 1 LPN on the day shift, 1 LPN on the evening shift, 4 CNA's/QMA's on the evening shift and 2 CNA's/QMA's on the night shift. On 11/26/23 the posting indicated there was 2 LPN's scheduled on the evening shift, 8 CNA's/QMA's on the day shift, and 4 CNA's/QMA's on the night shift. The schedule indicated there was 1 LPN on the evening shift, 7 CNA's/QMA's on the day shift, and 3 CNA's/QMA's on the night shift. During an interview on 12/7/23 at 8:57 a.m., the Director of Nursing indicated the Receptionist was responsible for updating the posting.			

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	This citation relates to Complaints IN00419693, IN00422944, and IN00423001.			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review, and interview, the facility failed to ensure the residents' environment was sanitary and comfortable, related to cob webs, dirt and debris on the floor, liquid feeding dried on IV/feeding pump poles, a feeding pump, and floors, cable and outlet covers loose or off, a soiled over the bed table, an over the bed table with a gouge, a cracked floor mat, a wedge pillow stored on the floor, and an accumulation of dust on a bathroom fan, for rooms on 2 of 2 Units. (B-Unit and A-Unit) Findings include: During an Environmental Tour, on 12/7/23 from 10 a.m. to 10:23 a.m., with Employee 1 and the Regional Vice President of Operations, the following was observed: 1. B-Unit a. Room 3, where one resident resided, had cobwebs on the floor under the closet door and under the desk and debris on the floor near the base boards. b. Room 8 had dried liquid feeding on the base of the IV pole. There was an IV pump on the pole. c. Room 9 was observed empty on 12/4/23 and 12/5/23 and on 12/5/23 at 9:35 a.m., there was dirt	F 0921	F**921** **Safe/Functional/Sanitary/Comfortable Environment** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** All privacy curtains have been taken down, washed and rehung. A4, the feeding pump and pole were cleaned, the over bed table	12/15/2023

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	and debris on the floor close to the baseboard, cobwebs between wall and the heating unit with multiple dead bugs, food splatters on the wall and what appeared to be a piece of puree orange substance on the floor. The cover to the cable outlet was missing. d. On 12/7/23 during the Environmental Tour, a male resident was now in Room 9, lying in bed. The above findings were still present. there was also food and a used dressing patch on the floor under the bed. e. Room 13, the top and base of the over the bed table was soiled. There was dried feeding on the base of the IV pole and an excessive amount of dust on the bathroom fan. f. Room 21, there was a large accumulation of debris in front of the closet for bed 1 and a dark substance on the privacy curtain for bed 2. 2. A-Unit a. Room 4 had dried feeding on the floor by bed 2. There was dried feeding on the feeding pump and the pole. and the over the bed table for bed 2 had a gouge out of it. The outlet cover next to bed 1 was loose and off. b. Room 5, the resident in bed 1 had been discharged on 9/6/23. Her personal belongings remained boxed up in the room. Dried liquid feeding remained on the floor next to bed 1. Bed 2 in the room was occupied by another resident. c. Room 15 bed 2, there was a mat with several cracks on the floor next to the bed and a bed wedge was stored on the floor behind the head of the bed. there was dirt and debris on the floor by		was replaced, and the outlet cover was replaced. A5, the room was deep cleaned and the discharged resident personal belongings were removed. A15, the mat next to bed was replaced and the room was deep cleaned. B3, the room was deep cleaned. B8, the IV pole and pump were cleaned. B9, the room was deep cleaned and cover to the cable outlet was replaced. B13, the room was deep cleaned, the IV pole was cleaned, and the dust on the bathroom fan was cleaned. B21, the room was deep cleaned; privacy curtains removed and cleaned. **2) How the facility identified other residents:** All the residents have the potential to be affected by this alleged practice. **3) Measures put into place/ System changes:**	

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	the closet and the corner of the room by the bathroom. During the observations, Employee 1 indicated the rooms were deep cleaned monthly and they were trying to start and deep clean all the rooms. Employee 1 and the Corporate Regional Consultant acknowledged all of the above findings. A facility policy, dated 9/1/2020, titled, "Safe/Clean/Comfortable/Homelike Environment", received as current from the Regional Vice President of Operations, indicated the cleaning staff would clean the noncritical medical equipment surfaces with a detergent/disinfectant. They would keep housekeeping surfaces, floors, walls, and tabletops, visibly clean on a regular basis. They would perform deep cleaning upon discharge of a resident, monthly, and as needed. They would clean walls, blinds, and window curtains when they were visibly soiled. The daily cleaning procedure, received from the Regional Vice President of Operations on 12/7/23 at 12:06 p.m., indicated daily cleaning included, but was not limited to, bedside tables and all flat surfaces. The walls were to be spot cleaned and the privacy curtains were to be inspected. The dust mop was to be used on the floor and followed by a damp mop. This citation relates to Complaints IN00415074 and IN00415577. 3.1-19(e)		Facility staff was re-educated on cleanliness of the facility including; ensuring noncritical medical equipment would be cleaned and or disinfected, housekeeping surfaces, floors, walls, heating units, and tabletops would be cleaned on a regular basis. Deep cleaning would be done upon discharge of resident, monthly, and as needed. Walls, blinds, and window curtains will be cleaned when visibly soiled. **4) How the corrective actions will be monitored:** The Administrator/Designee will observe 5 rooms weekly for 4 weeks and the bi-weekly thereafter to ensure compliance with cleanliness of noncritical medical equipment, housekeeping surfaces, floors, walls, heating units, tabletops, furniture, and overall cleanliness of resident's rooms and bathrooms. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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F 9999 Bldg. 00	16.2-3.1-13 Administration and management (g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any: (A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents. This State rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure the Indiana Department of Health (IDOH) had been notified of a major accident and an injury of unknown cause, related to a wheelchair tipping over in the facility bus during a transport and the resident required to be evaluated at the Emergency Room and a resident who had received a bruised eye/forehead for 2 of 3 residents reviewed for accidents. (Residents C and K)	F 9999	**5) Date of compliance: 12/15/2023** **F9999** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Investigation for the major accident and injury of unknown cause involving Resident's (C) and (K) was completed with findings. Resident (C) is no longer a resident in the facility. Resident (K) Head to toe assessment was completed and remains within baseline. MD and family were	12/15/2023

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	Findings include: 1. Resident C's closed record was reviewed on 12/4/23 at 10:21 a.m. The diagnoses included, but were not limited to, Parkinson's disease and dementia. A Significant Change Minimum Data Set assessment, dated 6/29/23, indicated short and long term memory problems, no behaviors, and required extensive assistance of two for bed mobility. A Nurse's Progress Note, dated 8/17/23 at 4:40 a.m., indicated the resident was observed on her left side in the bed. Her head was resting on the wall. There was a wedge positioned behind the resident's back for positioning. When the resident was rolled onto her left side a redness/bluish discoloration was observed on the left side of the forehead and left upper eyelid with swelling due to the her head resting against the wall. A cold compress was placed on the eye. The investigated note, dated 8/17/23, indicated the resident was unable to give a description of the event. The resident was positioned with wedge and rolled over with face landing against the wall next to the bed. The roommate was interviewed and indicated she had heard a, "thump", pulled the curtain and didn't see anyone in the room and did not see the resident on the floor, so she put the call light on for the nurse to come in. Employee 1 indicated he had provided care to the resident a few hours before finding the bruise and positioned her on her left side.		notified. Plan of Care was updated. **2) How the facility identified other residents:** All the residents have the potential to be affected by this alleged practice. **3) Measures put into place/ System changes:** Facility staff was re-educated on notifying/reporting to the Indiana Department of Health all major accidents and injuries of unknown cause. Staff is to report all accidents and injuries of unknown cause immediately to Abuse Coordinator or Manager on Duty. **4) How the corrective actions will be monitored:** The Administrator or Designee will audit all accidents and injuries 1 time weekly for 4 weeks and monthly thereafter to ensure compliance with facility reporting guidelines. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or**	

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	The resident indicated she was unsure what happened and that she "just rolled over". The Administrator indicated she had spoken with a family member and indicated the resident had rolled over and hit her head on the wall. The roommate had heard the noise and notified the nurse. During an interview on 12/5/23 at 2:24 p.m., Employee 3 indicated the resident had been turned onto her right side and positioned with a wedge and it appeared as if she had rolled forward and hit her head and face on the wall. She had been in her room at midnight to flush the feeding tube and there had been no markings on the resident's face. Her roommate had heard a thud and thought the resident had fallen and had not found her on the floor and notified the staff. The area was reddish and there was a little swelling. The mattress may have made her slip forward. During an interview on 12/5/23 at 2:53 p.m., the Administrator indicated the unusual occurrence had not been reported to the IDOH. 2. Resident K's record was reviewed on 12/5/23 at 1 p.m. The diagnoses included, but were not limited to, multiple sclerosis and convulsions. A Nurse's Note, dated 11/28/23 at 1:15 p.m., indicated the a call from the facility's Bus Driver indicated the resident had fallen while in the bus and had hit her head. She was driven to the Hospital Emergency Room and is being evaluated and treated. The investigation of the occurrence indicated the resident was interviewed on 11/28/23, and stated		**patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 12/15/2023**	

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	she had fallen while being transported to the hospital for a doctor's appointment. She had not felt the driver had strapped her wheelchair in properly and forgot to put the straps on her chair. While being transported, she felt her chair leaning. The Bus Driver left her on the floor of the bus because she had been in pain and drove immediately to the Emergency Room Cross reference F689 During an interview on 12/5/23 at 1:29 p.m., the Regional Vice President of Operations indicated the incident had not been reported to the IDOH since it was not a malfunction of the straps on the bus and there were no fractures. This citation relates to Complaint IN00415577.			