STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155481	A. BUILDING 00 B. WING	05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARBOR TRACE HEALTH & LIVING COMMUNITY	3701 HODGIN RD RICHMOND, IN 47374

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00351605, IN00352223 and IN00353064. Complaint IN00351605 Unsubstantiated due to lack of evidence. Complaint IN00352223 Unsubstantiated due to lack of evidence. Complaint IN00353064 - Substantiated. Federal/State deficiency related to the allegation are cited at F-684. Survey dates: May 5, & 6, 2021 Facility number: 000455 Provider number: 155481 AIM number: 100291010 Census Bed Type: SNF/NF: 9 SNF: 88 Residential: 21 Total: 118 Census Payor Type: Medicare: 18 Medicaid: 66 Other: 13 Total: 97 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 11, 2021	F 0000	**This plan of correction is to serve as Arbor Trace's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Arbor Trace or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.** **Arbor Trace respectfully requests a desk review for these deficiencies.**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care			

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

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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	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 record review and interview, the facility failed to complete an ongoing neurological assessment after an unwitnessed fall. This affected 1 of 4 residents reviewed for assessments. (Resident D) Findings include: Resident D's record was reviewed on 5/5/21 at 11:10 a.m., and indicated Resident D was admitted on 12/23/20 with diagnoses that included, but were not limited to, osteoarthritis of the neck, kyphosis (curved spine in the upper back), deterioration between the discs in the spinal column of the lumbar region, painful neck vertebra, type 2 diabetes mellitus, weakness and reduced mobility. A Post fall assessment, dated 12/28/20 at 7:29 a.m. indicated Resident D had an unwitnessed fall on 12/28/20 and was found laying on her left side, her physician was notified at 7:45 a.m. and family was notified on 12/28/20 at 7:45 a.m. Prior to the fall she was lying in bed, she was found next to the bed within 5 feet, she had poor footwear on, and wore heel boots, she was fully clothed, and she said she gotten out of bed to try to go home. She had no new skin problems, and the new interventions were neurological assessments,	F 0684	**F684 Quality of Care CFR(s): 483.25** **I. Resident D is no longer in the facility.** **II. All residents that have an unwitnessed fall or hit their head with a fall have the potential to be affected by the alleged deficient practice. All residents with falls requiring neurological checks in the past 30 days will be audited for accurate completion. Any identified issues will be communicated to the MD.** **III. Education will be provided to all licensed nursing staff related to the fall policy with focus on neurological checks. The systemic change includes the DON/Designee will audit neurological check documentation daily in clinical stand up to determine the information is completed.** **IV. The DON/Designee will**	05/21/2021

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	monitor vital signs, non skid footwear when in bed and while out of bed, resident education, call light in reach, and a "call don't fall" sign. A progress note, dated 12/28/2020 at 7:19 a.m., indicated: "Resident was found on the floor beside her bed lying on her left side with heel boots on. ROM (range of motion) WNL (within normal limits) and resident denies discomfort. Res (resident) assisted back into bed with x3 assist via the Hoyer lift. Resident states that she got out of bed because she was trying to go home. No apparent injury noted. Res is resting with call light within reach. [Resident D's physician], ADON, DON and son [name of son] notified. Neuro checks, fifteen minute checks put in place. Call don't fall sign placed in room." Review of the "Neurological Checks" form used to document neurological assessments (neuro checks), indicated the first neuro check was completed on 12/28/21 at 7:19 a.m., the second neuro check was completed on 12/28/21 at 7:30 a.m., the third one was competed at 7:45 a.m., and the fourth one was done at 8:00 a.m. The neuro checks were within normal limits at those times. The next neurological assessment was due at 9:00 a.m., as the form indicated the neuro checks were to be completed every 15 minutes for 4 times, then every hour for 4 times, then every shift for 72 hours. No neuro check was documented as being completed at 9:00 a.m. A progress note indicated: "12/28/2020 at 9:42 a.m. This nurse called into resident's room by therapy where resident was found with no pulse and was not breathing. Resident assessed by x2 nurses. Resident passed at 9:40 am. DON notified and will call the son. Social services notified."		**review falls that require neurological checks for complete documentation during clinical stand -up meeting. This will occur 5 days per week for 30 days then monthly for 11 months to total 12 months of monitoring. Results of audits will be reported to the QA Committee monthly to assist with additional recommendations if necessary.** **COMPLIANCE DATE: 5/21/2021**	

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	On 5/6/21 at 2:23 p.m., the Administrator reviewed the fall risk, and Resident D had not had a fall in the last month, and the Administrator indicated they make every new admission a fall risk. The Administrator indicated RN 1 said she thought using the Hoyer lift would be safer to assist the resident up with and that RN 1 didn't remember if she did the 9:00 a.m. neuro checks or not. Review of a "15 Minute Monitoring Record" dated 12/2020, indicated that RN 1 had initialed she checked on Resident D every 15 minutes, and documented where Resident D was, from 7:15 a.m. until 8:00 am., and another staff checked on Resident D from 8:15 a.m. until 9:30 a.m., and initialed where Resident D was at those times. On 5/6/21 at 3:19 p.m., the Administrator indicated they follow the Neurological Check form for when the checks are done. On 5/6/21 at 3:35 p.m., the Director of Nursing indicated they didn't have an additional policy on the neuro checks and they follow best practice. A Policy and Procedure for "Neurological Assessment was provided by the Director of Nursing on 5/6/21 at 3:10 p.m. The Policy included, but was not limited to, "Purpose: The purpose of this procedure is to provide guidelines for a neurological assessment: 1) upon physician order; 2) when following an unwitnessed fall; 3) subsequent to a fall with a suspected head injury; or 4) when indicated by resident condition...Steps in the Procedure...3. Perform neurological checks with the frequency as ordered or per falls protocol...Documentation: The following information should be recorded in the resident's medical record: 1. The date and time the procedure was performed. 2. The name and title of the			

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	individual(s) who performed the procedure. 3. All assessment data obtained during the procedure. 4. How the resident tolerated the procedure...." This Federal tag relates to Complaint IN00353064.			