STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155740	A. BUILDING 00 B. WING	07/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TIMBERCREST CHURCH OF THE BRETHREN HOME	2201 EAST ST NORTH MANCHESTER, IN 46962

(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 a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: July 11, 12, 13, 14, 15, and 16, 2021. Facility number: 000448 Provider number: 155740 AIM number: 100275140 Census Bed Type: SNF/NF: 54 Residential: 94 Total: 148 Census Payor Type: Medicare: 5 Medicaid: 25 Other: 24 Total: 54 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 23, 2021.	F 0000		
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the			

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

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	resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on record review and interview, the facility failed to ensure a physicians order for code status was in agreement with the residents preference for 1 of 3 residents reviewed for Advanced Directives. (Resident 34).	F 0578	Preparation and or execution of this plan does not constitute admission or agreement by Timbercrest that a deficiency exists. This plan is also not to be construed as an admission of fault	08/15/2021

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	Findings include: Resident 34's clinical record was reviewed on 7/12/21 at 3:06 p.m. Diagnoses included, but were not limited to, retention of urine, dependence on supplemental oxygen, type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene, low back pain and chronic kidney disease. Her current physicians order indicated she had a Class C, Medical Treatment Directive that indicated the resident was considered imminently terminal from a non-curable or non correctable illnesss. No CPR. Insure comfort measures only. No transfer to the hospital. Her signed Medical Treatment Directive indicated her preference was a Class B, Medical Treatment Directive that indicated conservative passive care, with no heroic measure to prolong life. New therapy may be initiated. Resident may be transferred to hospital if necessary for comfort. 1. No CPR 2. No intubation 3. No dialysis. She had a care plan, dated 5/25/21, that indicated she had an Advance Directive for Class B, her goal was no CPR, no intubation and no dialysis. Her approach was conservative passive care, with no heroic measure to prolong life. New therapy may be initiated. Resident may be transferred to hospital if necessary for comfort. An interview with the ADON on 7/14/21 at 2:23 p.m., she indicated the signed document and the order for advance directives should match. A current policy, titled "Advance Directive Policy and Procedure," provided by the DON on 7/15/21 at 10:19 a.m. indicated the following:		by Timbercrest, its employees, or agents who draft this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Action taken for the resident found to have been affected include the immediate verification of R#34 code status. It was entered consistently into all relevant locations within the electronic medical record. 2. Determining the code status or presence/absence of Advance Directives is required for all residents. Therefore, all residents have the potential to be affected. 3. A chart audit of the code status and advance directives of all residents was completed on 07/19/2021. No further discrepancies noted. 4. The policy on Advance Directives was reviewed and revised to include the change from use of TC Medical Directive to use of the Physician Order for Scope of Treatment per the advice of the Medical Director and approval by the QAA committee. A policy and procedure on how to communicate residents' code status was created. Social service staff and licensed nursing staff are educated on Timbercrest's revised Advance Directive Policy; the Plan of Correction for F578; the Communication of Code Status	

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	"PROCEDURE...D. At this time, Timbercrest uses Class A, B, C form and/or the Indiana Physician's Orders for Scope of Treatment (POST) form. E. All advance directive document copies will be obtained and located under the "Advance Directives Tab" the resident's medical record; and notations as to representatives, and information received noted on face sheet...." 3.1-4(f)(7)		Policy and Practice Guideline; and the POST form. 5. For a period of three months, the Director of Resident Care or designee will perform weekly medical record audits of new admissions and those residents on the MDS assessment schedule for consisted documentation of the resident's Advance Directive/code status throughout the electronic medical record. After three months, the Director of Resident Care or designee will complete a random medical record audit of at least 10 records for consistent documentation. Results of the audits will be discussed monthly with the QAPI committee and summary report provided to the QAA committee until such time it is determined that substantial compliance is maintained.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to notify the resident's	F 0684	/p> **1.** **1.** For identified resident upon further investigation the skin	08/15/2021

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	physician and facility wound nurse of a skin impairment to ensure treatment and interventions were in place to promote healing for 1 of 5 residents reviewed for skin impairments (Resident 23). Findings include: Resident 23's clinical record was reviewed on 7/12/21 at 10:00 a.m. Diagnoses included, but were not limited to, viral pneumonia, hypertension, peripheral vascular disease, and malignant neoplasm of prostate. A 5/5/21, quarterly, Minimum Data Set (MDS) assessment indicated he was severely cognitively impaired and required extensive assistance with ADLs and mobility. He had a current, 7/12/21, care plan problem of an open area to his right buttock related to possible scooting down in the chair. Review of a 7/10/21 wound assessment indicated he had a stage 2 pressure injury to his right buttock, measuring 2 centimeters (cm) long (L) x 3 cm wide (W) with the surrounding skin appearing to be weakened, possibly due to shearing. The assessment also indicated the wound was 0.2 cm L x 0.3 cm W, at the top of the right buttock. Ointment was applied to surrounding areas for protection, and a sacral foam dressing was applied to area. The clinical record lacked physician notification, resulting in a lack of treatment orders for the area. During an interview, on 7/13/21 at 2:39 p.m., the Wound Nurse indicated she was not aware of the resident having a skin impairment. She usually		impairment was identified as an abrasion, not a pressure injury. On 7-13-2021 Dr. Higgins was notified and order was given for Optifoam dressing every 3 days and PRN. Corrected open event to right gluteal abrasion by the Wound Care Nurse. **2.** **2.** To review all residents in the facility that could be affected, we completed an audit of all residents to ensure physician notification and appropriate interventions in place for skin impairments. **3.** **3.** To prevent future occurrences we have reviewed and revised our policies related to skin impairment. The updated Skin Care Policy will be reviewed by all nursing employees by August 15, 2021. Additionally, the Wound Nurse or designee will weekly audit all documented skin impairments for the appropriate identification of skin area, ensure physician notification, initiation of appropriate treatments to promote healing, and care plan in place. We are educating all nurses through the MatrixCare e-learning module, on the “Wound Management” tool. This will be initiated for skin impairments instead of an event. Education will be completed by August 15, 2021 along with implementation of new process. **4.** **4.** For the next 4 months, the Director of Nursing or designee	

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	ran a report for skin events on Wednesdays, but had not yet been made aware of the area. She confirmed she was not able to find a current treatment order for the area. During a wound care observation, on 7/13/21 at 3:38 p.m., Resident 23 had two linear open areas, with bright red wound beds and a small amount of active bleeding, to his right buttock. The Wound Nurse indicated the areas presented as abrasions, possibly from the resident scratching the area. She would contact the physician for treatment orders. Review of a current facility policy, titled "Skin Assessment Wound Evaluation," dated 4/2019 and provided by the ADON on 7/14/21 at 9:14 a.m., indicated the following: "The Facility will monitor the residents' skin integrity regularly, document and treat as appropriate any identified skin conditions...Notify the resident's physician of any skin impairment...Initiate treatment to identified skin conditions per treatment protocol and physician's order...." 3.1-37(a)		will audit all residents with skin impairments to be appropriately identified, physician notification, treatment in place and care plan updated. Will also audit skin impairments appropriately documented on Wound Management tool. Audit will occur weekly for 4 consecutive weeks, then every two weeks for 2 consecutive times, then monthly for 2 consecutive months. Results of the audits will be discussed monthly with the QAPI committee and summary report provided to the QAA committee until such time it is determined that substantial compliance is maintained.	
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and			

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	(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to assess a skin impairment and implement interventions to prevent the development of a pressure injury and failed to provide treatment and interventions to prevent the worsening of a pressure injury for 1 of 1 residents reviewed for pressure injuries (Resident 30). This deficient practice resulted in Resident 30's wound progressing from a reddened area with shearing to an unstageable pressure wound. Findings include: During a wound care observation, on 7/13/21 at 2:20 p.m., accompanied by the Wound Care Nurse and LPN 33, the following was observed: Resident 30 was in bed. She had an open wound to her coccyx, approximately the diameter of a softball and irregular in shape. The wound bed was covered in a white tissue substance with a thicker darkened area across the top of the wound. The Wound Nurse indicated the wound measured 2.8 centimeters (cm) long (L) x 3.6 cm wide (W) and was unstageable (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed). She had an additional open wound with a bright red wound bed, approximately the size of a jelly bean, adjacent to the larger wound. Resident 30's clinical record was reviewed on	F 0686	**Preparation and or execution of this plan does not constitute admission or agreement by Timbercrest that a deficiency exists. This plan is also not to be construed as an admission of fault by Timbercrest, its employees, or agents who draft this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.** 1. 1. For identified resident, on 7-14-2021 a care plan was added for "at risk for skin breakdown." Continue using the "unstageable pressure injury" care plan. Physician updated along with hospice. Treatment was changed from Optifoam to Santyl daily, cover with dressing. Foley catheter placed per hospice order related to pressure injury. 2. 2. To review all residents in the facility that could be affected, we completed an audit of all residents to ensure physician notification and appropriate interventions in place for skin impairments. 3. 3. To prevent future occurrences we have reviewed and revised our policies related to skin impairment. The updated "Skin	08/15/2021

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	7/11/21 at 2:17 p.m. Diagnoses included, but were not limited to, fracture of right femur neck (5/24/21), infection following procedure of deep incision surgical site, congestive heart failure, acute and chronic respiratory failure, atrial fibrillation, and chronic obstructive pulmonary disease (COPD). She had a current, 6/23/21, physician's order to cleanse her sacral (coccyx) wound with saline, apply antimicrobial foam dressing every 3 days. A 7/1/21, significant change, Minimum Data Set (MDS) Assessment indicated she was moderately cognitively impaired, required extensive assistance for ADLs and mobility, and had one stage 3 pressure injury. Review of a baseline care plan, dated 5/25/21, indicated preventative skin care of floating heels. There were no interventions related to her coccyx. She had a current care plan problem, initiated 6/2/21 and revised 7/8/21, of a stage 3 pressure injury to her sacral area, related to pressure and bowel incontinence. Interventions included monitor and record, keep skin clean and dry, and ensure her treatment was completed. She had a current, 6/24/21, care plan problem of impaired bed mobility related to right hip fracture, requiring assist bars x 2. She had a current, 7/14/21, care plan problem of risk for skin breakdown. There was no prior care plan developed for risk for skin breakdown in the clinical record. Review of a 5/24/21 admission assessment indicated her bilateral heels were pink, soft, and		Care Policy" and "Letter of Unavoidability Guidelines" will be reviewed by all nursing employees by August 15, 2021. The "At Risk for Skin Breakdown" care plan template was created. Goal added on the Baseline Care Plan Summary "Will remain free from skin breakdown." Additionally, the Wound Nurse or designee will weekly audit all documented skin impairments for the appropriate identification of skin area, ensure physician notification, initiation of appropriate treatments to promote healing, and care plan in place. We are educating all nurses through the MatrixCare e-learning module, on the "Wound Management" tool. This will be initiated for skin impairments instead of an event. Education will be completed by August 15, 2021 along with implementation of new process. Finally we will evaluate all residents newly admitted during the weekly IDT meeting for potential or actual skin impairment. 4. 4. For the next 4 months, the Director of Nursing or designee will audit all residents with skin impairments to be appropriately identified, physician notification, treatment in place and care plan updated. Will also audit skin impairments appropriately documented on Wound Management tool. Audit will occur weekly for 4 consecutive weeks,	

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	mushy; she had a red area to her coccyx with slight shearing noted, and a dry foam dressing was placed as a preventative measure. The clinical record lacked measurement of the reddened, sheared area to her coccyx, nor was a physician's order obtained for treatment of the area. Review of a 5/25/21 Braden skin risk assessment indicated she was at high risk for skin breakdown. A 5/31/21 progress note indicated a discussion with family of hospice services due to slow progression in therapy. A 5/31/21 Registered Dietician note indicated a reddened area to her coccyx. Review of a 6/2/21 wound assessment indicated a 2 cm L x 3 cm W x 1 cm depth stage 2 (partial-thickness loss of skin with exposed dermis; granulation tissue is not present) pressure injury to her coccyx. She was frequently incontinent of bowel, had limited movement related to her hip fracture, a poor appetite with weight loss, and an overall decline. She had been refusing therapy and not getting out of bed. A new order was obtained for antimicrobial foam dressing and a request made for a low air loss mattress. A 6/9/21 wound assessment indicated the wound measured 5.5 cm L x 6 cm W x 0.1 cm depth with 100% granulation (new connective tissue and microscopic blood vessels that form on the surfaces of a wound during the healing process). A 6/16/21 wound assessment indicated the wound measured 2 cm L x 2 cm W x 0.1 cm depth with		then every two weeks for 2 consecutive times, then monthly for 2 consecutive months. Results of the audits will be discussed monthly with the QAPI committee and summary report provided to the QAA committee until such time it is determined that substantial compliance is maintained.	

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	50% slough (dead cells adhered to the wound bed) and was a stage 3 (full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. If slough or eschar (thick, hardened dead tissue) obscures the extent of tissue loss this is an Unstageable Pressure Injury.) A 6/23/21 wound assessment indicated the wound measured 2 cm L x 2 cm W x 0.1 cm depth with 100% slough and was a stage 3. She was admitted to hospice services on 6/24/21 for congestive heart failure. A 6/30/21 wound assessment indicated the wound measured 2 cm L x 1.5 cm W x 0.1 cm depth with 50/50 slough/granulation tissue. A 7/8/21 wound assessment indicated the wound measured 3.9 cm L x 1.8 cm W x 0.1 cm depth with 100% slough and remained a stage 3. During an interview, on 7/13/21 at 2:37 p.m., the Wound Nurse indicated she assessed the resident's wound on a weekly basis. The biggest factor in the development of the wound was mobility loss and having been grossly incontinent of bowel at admission. There was slough present in the wound bed, so it was a stage 3. The area was worsening, so she would call the physician for new treatment orders. During an interview, on 7/15/21 at 1:42 p.m., the ADON indicated there was no care plan in place related to prevention of skin breakdown prior to 7/14/21. Review of a current facility policy, titled			

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	"PRESSURE ULCER PROTOCOL," dated 4/2019 and provided by the ADON on 7/14/21 at 9:24 a.m., indicated the following: "...Pressure ulcers and skin problems will be promptly reported to the attending physician, on call nurse, and WCC [wound care nurse]...The Skin Integrity Event shall be completed: a. Wound location b. Size of reddened and/or open area...8. The resident's care plan shall include the skin problem, approaches and goals for care...." 3.1-40(a)			
F 0689 SS=G 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, interview, and record review, the facility failed to provide supervision to prevent repeated falls and failed to prevent falls during staff-assisted transfers for 2 of 5 residents reviewed for falls (Residents 1 and 29). This deficiency resulted in occipital (skull bone) and hip fractures for Resident 1. Findings include: 1. On 7/12/21 at 1:27 p.m., Resident 1 was in bed. On 7/13/21 at 9:32 a.m., the resident was in bed. On 7/14/21 at 8:31 a.m., the resident was in bed.	F 0689	**Preparation and or execution of this plan does not constitute admission or agreement by Timbercrest that a deficiency exists. This plan is also not to be construed as an admission of fault by Timbercrest, its employees, or agents who draft this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.** 1. 1. For resident #29 CNA involved in transfer was personally	08/15/2021

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	Review of Resident 1's clinical record was completed on 7/11/21 at 2:47 p.m. Diagnoses included, but were not limited to, left hip fracture, restlessness and agitation, repeated falls, chronic kidney disease stage 2, and type 2 diabetes. A 3/23/21, admission, Minimum Data Set (MDS) assessment indicated he was moderately cognitively impaired. A 6/23/21, significant change, MDS assessment indicated he was moderately cognitively impaired and required extensive assistance with mobility and limited assistance with locomotion in his room. He had a current, 3/16/21, care plan problem, revised 7/8/21, of risk for falling related to poor safety awareness as he did not use his call light for assistance despite written reminders and signs and bowel and bladder incontinence. Interventions included, but were not limited to, bed in lowest position (7/6/21), mattress with raised perimeter (6/25/21), larger pants (6/25/21), 15 minute checks (5/7/21), reminder in room to call for assistance (5/5/21) and fall mat next to bed (5/3/21). Review of Resident 1's fall history in his clinical record indicated the following: On 4/3/21 at 11:00 p.m., he lost his balance in his bathroom while attempting to turn with one hand on transfer bar and the other on his rollator (walker). His gripper socks were on but worn down. The initial intervention to prevent further falls were staff re-educated and the resident was educated on standing with both hands on his rollator, and his gripper socks were replaced. He		educated on the proper transfer for resident. CNA sheets updated and will be updated weekly. Reeducated all staff on need for two assist with stand lift with resident #29. For resident #1 direct supervision was provided. It was also identified that resident #1 had increased falls from independently transferring to the bathroom. 2. 2. All residents have the potential to be affected. All employees will be reeducated by reviewing the “Limited Lift Policy” to be completed by August 15, 2021. Fall Risk Assessment were completed 8-3-2021 to 8-6-2021 on all residents in Healthcare and Crestwood. All residents were as well assessed for frequent incontinence on 7-12-2021 with the initiation of a QAPI Immediate Action Plan. 3. 3. To prevent future occurrences we have reviewed and updated the 15 minute guidelines for frequent rounding as a fall prevention. We assessed residents with continuous rounding for appropriateness as a fall prevention. These identified residents at high risk for falling will be reviewed at Morning Meeting. The Fall Prevention Committee met on 8-3-2021 and plan to start meeting twice a month instead of monthly. Next meeting is 8-9-2021. Initiated individual fall prevention program with restorative	

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	sustained an 8 centimeter (cm) long (L) x 8 cm wide (W) abrasion to his left mid-back, an 8 cm L x 1 cm W skin tear to his right forearm, a 15 cm L x 8 cm W abrasion and bruising to his right upper back, and a 1.5 cm L x 2 cm W sore on his right lower lip. On 4/10/21 at 8:15 p.m., he was found on the floor in his room in front of the TV with his bed covers on; he likely was caught in the covers while attempting to get up from bed. The initial intervention to prevent further falls was to assist him to the toilet and educate him to continue to use call light for any needs. The facility was unable to determine what happened to cause the fall; he had been toileted around 7 p.m. On 4/16/21 at 9:43 a.m., he had an unwitnessed fall in his room in front of his recliner. He had lost his balance while backing up to recliner to sit down and sat too quickly. The initial intervention to prevent further falls was to assist him to the toilet and the process was started. He had been toileted last at 9:00 a.m. On 5/5/21 at 8:42 a.m., he had a witnessed fall in his bathroom, and slid down the wall. Staff witnessed him losing strength and sliding down the wall, and he was assisted to the floor. The initial intervention to prevent further falls was a reminder sign in room to use his call light for assistance. He had been toileted an hour prior. On 5/28/21 at 2:15 a.m., he had an unwitnessed fall outside of his bathroom; he had lost balance and strength while walking to his bathroom without assistance. The initial intervention to prevent further falls was to assist him to the bathroom, and added scheduled toileting between 2:00 a.m. and 2:30 a.m.		nursing on 3 separate residents. Finally, we have identified residents who are frequently incontinent. Voiding diaries were completed to set up individualized toileting plans to proactively decrease unsupervised self-transfer attempts to bathroom resulting in falls. Education for all nursing employees on “Resident Centered Toileting Program” to be completed no later than 8-15-2021. 4. 4. For the next 4 months, the Director of Nursing or designee will perform random audits on proper transfer techniques according to the resident specific care plan. This will occur with at least 10 resident per week. The DON or designee will also audit the review of all resident who incurred a fall and residents receiving frequent rounding at morning meetings. Also audit all resident with a Fall Fisk score of greater than 10 during weekly therapy meeting. Audits will occur weekly for 4 consecutive weeks, then every two weeks for 2 consecutive times, then monthly for 2 consecutive months. Results of the audits will be discussed monthly with the QAPI committee and summary report provided to the QAA committee until such time it is determined that substantial compliance is maintained.	

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On 6/8/21 at 1:00 a.m., he had a witnessed fall in front of his recliner. He had been either standing up or sitting down in his recliner and was witnessed by a CNA sliding down the recliner and sitting on the floor. He had been assisted to the bathroom at 12:00 a.m. 15 minute checks were implemented and he was to be evaluated by therapy.

On 6/20/21 at 10:46 a.m., he was found beside his bed, with his pants around his knees; he had likely tripped trying to get out of bed, and his pants fell, as they were too big. He was on 15 minute checks and had just been resting in bed at 10:30 a.m. and had been assisted to the bathroom at 9:30 a.m. The immediate intervention to prevent further falls was to notify his family of a need for smaller pants.

On 7/3/21 at 3:00 p.m., he had an unwitnessed fall in his bathroom. He had been incontinent of bowel and bladder and his pants were down at the time. He likely lost balance due to his pants being down and had not activated his call light for assistance. He had been resting in bed 15 minutes prior to his fall. He had an abrasion to his left knee, swelling and abrasion to his left eyebrow, a nondisplaced fracture involving the left occipital bone and subcapital fracture of the left femoral neck.

Review of a 7/3/21 emergency department note indicated he had fallen and had a contusion to his left forehead and pain to his left hip. A CT scan of his spine indicated a non-displaced fracture of the left occipital bone. An x-ray indicated a left subcapital fracture of the left femoral neck. The resident and family did not wish to have surgical intervention and he was to be bed-bound going

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	forward. During an interview, on 7/15/21 at 9:21 a.m., QMA 35 indicated the resident had liked to do things himself and didn't want to ask for help. He was receptive if staff asked something of him, but he really didn't want to ask for help. He liked to toilet himself frequently without assistance. He had been on 15 minute checks, and also the staff member on the hall was responsible for checking in on him. He would become more incontinent as the day went on and was very hard of hearing; she was not sure how much he recalled due to being so hard of hearing. He used a white board a lot. During an interview, on 7/15/21 at 10:19 a.m., the DON indicated the resident had been on a toileting program to prevent falls. During an interview, on 7/15/21 at 10:36 a.m., the ADON indicated the resident didn't want to sit out in common area. He liked activities, but wanted to be in his room when not attending activities programs. His physical therapy had ended on a Friday, and he fell the next day, on Saturday. He needed help with clothing and toileting, and was not cognitively able to use urinal. He would get up without his rollator at times.2. Resident 29's clinical record was reviewed on 7/12/21 at 1:13 p.m. Diagnosis included, but were not limited to, recurrent moderate major depressive disorder, attention and concentration deficit, schizoaffective disorder, schizophrenia, difficulty in walking, other lack of coordination, muscle weakness (generalized), history of falling, repeated falls and unspecified abnormalities of gait and mobility. His medications included, but were not limited to,			

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	acetaminophen (pain reliever) 500 mg (milligram) four times daily, carvedilol (high blood pressure) 3.125 mg twice daily, donepezil (dementia) 10 mg daily, fluoxetine (anti-depressant) 40 mg daily, lisinopril (high blood pressure)10 mg daily, memantine (dementia)10 mg twice daily and tramadol (pain reliever) four times daily. A 3/9/21, quarterly, MDS (Minimum Data Set) fall assessment indicated he was a high risk for falls. A 5/26/21, quarterly, MDS indicated the resident was moderately cognitively impaired. He required extensive assistance of one staff member for bed mobility. He transferred with extensive assistance of two staff members. He used a wheelchair for mobility. He had one fall since admission or prior assessment with no injury. He had a 7/12/21 revised, fall care plan, that indicated he was at risk for falls related to unsteady balance, he required a stand-up lift for transfers, he had a history of leaning to left side and required lateral support on his left side, high-risk medication use, osteoporosis with history of fractures, back pain, urinary incontinence, poor safety awareness as evidenced by he had reached to floor to pick up papers. His most recent fall was 7/11/21. Interventions included, but were not limited to, for transfers with mechanical stand-up lift, use two staff assist to ensure safety, dated 4/15/21. A fall event form, dated 4/15/21 at 10:40 a.m., indicated the cause of the fall was the resident had removed the loop of stand lift sling. The new immediate intervention was initiated and communicated to staff, the resident required staff assistance when transferred. The initial root cause of fall was the resident removed one side of stand			

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lift harness while being transferred. IDT (Interdisplinary Team) indicated root cause analysis of fall was the resident was lowered to floor from mechanical stand up lift due to unhooking strap of sling connected to lift. Initial intervention was he would be a two assist for transfers with mechanical standup lift to ensure safety.

A nurses note, dated 4/15/21 at 11:14 a.m., indicated a staff member called the writer to report that the resident was lowered to the ground following transfer to the bathroom. The writer entered the room and found the resident on the bathroom floor in supine position, with stand lift in front of him. Once stand lift was moved, the resident then rolled to his left side and he was provided with a pillow until assessment was completed. He had no visual injuries nor complaints of pain. Intervention of two staff assist was implemented.

A review of the CNA assignment sheet, dated 6/30/21, indicated the resident required staff assistance of two and the stand up lift.

A nurses note, dated 7/11/21 at 10:00 p.m., indicated a CNA transferred the resident to bed using a stand up lift. The resident sat at the edge of bed, while the CNA moved the lift away, the resident lost his balance and the CNA was unable to move resident back on the bed. The resident was lowered to the ground. A skin tear to his left shoulder was noted.

A fall event form, dated 7/12/21 at 7:37 a.m., indicated the resident had received a skin tear to his left shoulder, measurements were 0.3 cm (centimeters) X 0.1 cm he had slipped off the bed. To prevent the fall from happening again, the

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	CNA was to find help during transfers. IDT root cause analysis of fall indicated the resident had lost his balance and slipped off bed when CNA assisted to bed with mechanical stand-up lift then removed stand-up lift. The initial intervention was the CNA was re-educated on the use of two staff members when transferring with mechanical stand-up lift for this resident. An IDT note, dated 7/12/21 at 9:00 a.m. indicated the residents most recent fall was reviewed, it was likely the resident lost his balance as the mechanical stand-up lift was being pulled away from the bed. Initial intervention of re-educating nursing staff, the resident required two staff members for transfers with mechanical stand-up lift. An interview with the ADON, on 7/14/21 at 2:17 p.m. she indicated with the 7/11/21 fall: the CNA had pulled the stand up lift away from the bed and the resident had lost his balance and fell. The newer CNA was re-educated and reminded the resident was a two assist with stand up lift. The CNA had used the stand up lift by himself. The fall, on 4/15/21, was when the two assist with the stand up lift was implemented. A different CNA had taken the resident to the bathroom and put the resident on the toilet, disconnected the sling from the stand up lift, got him dressed and stood him back up, pulled his brief and his pants up, he wiggled on the stand up lift and took his hand off the bar of the lift and got a hold of the loop of the sling. The resident stood himself up more on the lift and the loop came unhooked and the CNA had lowered him to the floor. A current policy, titled "FALLS, PREVENTION AND FOLLOW UP," provided by the DON on 7/15/21 at 10:19 a.m. indicated the following:			

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	"POLICY: It is the goal of the nursing staff to prevent as many falls as possible, but is nationally recognized through many studies that falls are a frequent occurrence in people over the age of 65... PROCEDURE: 1. Fall Risk Factors; a. Anyone with a history of falls within the past 30 days is likely to fall again. b. Chronic disease puts people at risk for falls that involve gait disturbance, balance impairment, and sensory loss (poor eyesight or hearing). c. People who require assistive devices (canes, walkers, crutches) due to the inappropriate use of these devices. d. Weakness and chronic pain... g. cognitive impairment...." 3.1-45(a)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use			

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	psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observation, interview, and record review, the facility failed to ensure residents did not receive psychotropic medications without indication for 1 of 5 residents reviewed for unnecessary medications (Resident 2). Findings include: On 7/11/21 at 2:15 p.m. Resident 2 was sitting in a chair at the end of the hall looking at the window. On 7/12/21 at 1:40 p.m. the resident walked to the dining room and sat in a chair at a table for a Bingo activity.	F 0758	The preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft and this plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. The medication regimen for resident #2 was reviewed by	08/15/2021

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	On 7/13/21 at 9:47 a.m. she participated in an exercise activity. On 7/13/21 at 10:32 a.m., she participated in an activity of hitting a ball with a foam tube. On 7/13/21 at 1:51 p.m., she, along with other residents, were assisted off the secure unit to attend a Resident Council meeting. On 7/14/21 at 9:27 a.m., she was outside in the courtyard watering flowers with an activity staff member. On 7/14/21 at 9:48 a.m. she participated in an activity related to devotions. The clinical record was reviewed on 7/12/21 at 1:38 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, generalized anxiety disorder, and restlessness and agitation. A 7/7/21 annual MDS (Minimum Data Set) assessment indicated she had moderate cognitive impairment. There had not been any moods or behaviors identified during the assessment period. She required supervision with bed mobility, transfers, to walk in room and in corridor, with locomotion on and off the unit, eating, and toilet use,and limited assistance with dressing and personal hygiene. She had received antianxiety medication every day during the assessment period. Physician orders included, but were not limited to the following: a. Observe resident closely for significant side		the physician on 7/15/21. The medication prescribed for restlessness and agitation was gradually reduced and ultimately discontinued. 2. The facility has determined that all residents have the potential to be affected. A review of all psychotropic medication orders and indications for use is ongoing and with completion date of 8/15/21. 3. The policies regarding psychotropic drug use, and reduction, and the Mood and Behavior policy were reviewed and revised by combing several separate procedures into one policy, "Use of Psychotropic Drugs." 4. All Licensed Nursing staff and the social service staff were in-serviced regarding the facility's policies addressing the use of psychotropic medications, as well as the policy on Mood and Behavior. A copy of the regulations regarding unnecessary drugs/unnecessary psychotropic meds and the facility's policy regarding use of psychotropic drugs are being provided to the physicians as a resource. 4. The Director of Nursing or designee will complete a weekly audit for six (6) consecutive weeks of all new psychoactive medication orders to ensure that appropriate indications of use of all psychotropic drugs	

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	effects to antianxiety/anxiolytic and report to the physician. Side effects: sedation, drowsiness, difficulty walking, dizziness, nausea, vomiting, confusion, falls, headaches, blurred vision, and skin rash. 0 = no side effects, 1 = yes, medical doctor notified and progress note written, every shift, order date was 3/4/21. b. Target behavior: repetitive concerns/worries/questions (ex: What are we supposed to be doing? Am I staying here? Do I live here? What room do I go to?) Chart In progress notes - intensity, frequency, successful interventions, unsuccessful interventions. If unsuccessful, please notify medical doctor, every shift. order date was 3/8/21. c. Divalproex (mood stabilizer), 125 mg delayed release sprinkle, one capsule twice a day at 9:00 a.m. and 4:00 p.m. for restlessness and agitation, order date was 4/29/21. d. Buspirone (antianxiety) five mg (milligram), one tablet twice at day at 11:00 a.m. and 4:00 p.m. for generalized anxiety disorder, order date was 6/21/21. A review of medication administration history indicated buspirone five mg twice a day at 11:00 a.m. and 4:00 p.m. had been ordered on 3/4/21, the order was changed on 4/29/21 to five mg twice a day at 9:00 a.m. and 4:00 p.m.., then changed again on 6/21/21 for five mg twice a day at 9:00 a.m. and 4:00 p.m. It also indicated before the divalproex order was changed on 4/29/21, it had been ordered on 3/20/21 to give 125 mg twice a day at 9:00 a.m. and 4:00 p.m. A current behavioral symptoms care plan, with a 3/4/21 start date indicated she had a history of		are clearly documented in the medical record. The behavior management team will meet on an ongoing monthly basis and will review all new psychoactive medication orders for appropriate indications of use, new or worsening behaviors, and any medications to be considered for a gradual dose reduction. Audit records will be reviewed by the QAPI committee on a monthly basis and summary will be provided to the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident/Family Group Councils for comment and suggestions.	

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	anxiety, restlessness and agitation, and demonstrated the following symptoms: displaying increase anxiousness, repetitive concerns/worries/questions as evidenced by: asking what we were supposed to do, did she stay here, did she live here, and what room did she go to. Received buspirone and divalproex. Interventions included, but were not limited to, administer antianxiety medication (buspirone) as ordered, encourage her to voice cause for anxiety and problem solve ways to reduce stressors, approach start dates were 3/4/21. A current psychosocial well-being care plan, with a 6/1/21 start date indicated she experienced wandering and exit seeking, would often ask repeatedly where home was, go to doors to leave, and packed items to leave. Interventions included, but were not limited to, approach from the front and walk in step with her before redirecting and if she looked for family/significant other, reassure her that others know where to find her, approach start dates were 6/1/21. A progress note, dated 2/23/21 at 9:45 p.m., indicated the resident had been up to the desk and staff members multiple times asking what room she slept in, that she didn't have pajamas at the facility, and had just arrived that day. She was redirected by activity staff putting a puzzle together and talking about nursery rhymes. A progress note, dated as a late entry on 3/3/21 at 8:04 p.m. for 2/26/21 at 7:39 p.m., indicated she had been up to the desk numerous times asking what was going on (paramedics were on site for another resident), asked what did she do, could she help, and what was going on. Staff attempted to redirect her without success about working a puzzle, looking at a magazine, and watching television in			

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	155740	A. BUILDING 00 B. WING	07/16/2021

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	the common area. A progress note, dated as a late entry on 3/3/21 at 8:07 p.m. for 3/2/21 at 8:04 p.m., indicated she had increases anxiety/sundowners beginning after dinner, approached staff and other residents asked what she was to do, did she stay there, did she live there, and what room did she go to. At times followed staff into other residents rooms when asking those questions. A progress note, dated 3/3/21 at 8:07 p.m., indicated the the psych NP (Nurse Practitioner) had called to check on her and was updated about an increase in anxiousness. Order for buspirone five mg twice a day was ordered. A progress note, dated 3/05/21 at 9:51 p.m., indicated she had been up to staff member several times asking where she was to go, what her room number was, and would someone get her up in the morning. A progress note, dated 3/09/21 at 8:31 p.m., indicated she had asked several times if she was to sleep in that room all the time, no difference in behavior with buspirdone. A progress note, dated 3/10/21 at 2:19 p.m., indicated the resident has had a good day, she did have some repetitive comments during the am activity that went on for about 10 min, but the Activity Aide was able to distract with the exercise group. She had an outing with her sister they went out for ice cream. The resident left about 1:45 p.m. and returned at 2:10p.m. excited about being able to go out. A progress note, dated 3/11/21 at 9:48 p.m., indicated the IDT (Interdisciplinary Team) had met			

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	to discuss plan of care, had been started on buspirdone due to anxiousness, repetitive questions, and sundowning. No behaviors since last IDT review. A progress note, dated 3/13/21 at 7:21 p.m., indicated she had been back and forth in the hall, stopped staff and asked the amount she was being charged for the room, and asked for family phone numbers. Assisted with call to her son. She had returned to the desk to asked to speak with her son, appeared a little more at ease after getting off the phone. About five minutes later asked about what room she was assigned, her son's phone number, about the bill, and how long she had been there. Call placed to psych NP and detailed message was left. A progress note, dated 3/13/21 at 9:34 p.m., indicated the psych NP had returned call and was updated on recent continued anxiousness, but the resident was resting quietly in bed at that time. A progress note, dated 3/19/21 at 8:58 p.m., indicated CNA (Certified Nurse Aide) had went in to help resident get ready for bed at approximately 8:20 p.m. and found her with her pajamas on and standing in her doorway to room, was holding her right wrist and told the CNA she fell trying to hurry up and get to the bathroom. Her right wrist had a light purple raised area approximately 4.0 cm (centimeters) X 4.0 cm X 0.5 cm at base of thumb and forefinger on posterior right hand. She indicated she can't move it and pain was getting worse. Ice pack applied, doctor notified, and received an order to send to out for evaluation. A progress note, dated 3/19/21 at 11:35 p.m., indicated emergency room staff indicated the resident had a closed fracture of her right wrist,			

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was to wear a Velcro splint, and would return to the facility.

A progress note, dated 3/19/21 at 11:55 p.m., indicated she had returned to the facility, smiling and talked with staff.

A progress note, dated 3/20/21 at 10:20 a.m., indicated she had received acetaminophen as part of her morning medications, had called her son four times so far that morning, told him she needed to go to the doctor or the hospital, son and staff reminded her she had returned from the hospital early that morning, and she complained of pain rated at least a 6. Call placed to inquire about pain medication. She had complained about having the splint on, and taken it off several times, asked why she had to wear it, and asked if her arm was broken. Staff answered questions and let her know she did have a fracture. Psych NP had called the facility, updated about the fracture and that between the pain, the splint, and the bruising, it caused her distress. New order received for divalproex sprinkles 125 mg twice a day.

A review of Point of Care (POC) responses related to moods and behaviors from March 1, 2021 through March 31, 2021 indicated the resident did not have any moods or behaviors except for one episode of rejection of care, refusal of shower, on 3/19/21.

A review of POC responses related to moods and behaviors from April 1, 2021 through May 31, 2021 indicated the resident did not have any moods or behaviors.

A behavior meeting progress note, dated 6/14/21 at 11:49 a.m., indicated she had presented with anxiety on May 19 and 20, 2021, would often ask

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	who was paying her bill. A review of POC responses related to moods and behaviors from June 1, 2021 through June 30, 2021 indicated the resident did not have any moods or behaviors except for one episode of rummaging on 6/14/21. A review of POC responses related to moods and behaviors from July 1, 2021 through July 14, 2021 indicated the resident did not have any moods or behaviors except for an episode of moving slow or fidgety/restless on 7/11/21 and 7/14/21 and an episode of pacing on 7/14/21. During an interview, on 7/15/21 at 10:20 a.m., LPN 7 indicated the resident had started on divalproex related to her anxiety of a fractured wrist and wasn't having the anxiety related to the fracture anymore. During an interview, on 7/15/21 at 11:03 a.m., the Social Service Director indicated divalproex would not have been started because of a fall, it was started related to her repetitive questions and worrying. Review of a current facility policy, titled "MOOD AND BEHAVIOR POLICY," undated and provided by the Social Service Director on 7/15/21 at 1:30 p.m., indicated "...OBJECTIVE OF THE MOOD AND BEHAVIOR POLICY AND PROCEDURE. The objective of the Mood and Behavior Policy and Procedure is to provide a plan of care that is individualized to the residents needs based upon the comprehensive assessment by the interdisciplinary team. This plan of care will include medically related social services to address mood and behavioral health services to attain or maintain the highest practicable			

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	well-being...." 3.1-48(a)(4)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: July 11, 12, 13, 14, 15, and 16, 2021. Facility number: 000448 Residential Census: 94 Timbercrest Church Of The Brethren Home was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality reveiw completed on July 23, 2021.	R 0000		