STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOOM AT WILLOW	2725 LAKE CIRCLE DR, INDIANAPOLIS, , 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00372446. Complaint IN00372446 - Substantiated. State deficiencies related to the allegation are cited at R52, R36, R29, R90 and R217. Survey date: February 10 and 11, 2022 Facility number: 010234 Residential Census: 24 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on February 21, 2022.	R 0000	*Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.*	
R 0029	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(d) (d) Residents have the right to be treated with consideration, respect,	R 0029	**R 029-Residents' Rights - Deficiency** **1.**	03/13/2022

	and recognition of their dignity and individuality. Based on observation, interview and record review, the facility failed to treat a cognitively impaired resident with dementia with respect and dignity while leaving him lay on the floor without a blanket or pillow for an undetermined amount of time for 1 of 3 residents reviewed for respect and dignity. (Resident B) Finding includes: A confidential interview was conducted during the course of the survey. The Confidential Interviewee indicated an EMS (Emergency Management Services) crew responded to a call for a resident who needed assistance off the floor on 1/31/22 at 9:50 a.m. The resident (Resident B) was located on the Memory Care unit and the EMS crew had been to this particular facility multiple times prior to assist the resident off the floor. When the EMS crew found the resident that particular day, he was found with vomit and feces on him. None of the staff who were working "seemed" to know what had happened or when it happened with the resident. The EMS crew assisted the resident back to bed and the facility staff indicated they would clean the resident up. There was no		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B discharged to St. Vincent hospital effective 2/1/2022. Effective 2/15/2022, QMA 11 and LPN 3 no longer provide services in the community. CNA 2 was re-educated on 3/2/2022 by the Regional Director of Care Services (RDCS) on the need to treat cognitively impaired residents with dementia with respect and dignity. **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** An observational audit of the memory care unit,	

	ambulance dispatched to the facility because the call came across as a lift assist. Resident B's record was reviewed on 2/10/22 at 12:00 p.m. Diagnoses included, but were not limited to, repeated falls, dementia, Type 2 diabetes mellitus and depression. During an interview, on 2/10/22 at 4:30 p.m., CNA 2 indicated she met LPN 3 coming out of Resident B's room sometime after 6:00 a.m., on 1/31/22. LPN 3 indicated he was on the floor and she was going to call 911. She went into his room to check on him. He was lying on his catheter, no blanket was used to cover him up or pillow was placed under his head. He had a T-Shirt and a brief on. During an interview, on 2/11/22 at 11:13 a.m., LPN 3 indicated she arrived to the facility, between 7:15 a.m. and 7:20 a.m., on 1/31/22. She received report from QMA 11. She asked how the residents on the 3rd floor were and she was told Resident B laid himself on the floor at 1:00 a.m., and had been on the floor ever since then, because he was uncomfortable lying in his bed. QMA 11 indicated he had placed himself on the floor, but no one had witnessed the resident place himself on the floor according to the information given to LPN 3.		interviews with current staff, and interviews with AL residents without cognitive impairment was completed on 3/1/22 and 3/2/22 by the Regional Director of Operations (RDO) to ensure resident rights are upheld and cognitively impaired residents with dementia are treated with respect and dignity. Audit results reviewed with RDCS and corrections made as necessary. **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Executive Director (ED) was re-educated on 2/11/2022 by the RDCS on the need to treat cognitively impaired residents with dementia with respect and dignity. Current Staff were re-educated on 3/2/2022 by the RDO the need to treat cognitively impaired residents with dementia with respect and dignity. New employees will be educated on the need to treat cognitively impaired residents with	

	LPN 3 checked on the resident and he was lying on his right side on top of a blanket, but was not covered up with a blanket and did not have a pillow under his head. He only had a brief and a T-shirt on. At approximately 9:45 a.m., she decided to call 911 to have the EMS crew assist him off the floor. She did not call the EMS crew earlier because she was letting the resident exert his resident's rights. She did not want to infringe on his rights to lay on the floor if that was what he choose to do, but after laying on the floor for approximately nine hours, she indicated she had to do something because he had been on the floor for an excessive amount of time. A current facility policy, titled "Resident Rights," dated 9/1/2016 and provided by the Interim ED on 2/10/22 at 4:18 p.m., indicated "...Process: Employees will honor each resident as an individual, treating them with respect and dignity at all times. Each resident has the right to, at minimum...To receive care, treatment and services which are adequate and appropriate...." This Residential tag relates to Complaint IN00372446. Based on observation, interview and record review, the facility		dementia with respect and dignity during orientation. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Effective 3/7/2022, the ED or designee will complete 5 observational audits on the memory care unit and interview 2 staff members to ensure resident rights are upheld and cognitively impaired residents with dementia are treated with respect and dignity. The observational audits and interviews will occur weekly for four weeks, biweekly for four weeks, then monthly for one month. Interviews and audits will be reviewed at monthly QI meeting. The QI Committee will determine if continued interviews are necessary based on 3 consecutive months of compliance. Monitoring will be on-going	

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	his head. He only had a brief and a T-shirt on. At approximately 9:45 a.m., she decided to call 911 to have the EMS crew assist him off the floor. She did not call the EMS crew earlier because she was letting the resident exert his resident's rights. She did not want to infringe on his rights to lay on the floor if that was what he choose to do, but after laying on the floor for approximately nine hours, she indicated she had to do something because he had been on the floor for an excessive amount of time. A current facility policy, titled "Resident Rights," dated 9/1/2016 and provided by the Interim ED on 2/10/22 at 4:18 p.m., indicated "...Process: Employees will honor each resident as an individual, treating them with respect and dignity at all times. Each resident has the right to, at minimum...To receive care, treatment and services which are adequate and appropriate...." This Residential tag relates to Complaint IN00372446.			
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal	R 0036	**R 036 Residents' Rights – Deficiency** **1. What corrective action(s) will be**	03/13/2022

	representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review, the facility failed to notify a resident's family member and physician of wounds of unknown origin on his body, failed to notify the physician the resident laid on the floor for an undetermined amount of time after a potential unwitnessed fall and failed to notify the resident's family he was in need of a larger bed for 1 of 3 residents reviewed for change in condition (Resident B). Finding includes: A confidential interview was conducted during the course of the survey. The Confidential Interviewee indicated an EMS (Emergency Management Services) crew responded to a call for a resident who needed assistance off the floor on 1/31/22 at 9:50 a.m. The resident (Resident B) was located on the Memory Care unit and the EMS crew had been to this particular facility		**accomplished for those residents found to have been affected** **by the deficient practice:** Resident B discharged to St. Vincent hospital effective 2/1/2022. Effective 2/15/2022, QMA 11 and LPN 3 no longer provide services in the community. CNA 8 will be re-educated prior to the start of their next shift in the community by the ED or designee on the need to immediately notify a licensed nurse or the ED of a change in condition and document changes on 24 hour report sheet CNA 2 and QMA 9 were re-educated on 3/2/2022 by RDCS on the need to immediately notify a licensed nurse or the ED of a change in condition and document changes on 24 hour report sheet.	

	multiple times prior to assist this resident off the floor. When the EMS crew found the resident, he was found with vomit and feces on him. None of the staff who were working "seemed" to know what had happened or when it happened with the resident. The EMS crew was never able to determine who called 911 and asked for assistance to get the resident off the floor. The EMS crew assisted the resident back to bed and the facility staff indicated they would clean the resident up. There was no ambulance dispatched to the facility because the call came across as a lift assist. There were no injuries at that time. Due to the EMS crew working 24 hour shifts, later in their shift on 2/1/22 at 4:00 a.m., they were called back out to the same facility for the same resident (Resident B) for other medical complaints and he was transported to the hospital. The ambulance and fire engine was sent out to the facility on this call because the call was sent out as a fall with an injured person. Resident B complained to the EMS crew about an abrasion on his left knee, swelling to the left knee and complaints of right shoulder pain. The EMS crew had concerns because the staff had called at 4:00 a.m., on 2/1/22, and the staff who came into the room indicated she had		**2.** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** An audit of current resident service notes for the last 30 days was completed on 3/2/2022 by the RDCS to ensure the resident's legal representative and physician was notified of a change in condition or resident concern. Audit results reviewed corrections made as necessary. **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The ED was re-educated on 2/11/2022 by the RDCS on the need to immediately notify a resident's physician and legal representative of a change in condition. Current Staff were re-educated on 3/2/2022 by the RDO on the need to immediately notify a resident's	

	been on duty since 10:00 p.m., on 1/31/22, and she had just now made her rounds into Resident B's room. The EMS crew was concerned the staff had waited since 10:00 p.m., before making rounds on Resident B. During an interview, on 2/10/22 at 4:30 p.m., CNA 2 indicated she met LPN 3 coming out of Resident B's room on 1/31/22. LPN 3 indicated he was on the floor and she was going to call 911. CNA 2 indicated the resident told her, he did not fall, he laid himself on the floor as he frequently did at times. He slid himself onto the floor at times to sleep because he did not like the bed he had. CNA 2 indicated it was not unusual for Resident B to hang his feet from the edge of his bed because the bed length was too short for him. During an interview, on 2/10/22 at 8:15 a.m., with the Interim ED (Executive Director) and Interim DON (Director of Nursing) in attendance. The Interim ED indicated Resident B fell and got an abrasion to his left knee on the night shift of 1/31/22. The paramedics came immediately to assist him off the floor. Staff indicated he would put himself on the floor and the medics and firemen would have to come and assist him back into bed. He would often put himself on		physician and legal representative of a change in condition and document changes on 24 hour report sheet. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Effective 3/7/2022, the Care Services Manager (CSM) or designee will review the 24 hour report sheet for changes in resident condition and the resident record will be reviewed to ensure family and physician have been notified. This review will occur 5 times per week for 4 weeks, then 3 times per week for 4 weeks, then weekly for 4 weeks. Results will be reviewed at monthly QI meeting. The QI Committee will determine if continued interviews are necessary based on 3 consecutive months of compliance. Monitoring will be on-going	

	the floor because his son bought him a new bed and he did not like the bed. The resident indicated to staff the bed was not comfortable and he preferred to lay on the floor. LPN 3 came into work, on the dayshift, on 1/31/22, when she came on duty, she was told in report Resident B had been lying on the floor since between 4:00 a.m. and 5:00 a.m., by his choice to sleep on the floor. At approximately 11:00 a.m. to 12:00 p.m., on 1/31/22, LPN 3 was able to get the resident to allow the EMS crew to assist him up into his bed. EMS crew had to assist him into bed when he placed himself on the floor because he was a large man and the staff could not get him up. He was assisted back into bed. LPN 3 notified the son regarding the resident being found lying on the floor and the EMS crew assisting him to bed. On 2/1/22, during the night shift, Resident B was transported to the hospital by ambulance between 4:00 a.m. and 5:00 a.m. CNA 8 and QMA 9 were on duty on the Memory Care unit. CNA 8 noticed a skin condition change in Resident B and reported the change to QMA 9 on 2/1/22 at 12:30 a.m. His left knee had an abrasion without a scab. The next time CNA 8 checked on the resident and changed his brief on 2/1/22 at			

	4:00 a.m., he complained of pain. CNA 8 had to get assistance from another CNA to assist her to change his shirt and brief, which was out of the normal for Resident B. CNA 8 observed a blister on his stomach, an open skin area (area like a scrap) on the back of his right shoulder, an open skin area to his upper and outer inner arm, inner forearm and his hand had an open skin area with a scrap. CNA 8 went and informed QMA 9. QMA 9 talked about Resident B's condition and the Memory Care Manager (MCM) told her to send him to the hospital on 2/1/22. Resident B's record was reviewed on 2/10/22 at 12:00 p.m. Diagnoses included, but were not limited to, repeated falls, dementia, Type 2 diabetes mellitus and depression. The resident's record lacked any progress notes indicating the physician or son had been notified regarding the residents wounds, he had laid on the floor for an undetermined amount of time after a potential fall, or the resident required a larger bed. An untitled document from the Pike Township Fire Department, dated 2/1/22, indicated Resident B's chief complaint was his right shoulder, left knee and foot pain. His secondary complaint was his right abdomen and flank			

	area. Under the comment section a note was documented indicating the resident appeared to have burns to the upper right quadrant of his abdomen skin with a blister present. He had right flank and right back pain. He would not move his right arm to determine range of motion. His right anterior forearm had abrasions, which looked like a burn. The left medial knee had an abrasion with redness and swelling and he had pain to his left foot and heel. The ambulance was dispatched to the facility for an injured person. Resident B was lying in bed. The staff indicated to the EMS crew they were making their rounds and found the resident with an abrasion to his left medial knee with swelling, redness and he was having pain. He also complained of pain in his left foot and heel. He complained of right shoulder pain and yelled when the front and back of it was touched. He had what "appeared" to be blistered burns to his upper right quadrant abdomen and right flank area with matching burns to the front right forearm. Another EMS crew was on scene indicating they were dispatched to this particular facility for this resident less than 24 hours ago for a lift assist and he was covered in feces and there was no staff present. When the EMS crew arrived, they were not given any report			

	from the day shift about the resident falling or any injuries. The facility staff had just did their initial rounds on this resident for their night shift. The facility staff were not helpful in regards to the injuries the resident sustained. A document, titled "ER Triage Note" dated 2/1/22 at 5:19 a.m., indicated the chief complaint was a fall with injury on 1/31/22 with left shoulder, left knee and right foot pain and swelling. He had an unwitnessed fall and sustained some burns to the right chest wall and right shoulder on the Memory Care unit at the facility where he lived. There was nothing in the room for him to get burned on. He complained of constant, moderate and achy pain to his left knee, right ankle and right shoulder. He had dementia. He had swelling to his left knee and blistering to the right chest wall and the right shoulder. He needed a social work consult to discern his Memory Care situation and whether or not an APS (Adult Protective Services) report needed to be filed. He was not "safe to return to where he was living." During an interview, on 2/11/22 at 11:13 a.m., LPN 3 indicated she arrived at the facility somewhere between 7:15 a.m. and 7:20 a.m., on 1/31/22. She received report from QMA 11.			

	She asked how the residents on the 3rd floor were and she was told Resident B laid himself on the floor at 1:00 a.m., and had been on the floor ever since then, because he was uncomfortable laying in his bed. QMA 11 indicated he had placed himself on the floor, but no one had witnessed the resident place himself on the floor according to the information given to LPN 3. LPN 3 checked on the resident and he was lying on his right side, on top of a blanket, but was not covered up with a blanket and did not have a pillow under his head. He only had a brief and a T-shirt on. At approximately 9:45 a.m., she decided to call 911 to have the EMS crew assist him off the floor. She did not call the EMS crew earlier because she was letting the resident exert his resident's rights. She did not want to infringe on his rights to lay on the floor if this was what he choose to do, but after laying on the floor for approximately nine hours, she indicated she had to do something because he had been on the floor an excessive amount of time. She indicated she did not notify his son at the time of the telephone call about the resident placing himself on the floor or he did not think his bed was comfortable. LPN 3 did not notify Resident B's physician regarding the open areas she observed during the skin			

assessment she completed or that he laid on the floor from approximately 1:00 a.m. to 10:00 a.m.

During an interview, on 2/11/22 at 12:40 p.m., the son indicated Resident B lived on the Memory Care unit at the facility. He fell on 1/31/22, sometime during the nightshift and staff left him on the floor until approximately 9:00 a.m., when the Fire department was called to assist him off the floor. He was assisted to bed, cleaned up, assessed for injuries and ate breakfast. On 2/1/22 at approximately 4:30 a.m., the son received a call indicating the resident was being sent to the hospital because he was in pain. While at the hospital, he was told by the Emergency Room (ER) staff, Resident B had numerous open wounds, a laceration and bruising to his wrists, ankles, abdomen, knees and shoulders. The ER Doctor indicated the open wounds and blisters appeared to be "burn wounds", which may have occurred from where the resident attempted to get himself up, off the floor, after he fell, and laid there for an extended amount of time on 1/31/22. The son was not informed of the new areas, by the facility prior to going to the hospital. Resident B was admitted to the hospital for his injuries and he remained at the

	hospital as of 2/10/22. A current facility policy, titled "Change In Condition," dated 9/1/2016 and provided by the Interim ED on 2/10/22 at 4:18 p.m., indicated "Policy: The Care Services Manager or designee is responsible for responding to a resident's change of condition, making appropriate notifications and implementing appropriate interventions. Process: A change of condition is identified as a condition anticipated to last more than 14 days. Staff will report to the CSM and/or ED, any observations that indicate a possible change of condition. The CSM and/or ED will document the observation and findings in the Resident Service Notes. Resident Care Partners may document initial observations on the First Responder Worksheet in the absence of the CSM and Executive Director. The CSM may direct staff regarding additional monitoring or interventions using the Short Term Monitor, if the condition is expected to last 14 days or less. If the condition is expected to last more than 14 days, a significant change evaluation will be completed. The Care Services Manager will notify the physician and responsible party, and document notifications. The CSM will identify possible causes or contributing factors,			

	and initiate appropriate interventions after consulting with the resident's physician or other healthcare provider. A Change in Condition assessment/evaluation will be completed timely, according to the state regulatory requirement, and an updated care plan conference held with resident and/or financially responsible party, to discuss the physical changes, as well as the care plan updates identifying needs and preferences." This Residential tag relates to Complaint IN00372446. Based on interview and record review, the facility failed to notify a resident's family member and physician of wounds of unknown origin on his body, failed to notify the physician the resident laid on the floor for an undetermined amount of time after a potential unwitnessed fall and failed to notify the resident's family he was in need of a larger bed for 1 of 3 residents reviewed for change in condition (Resident B). Finding includes: A confidential interview was conducted during the course of the survey. The Confidential Interviewee indicated an EMS (Emergency Management Services) crew responded to a call for a resident who needed			

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knee and complaints of right shoulder pain. The EMS crew had concerns because the staff had called at 4:00 a.m., on 2/1/22, and the staff who came into the room indicated she had been on duty since 10:00 p.m., on 1/31/22, and she had just now made her rounds into Resident B's room. The EMS crew was concerned the staff had waited since 10:00 p.m., before making rounds on Resident B.

During an interview, on 2/10/22 at 4:30 p.m., CNA 2 indicated she met LPN 3 coming out of Resident B's room on 1/31/22. LPN 3 indicated he was on the floor and she was going to call 911. CNA 2 indicated the resident told her, he did not fall, he laid himself on the floor as he frequently did at times. He slid himself onto the floor at times to sleep because he did not like the bed he had. CNA 2 indicated it was not unusual for Resident B to hang his feet from the edge of his bed because the bed length was too short for him.

During an interview, on 2/10/22 at 8:15 a.m., with the Interim ED (Executive Director) and Interim DON (Director of Nursing) in attendance. The Interim ED indicated Resident B fell and got an abrasion to his left knee on the night shift of 1/31/22. The paramedics came immediately

	to assist him off the floor. Staff indicated he would put himself on the floor and the medics and firemen would have to come and assist him back into bed. He would often put himself on the floor because his son bought him a new bed and he did not like the bed. The resident indicated to staff the bed was not comfortable and he preferred to lay on the floor. LPN 3 came into work, on the dayshift, on 1/31/22, when she came on duty, she was told in report Resident B had been lying on the floor since between 4:00 a.m. and 5:00 a.m., by his choice to sleep on the floor. At approximately 11:00 a.m. to 12:00 p.m., on 1/31/22, LPN 3 was able to get the resident to allow the EMS crew to assist him up into his bed. EMS crew had to assist him into bed when he placed himself on the floor because he was a large man and the staff could not get him up. He was assisted back into bed. LPN 3 notified the son regarding the resident being found lying on the floor and the EMS crew assisting him to bed. On 2/1/22, during the night shift, Resident B was transported to the hospital by ambulance between 4:00 a.m. and 5:00 a.m. CNA 8 and QMA 9 were on duty on the Memory Care unit. CNA 8 noticed a skin condition change in Resident B and			

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	Pike Township Fire Department, dated 2/1/22, indicated Resident B's chief complaint was his right shoulder, left knee and foot pain. His secondary complaint was his right abdomen and flank area. Under the comment section a note was documented indicating the resident appeared to have burns to the upper right quadrant of his abdomen skin with a blister present. He had right flank and right back pain. He would not move his right arm to determine range of motion. His right anterior forearm had abrasions, which looked like a burn. The left medial knee had an abrasion with redness and swelling and he had pain to his left foot and heel. The ambulance was dispatched to the facility for an injured person. Resident B was lying in bed. The staff indicated to the EMS crew they were making their rounds and found the resident with an abrasion to his left medial knee with swelling, redness and he was having pain. He also complained of pain in his left foot and heel. He complained of right shoulder pain and yelled when the front and back of it was touched. He had what "appeared" to be blistered burns to his upper right quadrant abdomen and right flank area with matching burns to the front right forearm. Another EMS crew was on scene indicating they were dispatched to this particular			

	facility for this resident less than 24 hours ago for a lift assist and he was covered in feces and there was no staff present. When the EMS crew arrived, they were not given any report from the day shift about the resident falling or any injuries. The facility staff had just did their initial rounds on this resident for their night shift. The facility staff were not helpful in regards to the injuries the resident sustained. A document, titled "ER Triage Note" dated 2/1/22 at 5:19 a.m., indicated the chief complaint was a fall with injury on 1/31/22 with left shoulder, left knee and right foot pain and swelling. He had an unwitnessed fall and sustained some burns to the right chest wall and right shoulder on the Memory Care unit at the facility where he lived. There was nothing in the room for him to get burned on. He complained of constant, moderate and achy pain to his left knee, right ankle and right shoulder. He had dementia. He had swelling to his left knee and blistering to the right chest wall and the right shoulder. He needed a social work consult to discern his Memory Care situation and whether or not an APS (Adult Protective Services) report needed to be filed. He was not "safe to return to where he was living."			

	During an interview, on 2/11/22 at 11:13 a.m., LPN 3 indicated she arrived at the facility somewhere between 7:15 a.m. and 7:20 a.m., on 1/31/22. She received report from QMA 11. She asked how the residents on the 3rd floor were and she was told Resident B laid himself on the floor at 1:00 a.m., and had been on the floor ever since then, because he was uncomfortable laying in his bed. QMA 11 indicated he had placed himself on the floor, but no one had witnessed the resident place himself on the floor according to the information given to LPN 3. LPN 3 checked on the resident and he was lying on his right side, on top of a blanket, but was not covered up with a blanket and did not have a pillow under his head. He only had a brief and a T-shirt on. At approximately 9:45 a.m., she decided to call 911 to have the EMS crew assist him off the floor. She did not call the EMS crew earlier because she was letting the resident exert his resident's rights. She did not want to infringe on his rights to lay on the floor if this was what he choose to do, but after laying on the floor for approximately nine hours, she indicated she had to do something because he had been on the floor an excessive amount of time. She indicated she did not notify his son at the time of the telephone call about			

	the resident placing himself on the floor or he did not think his bed was comfortable. LPN 3 did not notify Resident B's physician regarding the open areas she observed during the skin assessment she completed or that he laid on the floor from approximately 1:00 a.m. to 10:00 a.m. During an interview, on 2/11/22 at 12:40 p.m., the son indicated Resident B lived on the Memory Care unit at the facility. He fell on 1/31/22, sometime during the nightshift and staff left him on the floor until approximately 9:00 a.m., when the Fire department was called to assist him off the floor. He was assisted to bed, cleaned up, assessed for injuries and ate breakfast. On 2/1/22 at approximately 4:30 a.m., the son received a call indicating the resident was being sent to the hospital because he was in pain. While at the hospital, he was told by the Emergency Room (ER) staff, Resident B had numerous open wounds, a laceration and bruising to his wrists, ankles, abdomen, knees and shoulders. The ER Doctor indicated the open wounds and blisters appeared to be "burn wounds", which may have occurred from where the resident attempted to get himself up, off the floor, after he fell, and laid there for an extended amount of time on			

	1/31/22. The son was not informed of the new areas, by the facility prior to going to the hospital. Resident B was admitted to the hospital for his injuries and he remained at the hospital as of 2/10/22. A current facility policy, titled "Change In Condition," dated 9/1/2016 and provided by the Interim ED on 2/10/22 at 4:18 p.m., indicated "Policy: The Care Services Manager or designee is responsible for responding to a resident's change of condition, making appropriate notifications and implementing appropriate interventions. Process: A change of condition is identified as a condition anticipated to last more than 14 days. Staff will report to the CSM and/or ED, any observations that indicate a possible change of condition. The CSM and/or ED will document the observation and findings in the Resident Service Notes. Resident Care Partners may document initial observations on the First Responder Worksheet in the absence of the CSM and Executive Director. The CSM may direct staff regarding additional monitoring or interventions using the Short Term Monitor, if the condition is expected to last 14 days or less. If the condition is expected to last more than 14 days, a significant change evaluation			

	will be completed. The Care Services Manager will notify the physician and responsible party, and document notifications. The CSM will identify possible causes or contributing factors, and initiate appropriate interventions after consulting with the resident's physician or other healthcare provider. A Change in Condition assessment/evaluation will be completed timely, according to the state regulatory requirement, and an updated care plan conference held with resident and/or financially responsible party, to discuss the physical changes, as well as the care plan updates identifying needs and preferences." This Residential tag relates to Complaint IN00372446.			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.	R 0052	**R 052** **Residents' Rights - Offense** **1.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B was discharged to St. Vincent hospital effective 2/1/2022.	03/13/2022

	Based on observation, interview and record review, the facility failed to ensure a resident was free from neglect when the facility failed to assist a cognitively impaired dementia resident off the floor, who had laid there an undetermined amount of time, the facility was unable to determine if the resident had fallen or placed himself onto the floor and the facility failed to investigate and report wounds of unknown origin to the Indiana Department of Health for 1 of 3 residents being reviewed for neglect (Resident B). Resident B developed open wounds of an unknown origin following being left on the floor for an undetermined amount of time. Finding includes: A confidential interview was conducted during the course of the survey. The Confidential Interviewee indicated an EMS (Emergency Management Services) crew responded to a call for a resident who needed assistance off the floor on 1/31/22 at 9:50 a.m. The resident (Resident B) was located on the Memory Care unit and the EMS crew had been to this particular facility multiple times prior to assist the resident off the floor. When the EMS crew found the resident that particular day, he was found with vomit and feces on		Effective 2/15/2022, QMA 11 and LPN 3 no longer provide services in the community. CNA 8 will be re-educated prior to the start of their next shift in the community by the ED or designee on abuse, resident rights, and IDOH reporting requirements, including investigation of wounds of unknown origin. The Memory Care Manager (MCM) is on sick leave and will be re-educated prior to the start of their next shift in the community by the ED or designee on abuse, resident rights, and IDOH reporting requirements, including investigation of wounds of unknown origin. CNA 2 and QMA 9 were re-educated on 3/2/2022 by the RDCS on abuse, resident rights, and IDOH reporting requirements, including investigation of wounds of unknown origin. **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and**	

	him. None of the staff who were working "seemed" to know what had happened or when it happened. The EMS crew was never able to determine who called 911 and asked for assistance to get the resident off the floor. None of the staff available at the time the EMS crew assisted the resident to bed indicated they had called 911. The EMS crew assisted the resident back to bed and the facility staff indicated they would clean the resident up. There was no ambulance dispatched to the facility because the call came across as a lift assist. There were no injuries at that time. Due to the EMS crew working 24 hour shifts, later in their shift on 2/1/22 at 4:00 a.m., they were called back out to the same facility for the same resident (Resident B) for other medical complaints and he was transported to the hospital. The same EMS crew who came out to assist him on 1/31/22, came back out on 2/1/22 at 4:30 a.m. The ambulance and fire engine was sent out to the facility on this call because the call was sent out as a fall with an injured person. Resident B complained to the EMS crew about an abrasion on his left knee, swelling to this left knee and complaints of right shoulder pain. The EMS crew had concerns because the staff had		**what corrective action will be taken:** An observational audit of the memory care unit, skin assessments of current memory care residents, interviews with current staff, and interviews with AL residents without cognitive impairment was completed on 3/1-3/2/2022 by the RDO and the CSM to ensure resident rights are upheld, cognitively impaired residents with dementia are treated with respect and dignity, and wounds or unknown origin are investigated and reported to IDOH. Audit results reviewed with RDCS and corrections made as necessary. **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The ED was re-educated on 2/11/2022 by the RDCS on abuse, resident rights, and IDOH reporting requirements, including investigation of wounds of unknown origin. Current staff were re-educated	

	called at 4:00 a.m., on 2/1/22, and the staff who came into the room indicated she had been on duty since 10:00 p.m., on 1/31/22, but she had just now made her rounds into Resident B's room. The facility staff indicated they were not given report on Resident B's status prior to the dayshift leaving the facility. The EMS crew was concerned the staff had waited since 10:00 p.m., before making rounds on Resident B. During an interview, on 2/10/22 at 4:30 p.m., CNA 2 indicated she met LPN 3 coming out of Resident B's room on 1/31/22. LPN 3 indicated he was on the floor and she was going to call 911. CNA 2 indicated the resident told her he did not fall, he laid himself on the floor as he frequently did at times. He slid himself onto the floor to sleep because he did not like the bed he had. His bed had a black iron frame with a mattress. She went into his room to check on him and as she opened up the door, he asked her what she wanted. He was laying on his catheter, no blanket was used to cover him up or pillow was placed under his head. He had a T-Shirt and a brief on. CNA 2 had checked on him one other time, but she could not remember what time that was. She was with another resident when the EMS crew came up to the resident's room. There was		on 3/2/2022 by the RDO on abuse, resident rights, and reporting requirements including investigation of wounds of unknown origin. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Effective 3/7/2022, the ED or designee will complete 5 observational audits on the memory care unit, 5 skin assessments, and interview 2 staff members to ensure resident rights are upheld, cognitively impaired residents with dementia are free from neglect, and wounds of unknown origin are investigated and reported to IDOH. The observational audits, skin assessments, and interviews will occur weekly for four weeks, biweekly for four weeks, then monthly for one month. Interviews and audits will be reviewed at monthly QI meeting. The QI Committee will determine if continued interviews are necessary based on 3 consecutive months of compliance. Monitoring will	

	no staff in his room when EMS arrived. She went to look for his nurse and while she was looking for his nurse, the EMS crew put the resident back to bed. CNA 2 indicated the EMS crew told her, the resident had vomit on him, but she did not find any vomit on him. She indicated there was some stool in his brief. CNA 2 indicated it was not unusual for Resident B to hang his feet from the edge of his bed because the bed length was too short for him. During an interview, on 2/10/22 at 8:15 a.m., with the Interim ED (Executive Director) and Interim DON (Director of Nursing) in attendance. The Interim ED indicated Resident B fell and got an abrasion to his left knee on the night shift of 1/31/22. The paramedics came immediately to assist him off the floor. Staff indicated he would put himself on the floor and the medics and firemen would have to come and assist him back into bed. He would often put himself on the floor because his son bought him a new bed and he did not like the bed. He indicated to staff the bed was not comfortable and he preferred to lay on the floor. LPN 3 came into work on the dayshift, on 1/31/22. When she came on duty, she was told in report, Resident B had been laying on the floor since between 4:00 a.m. and 5:00		be on-going	

	a.m., by his choice to sleep on the floor. Three different staff members had checked on him prior to 911 being called and nothing indicated at any of those times he had fallen. Nothing in his apartment was out of place, he was not injured, and every time a staff member checked on him, he indicated he was "fine" and he wanted to be left alone to sleep. At approximately 11:00 a.m. to 12:00 p.m., on 1/31/22, LPN 3 was able to get the resident to allow the EMS crew to assist him up into his bed. EMS crew had to assist him into bed when he placed himself on the floor because he was a large man and the staff could not get him up. The Interim ED and Interim DON had no knowledge of the resident having emesis or feces on him when he was assisted back to bed. LPN 3 indicated she had asked the resident if he wanted to eat while lying on the floor and after getting back into bed and he did not want to eat. She did go get him two glasses of water as the EMS crew was exiting the elevator, so she was not in the resident's room when they arrived. LPN 3 notified the son regarding the resident being found lying on the floor and the EMS crew assisting him to bed. On 2/1/22, night shift, Resident B was transported to the hospital by ambulance between			

	4:00 a.m. and 5:00 a.m. CNA 8 and QMA 9 were on duty on the Memory Care unit. CNA 8 noticed a skin condition change in Resident B and reported the change to QMA 9 on 2/1/22 at 12:30 a.m. His left knee had an abrasion without a scab. This change was reported to the ED by QMA 9. The next time, CNA 8 checked on the resident and changed his brief on 2/1/22 at 4:00 a.m., he complained of pain. CNA 8 had to get assistance from another CNA to assist her to change his shirt and brief, which was out of the normal for Resident B. CNA 8 observed a blister on his stomach, an open skin area (area like a scrap) on the back of his right shoulder, an open skin area to his upper and outer inner arm, inner forearm and his hand had an open skin area with a scrap. CNA 8 went and got QMA 9 who was speaking to the Memory Care Manager (MCM) at the time. QMA 9 talked about Resident B's condition and the MCM told her to send him to the hospital. During an interview, on 2/10/22 at 11:32 a.m., the Interim ED was in attendance and showed this surveyor pictures off a cellphone Resident B's son sent to her of some of his wounds which were observed in the ER at the hospital. She also had pictures of the way his apartment was set up prior to			

	his son moving his bed out. Moving boxes were observed in the pictures. There was a picture observed of a bed with a black wrought iron frame in an oval/rectangle shape surrounding a mattress on the all the sides and the back of the frame. The front of the frame was left open. The mattress had brown rings on it. She indicated he placed himself on the floor and slept there due to his bed was uncomfortable because it was not long enough for him. A laminate tile type floor was observed under the bed. There was a chest of Drawers to the right side of the bed sitting on the laminate tile floor. Four wound pictures were observed. The left knee open wound had no skin with a red wound bed and redness surrounding the wound. The abdomen picture was observed to have two yellow fluid filled blisters. The right shoulder picture was observed to have two open wounds with a red wound bed and pieces of shredded skin around the edges. The right forearm picture was observed to have an open wound with a red wound bed with shredded skin along the edges. The MCM instructed QMA 9 to send Resident B to the hospital because of these new wounds and he was in pain on 2/1/22. Resident B's record was reviewed on 2/10/22 at 12:00			

	p.m. Diagnoses included, but were not limited to, repeated falls, dementia, Type 2 diabetes mellitus and depression. A visit note from Resident B's physician, dated 12/10/21, indicated he had a difficult time sitting up during the assessment and was very weak. He was encouraged to participate in Physical Therapy (PT), so he could get stronger. The physician spoke to the resident's son regarding starting him on an antidepressant and he was agreeable. His review of systems indicated he had generalized weakness and depression. He was at risk for falls, had generalized weakness and was sedentary, so the physician was recommending PT. The resident's record included, but were not limited to, the following progress notes: On 1/19/22 at 5:40 a.m., the resident was found on the floor during the staff's final check for their shift. He was sitting on his bottom and leaning on the bed facing the door. He indicated he slid from the bed when trying to get up. On 1/28/22 at 4:25 a.m., the resident complained of left knee pain. On a pain scale from 0 being no pain and 10 being the worst pain, he indicated his pain			

	was a level 8 out of 10. Pain medication was given. On 1/28/22 at 5:15 a.m., pain medication was effective. On 1/29/22 at 3:45 a.m., the resident when touched during rounds screamed in pain. He had 2+ edema to his bilateral lower extremities. Pain medication given after getting permission from Interim ED. (Note written by QMA) On 1/29/22 at 12:00 p.m., the writer (Interim ED) was at home and she received a call from the charge nurse who indicated the resident had 2+ non-pitting bilateral edema. The physician's office was notified and indicated the resident had no diagnosis of CHF, however his bed was not long enough and his feet hung over the edge, which was likely contributing to the bilateral edema. The physician's representative indicated this person would notify Resident B's family regarding the need for a different bed and the resident would be seen during the next scheduled visit to the facility. On 2/1/22 at 4:25 a.m., while providing care and doing a transfer, Resident B was in severe pain. There were bruises of unknown origin on the resident's right shoulder, right hand, and left thigh. He was sent to the ER for evaluation as			

instructed by the ED.

The progress notes lacked documentation of the events, which occurred on the night and dayshifts of 1/31/22.

Due to no written statements from QMA 9 and 11 about what took place during the incidents of 1/31/22 and 2/1/22, the inability to reach QMA 9 and 11 by phone for interviews and no documentation in the progress notes from staff members for the incidents, there was no way to determine if the resident fell on the floor, laid himself on the floor, or how long he was on the floor.

An untitled document, from the Pike Township Fire Department, dated 2/1/22, indicated Resident B's chief complaint was his right shoulder, left knee, and foot pain. His secondary complaint was his right abdomen and flank area. Under the comment section, a note was documented indicating the resident appeared to have burns to the upper right quadrant of his abdomen skin with a blister present. He had right flank and right back pain. He was uncooperative with the assessment and movement. He would not move his right arm to determine range of motion. His right anterior forearm had abrasions, which looked like a burn. The left medial knee had an abrasion with redness and

	swelling and he had pain to his left foot and heel. The ambulance was dispatched to the facility for an injured person. Resident B was lying in bed. The staff indicated to the EMS crew they were making their rounds and found the resident with an abrasion to his left medial knee with swelling, redness and he was having pain. He also complained of pain in his left foot and heel. He complained of right shoulder pain and yelled when the front and back of it was touched. He was not cooperative with the assessment or movement. He had what "appeared" to be blistered burns to his upper right quadrant abdomen and right flank area with matching burns to the front right forearm. Another EMS crew was on scene indicating they were dispatched to this particular facility for this resident less than 24 hours ago for a lift assist and he was covered in feces and there was no staff present. The staff present at the time the EMS crew was at the facility on 2/1/22 at 4:50 a.m., indicated they were not given any report from the day shift about the resident falling or any injuries. They had just did their initial rounds on this resident for their night shift. The facility staff were not helpful in regards to the injuries the resident sustained. A document, titled "ER Triage			

	Note," dated 2/1/22 at 5:19 a.m., indicated the chief complaint was a fall with injury on 1/31/22 with left shoulder, left knee and right foot pain and swelling. He had an unwitnessed fall and sustained some burns to the right chest wall and right shoulder on the Memory Care unit at the facility where he lived. There was nothing in the room for him to get burned on. EMS was called out for a lift assist 12 hours earlier and he was found in his own stool. He complained of constant, moderate and achy pain to his left knee, right ankle and right shoulder. He had dementia. He had swelling to his left knee and blistering to the right chest wall and the right shoulder. He needed a social work consult to discern his Memory Care situation and whether or not an APS (Adult Protective Services) report needed to be filed. He was not "safe to return to where he was living." A document, titled "Injury Identification Log," dated 2/1/22 at 1:00 p.m., indicated the resident had the following wounds upon admission to the ER: 1. Right anterior (front) shoulder, the area measured 8 cm (centimeters) x 6 cm. The area contained two wounds with a moist pink wound bed and the			

wound edges had abraded skin.

2. Right outer forearm, the area measured 2 cm x greater than 8 cm. The area contained three wounds and the wound bed was brown with jagged wound edges with abraded skin edges.

3. Right upper inner forearm, the area measured approximately 8 cm x 8 cm. The area contained a wound, which measured 5 cm x 4 cm. The wound bed was beefy red with wound edges with abraded skin. The area was tender to palpation.

4. Right lower inner forearm, the area measured approximately 4 cm x 6 cm. The area contained an abrasion and multiple areas of yellow skin discoloration.

5. Right upper medial quadrant of abdomen, the area measured approximately 7 cm x 7.5 cm of pink skin discoloration with a serous fluid filled pocket of skin resembling a blister present. The area was tender with palpitations.

6. Right upper distant quadrant of abdomen, the area contained a serous fluid filled pocket of skin resembling a blister, an area of pink skin discoloration and the area was tender to palpations.

7. Left inner knee, the area measured approximately 6 cm x

	6 cm. The area contained a wound with a yellow wound bed and abraded skin on the would edges. There was pink skin discoloration surrounding the wound. 8. Left upper thigh, the area measured approximately 4 cm x 6 cm and contained multiple abrasions. A document, titled "Consult Note: Adult-Geriatric Medicine," from the hospital, dated 2/1/22 at 4:15 p.m., indicated the resident was brought to the ER from the facility he lived at by EMS after an unwitnessed fall on 1/31/22. EMS was at the facility twice on 1/31/22. The first time EMS went to the facility, Resident B was found in his own urine/feces and the staff needed EMS to assist lift him. The second time EMS went to the facility, he was discovered down with new burns to his right arm and right chest which were not there when they were there the first time. Social work and Case Management were consulted. The Case Manager indicated the resident had suspicious burn marks on his chest, abdomen and shoulder and he would not be sent back to the facility. The resident had suspicious lesions from the facility and was unable to provide a history of events. There was a concern for neglect versus abuse at the facility. The			

	physician in the ER was not comfortable sending the resident back to the facility and the son did not want his father to go back to the facility. A document, titled "Consult Note-Adult Burn Visit," from the hospital, dated 2/1/22 at 6:57 p.m., indicated the resident was brought to the ER by way of EMS after an unwitnessed fall at the facility on 1/31/22. The wound team was consulted to evaluate his wounds as there was a concern his wounds were for burn injuries. The resident did not remember being exposed to any heat or dropping hot liquid on him. The EMS was called twice to the facility on 2/1/22, regarding the resident. The first time, he was found in his own urine and feces and needed EMS to assist lift him off the floor. EMS was called a second time and he was discovered down with new burns to his right arm and right chest which were not there earlier when EMS was there. The right arm wrist and forearm wounds had dark eschar. The right side antecubital and shoulder wounds "appear" to be a ruptured blister. The right shoulder wound "appear" to be a ruptured blister. The right abdominal area had a large blister, which was ruptured at the resident's bedside. All the wounds, except the right wrist and forearm, blanch easily. The			

	resident did not remember sustaining any burns while at the facility. There was a question as to whether or not the resident was on the floor next to his bed for a considerable period of time. He had partial-thickness injuries to the left knee, right arm, right shoulder and right abdomen. The areas on the right arm and abdomen blanched. The areas on the left leg and right wrist were deeper partial-thickness injuries and did not blanch. The treatment will include antibiotic ointment and Santyl to help lift the eschar away, but if that did not work, the resident would most likely have to have a surgical debridement in the operating room. The facility service plan, for Resident B, lacked fall interventions to prevent further falls, documentation indicating the resident preferred to lay on the floor to sleep due to his bed was uncomfortable to him, and that he placed himself on the floor at times and the EMS crew had to come to the facility to assist lift him back into bed. During an interview, on 2/10/22 at 3:50 p.m., with Resident B, in Resident B's hospital room, he indicated the early morning of 1/31/22, he fell. He was oriented to person and time. He indicated no staff member burned him with anything and he had no			

	idea how he got the wounds. During an interview, on 2/11/22 at 11:13 a.m., LPN 3 indicated she arrived to the facility somewhere between 7:15 a.m. and 7:20 a.m., on 1/31/22. She received report from QMA 11. She asked how the residents on the 3rd floor were and she was told Resident B laid himself on the floor at 1:00 a.m., and had been on the floor ever since then, because he was uncomfortable laying in his bed. QMA 11 indicated he had placed himself on the floor, but no one had witnessed the resident place himself on the floor according to the information given to LPN 3. LPN 3 checked on the resident and he was laying on his right side on top of a blanket, but was not covered up with a blanket and did not have a pillow under his head. He only had a brief and a T-shirt on. LPN 3 went back to check on Resident B at 8:00 a.m., and asked him to get up and get into the bed and he did not want to get up. At approximately 9:45 a.m., she decided to call 911 to have the EMS crew assist him off the floor. She did not call the EMS crew earlier because she was letting the resident exert his resident's rights and she did not want to infringe on his rights to lay on the floor if that was what he choose to do, but after lying on the floor for approximately			

nine hours, she indicated she had to do something because he had been on the floor for an excessive amount of time.

After the EMS crew assisted him to bed at approximately 10:00 a.m., on 1/31/22, she did a skin assessment and observed what "appeared" to be non-intact blisters (quarter sized open areas without skin covering them) to Resident B's right shin, right forearm and on his left ankle by his left foot. LPN 3 notified the resident's son he had laid on the floor from approximately 1:00 a.m. to 10:00 a.m. She informed the son of the open areas she observed on the skin assessment she completed. LPN 3 did not notify Resident B's physician regarding the open areas she observed or he laid on the floor from approximately 1:00 a.m. to 10:00 a.m. She was not present when the EMS crew came and assisted the resident to bed because she was attending to another resident on the second floor. LPN 3 indicated she did not document any of the events from 1/31/22, in the resident's medical record, but she was going to go back and place a "late entry" piece of documentation in the resident's chart regarding the events, which occurred on 1/31/22. She indicated she did not take care of the resident on the 2/1/22,

	which was the day he was sent out in the early morning on the night shift. During an interview, on 2/11/22 at 11:54 a.m., the MCM indicated she was notified Resident B had skin areas by CNA 2 on 1/31/22, and she notified LPN 3 of those skin areas and she completed a skin assessment. On 2/1/22 at approximately 4:00 a.m., while the MCM was talking with QMA 9 on the phone regarding another resident being sent out to the hospital, QMA 9 informed her Resident B was worse than he had been earlier in the shift when the staff checked on him. The MCM indicated she thought QMA 9 was a nurse not a QMA, so after QMA 9 kept telling her he was getting worse, she told her to send the resident out to the hospital. She indicated she was not a clinical person, she was not qualified to assess residents and she did not know why the QMA was discussing Resident B's condition with her instead of calling the nurse on call. She informed the Interim ED of Resident B being sent to the hospital after the resident's son called her to tell her he would be in the facility at 8:00 a.m., for a meeting to discuss his father's care. During an interview, on 2/11/22 at 12:40 p.m., the son indicated Resident B lived on the Memory			

	Care unit at the facility. He fell on 1/31/22, sometime during the nightshift and staff left him on the floor until approximately 9:00 a.m., when the Fire department was called to assist him off the floor. He was assisted to bed, cleaned up, assessed for injuries and ate breakfast. On 2/1/22 at approximately 4:30 a.m., the son received a call indicating the resident was being sent to the hospital because he was in pain. While at the hospital, he was told by the Emergency Room (ER) staff, Resident B had numerous open wounds, a laceration, and bruising to his wrists, ankles, abdomen, knees and shoulders. The ER Doctor indicated the open wounds and blisters appeared to be "burn wounds," which may have occurred from where the resident attempted to get himself up, off the floor, after he fell, and laid there for an extended amount of time on 1/31/22. The son was not informed of the new areas, by the facility prior to going to the hospital. Resident B was admitted to the hospital for his injuries and he remained at the hospital as of 2/10/22. The ER Doctor indicated he did not feel it was safe for Resident B to be taken back to the facility he came from. He was not informed by the resident's physician, at the facility, the resident's bed was too short for			

	him and he had no idea he needed another bed. During an interview, on 2/11/22 at 2:11 p.m., CNA 8 indicated she worked on 1/31/22 to 2/1/22 from 10:00 p.m. to 6:00 a.m. She notified QMA 9, on 2/1/22 at approximately 3:30 a.m., regarding a "blister looking" wound on Resident B's abdomen, a scrap on his left knee, the back of his right shoulder, right forearm and hand was skinned. She had never observed him lay himself on the floor. His left knee was painful at the kneecap and he was unable to move. She had checked on Resident B two other times during her shift, but she did not know the exact times. The evening shift had told her in report they could not get the resident's brief up all the way because of he complained of pain to his left knee. She would always make sure she had assistance when she provided care for him because she was short. He could sit up in bed and stand up with his walker, but he was not able to do either that night due to he complained of pain to his left knee. During an interview, on 2/11/22 at 3:17 p.m., the Interim ED and Interim DON were in attendance. The Interim ED indicated QMA 9 did not report the open areas she observed on			

	Resident B on 2/1/22, to her, instead she reported the concerns to the MCM. The Interim ED indicated she did not report the wounds of unknown origin or the event of the resident found lying on the floor for an undetermined amount of time to the state and she did not investigate the cause of the wounds of unknown origin. She should have reported the wounds and investigated them when she became aware of them. On the morning of 1/31/22, QMA 11 should have called one of the three Nurses on call when she found Resident B on the floor, for further instructions on what she should have done. There were no documentation, the physician followed up with the son regarding the bed. The staff indicated he had laid himself on the floor. As far as she knew, the son was not called in an attempt to get him off the floor. The son would have come out to try to get him off the floor and the staff should have called him. There was no documentation for any of the events, which occurred for the night shift or dayshift on 1/31/22. After being shown the Service Plan of Resident B's, the Interim ED indicated there was no interventions for falls, the resident placed himself on the floor, the resident preferred to sleep on the floor versus his bed or his bed was not appropriate			

	for him due to his feet hung off the side of the bed. The MCM should not have instructed QMA 9 to send Resident B to the hospital. By giving QMA 9 those kind of instructions, she was working outside her scope of practice as a Memory Care Manager. The Interim ED indicated QMA 11 documented on the progress note, dated 2/1/22 at 4:25 a.m., that she instructed her to send Resident B to the hospital and this was incorrect, it was the MCM who instructed her to send him to the hospital. QMA 11 documented incorrectly. A current facility policy, titled "Resident Fall Response," dated 9/1/2016 and provided by the Interim ED on 2/10/22 at 4:18 p.m., indicated "Policy: To provide the staff guidance on responding to resident falls. Process: Assess Situation: Communicate with the resident and ask if he or she is in any pan and, if so, the location of the pain. Do not move the resident. Make the resident as comfortable as possible; use pillows and blankets as needed...Assess resident's discomfort...Perform a brief check of the resident to include feeling elbows, shoulders, back, hips and knees. If the resident is suspected to have struck their head or the resident was witnessed striking their head (even if no any [sic] injuries are			

	noted), IMMEDIATELY CALL 9-1-1. Emergency personnel should be informed that the resident needs to be assessed for a possible closed head injury. If the check reveals painful areas or bumps, or if his/her limbs are in an unnatural position, encourage the resident to remain on the floor until an ambulance arrives...Notify the Care Services Manager for further instructions. The Care Service Manager will: Decide whether transporting the resident to the hospital is/is not necessary. Ask for additional instructions. Direct staff to call to 9-1-1. Staff should follow instructions and be prepared to report observations (including vital signs) and information to emergency dispatcher. Direct staff to arrange non-emergency transportation to the hospital. Staff should follow instructions on how to arrange with hospital. If unable to reach the Care Service Manager or executive Director, call 9-1-1 immediately. Again, report observations (including vital signs) and information reported by the resident...Await Help...Do not, unless absolutely necessary, leave the resident alone until emergency assistance arrives...Documentation: Complete appropriate documentation following established procedures. Remedial measures taken to ensure resident safety (i.e.			

	frequent checks, Short Term Health Monitor Physical Therapy assessment, etc.). Measurement to prevent further falls to be added to Short Term Health Monitor and/or Negotiated Service Agreement. Reporting: Follow the Enivant Incident Reporting Guidelines for additional notifications that may be required. In addition, the Executive Director and/or Care Services Manager is responsible for following state-specific reporting guidelines." This Residential tag relates to Complaint IN00372446. Based on observation, interview and record review, the facility failed to ensure a resident was free from neglect when the facility failed to assist a cognitively impaired dementia resident off the floor, who had laid there an undetermined amount of time, the facility was unable to determine if the resident had fallen or placed himself onto the floor and the facility failed to investigate and report wounds of unknown origin to the Indiana Department of Health for 1 of 3 residents being reviewed for neglect (Resident B). Resident B developed open wounds of an unknown origin following being left on the floor for an undetermined amount of time.			

	Finding includes: A confidential interview was conducted during the course of the survey. The Confidential Interviewee indicated an EMS (Emergency Management Services) crew responded to a call for a resident who needed assistance off the floor on 1/31/22 at 9:50 a.m. The resident (Resident B) was located on the Memory Care unit and the EMS crew had been to this particular facility multiple times prior to assist the resident off the floor. When the EMS crew found the resident that particular day, he was found with vomit and feces on him. None of the staff who were working "seemed" to know what had happened or when it happened. The EMS crew was never able to determine who called 911 and asked for assistance to get the resident off the floor. None of the staff available at the time the EMS crew assisted the resident to bed indicated they had called 911. The EMS crew assisted the resident back to bed and the facility staff indicated they would clean the resident up. There was no ambulance dispatched to the facility because the call came across as a lift assist. There were no injuries at that time. Due to the EMS crew working 24 hour shifts, later in their shift			

	on 2/1/22 at 4:00 a.m., they were called back out to the same facility for the same resident (Resident B) for other medical complaints and he was transported to the hospital. The same EMS crew who came out to assist him on 1/31/22, came back out on 2/1/22 at 4:30 a.m. The ambulance and fire engine was sent out to the facility on this call because the call was sent out as a fall with an injured person. Resident B complained to the EMS crew about an abrasion on his left knee, swelling to this left knee and complaints of right shoulder pain. The EMS crew had concerns because the staff had called at 4:00 a.m., on 2/1/22, and the staff who came into the room indicated she had been on duty since 10:00 p.m., on 1/31/22, but she had just now made her rounds into Resident B's room. The facility staff indicated they were not given report on Resident B's status prior to the dayshift leaving the facility. The EMS crew was concerned the staff had waited since 10:00 p.m., before making rounds on Resident B. During an interview, on 2/10/22 at 4:30 p.m., CNA 2 indicated she met LPN 3 coming out of Resident B's room on 1/31/22. LPN 3 indicated he was on the floor and she was going to call 911. CNA 2 indicated the resident told her he did not fall,			

	he laid himself on the floor as he frequently did at times. He slid himself onto the floor to sleep because he did not like the bed he had. His bed had a black iron frame with a mattress. She went into his room to check on him and as she opened up the door, he asked her what she wanted. He was laying on his catheter, no blanket was used to cover him up or pillow was placed under his head. He had a T-Shirt and a brief on. CNA 2 had checked on him one other time, but she could not remember what time that was. She was with another resident when the EMS crew came up to the resident's room. There was no staff in his room when EMS arrived. She went to look for his nurse and while she was looking for his nurse, the EMS crew put the resident back to bed. CNA 2 indicated the EMS crew told her, the resident had vomit on him, but she did not find any vomit on him. She indicated there was some stool in his brief. CNA 2 indicated it was not unusual for Resident B to hang his feet from the edge of his bed because the bed length was too short for him. During an interview, on 2/10/22 at 8:15 a.m., with the Interim ED (Executive Director) and Interim DON (Director of Nursing) in attendance. The Interim ED indicated Resident B fell and got an abrasion to his left knee on			

	the night shift of 1/31/22. The paramedics came immediately to assist him off the floor. Staff indicated he would put himself on the floor and the medics and firemen would have to come and assist him back into bed. He would often put himself on the floor because his son bought him a new bed and he did not like the bed. He indicated to staff the bed was not comfortable and he preferred to lay on the floor. LPN 3 came into work on the dayshift, on 1/31/22. When she came on duty, she was told in report, Resident B had been laying on the floor since between 4:00 a.m. and 5:00 a.m., by his choice to sleep on the floor. Three different staff members had checked on him prior to 911 being called and nothing indicated at any of those times he had fallen. Nothing in his apartment was out of place, he was not injured, and every time a staff member checked on him, he indicated he was "fine" and he wanted to be left alone to sleep. At approximately 11:00 a.m. to 12:00 p.m., on 1/31/22, LPN 3 was able to get the resident to allow the EMS crew to assist him up into his bed. EMS crew had to assist him into bed when he placed himself on the floor because he was a large man and the staff could not get him up. The Interim ED and Interim			

	DON had no knowledge of the resident having emesis or feces on him when he was assisted back to bed. LPN 3 indicated she had asked the resident if he wanted to eat while lying on the floor and after getting back into bed and he did not want to eat. She did go get him two glasses of water as the EMS crew was exiting the elevator, so she was not in the resident's room when they arrived. LPN 3 notified the son regarding the resident being found lying on the floor and the EMS crew assisting him to bed. On 2/1/22, night shift, Resident B was transported to the hospital by ambulance between 4:00 a.m. and 5:00 a.m. CNA 8 and QMA 9 were on duty on the Memory Care unit. CNA 8 noticed a skin condition change in Resident B and reported the change to QMA 9 on 2/1/22 at 12:30 a.m. His left knee had an abrasion without a scab. This change was reported to the ED by QMA 9. The next time, CNA 8 checked on the resident and changed his brief on 2/1/22 at 4:00 a.m., he complained of pain. CNA 8 had to get assistance from another CNA to assist her to change his shirt and brief, which was out of the normal for Resident B. CNA 8 observed a blister on his stomach, an open skin area (area like a scrap) on the back of his right shoulder, an open skin area to his upper and outer			

	inner arm, inner forearm and his hand had an open skin area with a scrap. CNA 8 went and got QMA 9 who was speaking to the Memory Care Manager (MCM) at the time. QMA 9 talked about Resident B's condition and the MCM told her to send him to the hospital. During an interview, on 2/10/22 at 11:32 a.m., the Interim ED was in attendance and showed this surveyor pictures off a cellphone Resident B's son sent to her of some of his wounds which were observed in the ER at the hospital. She also had pictures of the way his apartment was set up prior to his son moving his bed out. Moving boxes were observed in the pictures. There was a picture observed of a bed with a black wrought iron frame in an oval/rectangle shape surrounding a mattress on the all the sides and the back of the frame. The front of the frame was left open. The mattress had brown rings on it. She indicated he placed himself on the floor and slept there due to his bed was uncomfortable because it was not long enough for him. A laminate tile type floor was observed under the bed. There was a chest of Drawers to the right side of the bed sitting on the laminate tile floor. Four wound pictures were observed. The left knee open wound had no skin with a red wound bed			

	and redness surrounding the wound. The abdomen picture was observed to have two yellow fluid filled blisters. The right shoulder picture was observed to have two open wounds with a red wound bed and pieces of shredded skin around the edges. The right forearm picture was observed to have an open wound with a red wound bed with shredded skin along the edges. The MCM instructed QMA 9 to send Resident B to the hospital because of these new wounds and he was in pain on 2/1/22. Resident B's record was reviewed on 2/10/22 at 12:00 p.m. Diagnoses included, but were not limited to, repeated falls, dementia, Type 2 diabetes mellitus and depression. A visit note from Resident B's physician, dated 12/10/21, indicated he had a difficult time sitting up during the assessment and was very weak. He was encouraged to participate in Physical Therapy (PT), so he could get stronger. The physician spoke to the resident's son regarding starting him on an antidepressant and he was agreeable. His review of systems indicated he had generalized weakness and depression. He was at risk for falls, had generalized weakness and was sedentary, so the physician was recommending			

PT.

The resident's record included, but were not limited to, the following progress notes:

On 1/19/22 at 5:40 a.m., the resident was found on the floor during the staff's final check for their shift. He was sitting on his bottom and leaning on the bed facing the door. He indicated he slid from the bed when trying to get up.

On 1/28/22 at 4:25 a.m., the resident complained of left knee pain. On a pain scale from 0 being no pain and 10 being the worst pain, he indicated his pain was a level 8 out of 10. Pain medication was given.

On 1/28/22 at 5:15 a.m., pain medication was effective.

On 1/29/22 at 3:45 a.m., the resident when touched during rounds screamed in pain. He had 2+ edema to his bilateral lower extremities. Pain medication given after getting permission from Interim ED. (Note written by QMA)

On 1/29/22 at 12:00 p.m., the writer (Interim ED) was at home and she received a call from the charge nurse who indicated the resident had 2+ non-pitting bilateral edema. The physician's office was notified and indicated the resident had no diagnosis of CHF, however his bed was not

	long enough and his feet hung over the edge, which was likely contributing to the bilateral edema. The physician's representative indicated this person would notify Resident B's family regarding the need for a different bed and the resident would be seen during the next scheduled visit to the facility. On 2/1/22 at 4:25 a.m., while providing care and doing a transfer, Resident B was in severe pain. There were bruises of unknown origin on the resident's right shoulder, right hand, and left thigh. He was sent to the ER for evaluation as instructed by the ED. The progress notes lacked documentation of the events, which occurred on the night and dayshifts of 1/31/22. Due to no written statements from QMA 9 and 11 about what took place during the incidents of 1/31/22 and 2/1/22, the inability to reach QMA 9 and 11 by phone for interviews and no documentation in the progress notes from staff members for the incidents, there was no way to determine if the resident fell on the floor, laid himself on the floor, or how long he was on the floor. An untitled document, from the Pike Township Fire Department, dated 2/1/22, indicated Resident			

	B's chief complaint was his right shoulder, left knee, and foot pain. His secondary complaint was his right abdomen and flank area. Under the comment section, a note was documented indicating the resident appeared to have burns to the upper right quadrant of his abdomen skin with a blister present. He had right flank and right back pain. He was uncooperative with the assessment and movement. He would not move his right arm to determine range of motion. His right anterior forearm had abrasions, which looked like a burn. The left medial knee had an abrasion with redness and swelling and he had pain to his left foot and heel. The ambulance was dispatched to the facility for an injured person. Resident B was lying in bed. The staff indicated to the EMS crew they were making their rounds and found the resident with an abrasion to his left medial knee with swelling, redness and he was having pain. He also complained of pain in his left foot and heel. He complained of right shoulder pain and yelled when the front and back of it was touched. He was not cooperative with the assessment or movement. He had what "appeared" to be blistered burns to his upper right quadrant abdomen and right flank area with matching burns to the front right forearm. Another EMS crew was on			

	scene indicating they were dispatched to this particular facility for this resident less than 24 hours ago for a lift assist and he was covered in feces and there was no staff present. The staff present at the time the EMS crew was at the facility on 2/1/22 at 4:50 a.m., indicated they were not given any report from the day shift about the resident falling or any injuries. They had just did their initial rounds on this resident for their night shift. The facility staff were not helpful in regards to the injuries the resident sustained. A document, titled "ER Triage Note," dated 2/1/22 at 5:19 a.m., indicated the chief complaint was a fall with injury on 1/31/22 with left shoulder, left knee and right foot pain and swelling. He had an unwitnessed fall and sustained some burns to the right chest wall and right shoulder on the Memory Care unit at the facility where he lived. There was nothing in the room for him to get burned on. EMS was called out for a lift assist 12 hours earlier and he was found in his own stool. He complained of constant, moderate and achy pain to his left knee, right ankle and right shoulder. He had dementia. He had swelling to his left knee and blistering to the right chest wall and the right shoulder. He needed a social work consult to discern his			

Memory Care situation and whether or not an APS (Adult Protective Services) report needed to be filed. He was not "safe to return to where he was living."

A document, titled "Injury Identification Log," dated 2/1/22 at 1:00 p.m., indicated the resident had the following wounds upon admission to the ER:

1. Right anterior (front) shoulder, the area measured 8 cm (centimeters) x 6 cm. The area contained two wounds with a moist pink wound bed and the wound edges had abraded skin.

2. Right outer forearm, the area measured 2 cm x greater than 8 cm. The area contained three wounds and the wound bed was brown with jagged wound edges with abraded skin edges.

3. Right upper inner forearm, the area measured approximately 8 cm x 8 cm. The area contained a wound, which measured 5 cm x 4 cm. The wound bed was beefy red with wound edges with abraded skin. The area was tender to palpation.

4. Right lower inner forearm, the area measured approximately 4 cm x 6 cm. The area contained an abrasion and multiple areas of yellow skin discoloration.

	5. Right upper medial quadrant of abdomen, the area measured approximately 7 cm x 7.5 cm of pink skin discoloration with a serous fluid filled pocket of skin resembling a blister present. The area was tender with palpitations. 6. Right upper distant quadrant of abdomen, the area contained a serous fluid filled pocket of skin resembling a blister, an area of pink skin discoloration and the area was tender to palpations. 7. Left inner knee, the area measured approximately 6 cm x 6 cm. The area contained a wound with a yellow wound bed and abraded skin on the would edges. There was pink skin discoloration surrounding the wound. 8. Left upper thigh, the area measured approximately 4 cm x 6 cm and contained multiple abrasions. A document, titled "Consult Note: Adult-Geriatric Medicine," from the hospital, dated 2/1/22 at 4:15 p.m., indicated the resident was brought to the ER from the facility he lived at by EMS after an unwitnessed fall on 1/31/22. EMS was at the facility twice on 1/31/22. The first time EMS went to the facility, Resident B was found in his own urine/feces and the staff			

	needed EMS to assist lift him. The second time EMS went to the facility, he was discovered down with new burns to his right arm and right chest which were not there when they were there the first time. Social work and Case Management were consulted. The Case Manager indicated the resident had suspicious burn marks on his chest, abdomen and shoulder and he would not be sent back to the facility. The resident had suspicious lesions from the facility and was unable to provide a history of events. There was a concern for neglect versus abuse at the facility. The physician in the ER was not comfortable sending the resident back to the facility and the son did not want his father to go back to the facility. A document, titled "Consult Note-Adult Burn Visit," from the hospital, dated 2/1/22 at 6:57 p.m., indicated the resident was brought to the ER by way of EMS after an unwitnessed fall at the facility on 1/31/22. The wound team was consulted to evaluate his wounds as there was a concern his wounds were for burn injuries. The resident did not remember being exposed to any heat or dropping hot liquid on him. The EMS was called twice to the facility on 2/1/22, regarding the resident. The first time, he was found in his own urine and feces and			

	needed EMS to assist lift him off the floor. EMS was called a second time and he was discovered down with new burns to his right arm and right chest which were not there earlier when EMS was there. The right arm wrist and forearm wounds had dark eschar. The right side antecubital and shoulder wounds "appear" to be a ruptured blister. The right shoulder wound "appear" to be a ruptured blister. The right abdominal area had a large blister, which was ruptured at the resident's bedside. All the wounds, except the right wrist and forearm, blanch easily. The resident did not remember sustaining any burns while at the facility. There was a question as to whether or not the resident was on the floor next to his bed for a considerable period of time. He had partial-thickness injuries to the left knee, right arm, right shoulder and right abdomen. The areas on the right arm and abdomen blanched. The areas on the left leg and right wrist were deeper partial-thickness injuries and did not blanch. The treatment will include antibiotic ointment and Santyl to help lift the eschar away, but if that did not work, the resident would most likely have to have a surgical debridement in the operating room. The facility service plan, for			

	Resident B, lacked fall interventions to prevent further falls, documentation indicating the resident preferred to lay on the floor to sleep due to his bed was uncomfortable to him, and that he placed himself on the floor at times and the EMS crew had to come to the facility to assist lift him back into bed. During an interview, on 2/10/22 at 3:50 p.m., with Resident B, in Resident B's hospital room, he indicated the early morning of 1/31/22, he fell. He was oriented to person and time. He indicated no staff member burned him with anything and he had no idea how he got the wounds. During an interview, on 2/11/22 at 11:13 a.m., LPN 3 indicated she arrived to the facility somewhere between 7:15 a.m. and 7:20 a.m., on 1/31/22. She received report from QMA 11. She asked how the residents on the 3rd floor were and she was told Resident B laid himself on the floor at 1:00 a.m., and had been on the floor ever since then, because he was uncomfortable laying in his bed. QMA 11 indicated he had placed himself on the floor, but no one had witnessed the resident place himself on the floor according to the information given to LPN 3. LPN 3 checked on the resident and he was laying on his right side on top of a blanket, but was not			

	covered up with a blanket and did not have a pillow under his head. He only had a brief and a T-shirt on. LPN 3 went back to check on Resident B at 8:00 a.m., and asked him to get up and get into the bed and he did not want to get up. At approximately 9:45 a.m., she decided to call 911 to have the EMS crew assist him off the floor. She did not call the EMS crew earlier because she was letting the resident exert his resident's rights and she did not want to infringe on his rights to lay on the floor if that was what he choose to do, but after lying on the floor for approximately nine hours, she indicated she had to do something because he had been on the floor for an excessive amount of time. After the EMS crew assisted him to bed at approximately 10:00 a.m., on 1/31/22, she did a skin assessment and observed what "appeared" to be non-intact blisters (quarter sized open areas without skin covering them) to Resident B's right shin, right forearm and on his left ankle by his left foot. LPN 3 notified the resident's son he had laid on the floor from approximately 1:00 a.m. to 10:00 a.m. She informed the son of the open areas she observed on the skin assessment she completed. LPN 3 did not notify Resident B's physician regarding the			

	open areas she observed or he laid on the floor from approximately 1:00 a.m. to 10:00 a.m. She was not present when the EMS crew came and assisted the resident to bed because she was attending to another resident on the second floor. LPN 3 indicated she did not document any of the events from 1/31/22, in the resident's medical record, but she was going to go back and place a "late entry" piece of documentation in the resident's chart regarding the events, which occurred on 1/31/22. She indicated she did not take care of the resident on the 2/1/22, which was the day he was sent out in the early morning on the night shift. During an interview, on 2/11/22 at 11:54 a.m., the MCM indicated she was notified Resident B had skin areas by CNA 2 on 1/31/22, and she notified LPN 3 of those skin areas and she completed a skin assessment. On 2/1/22 at approximately 4:00 a.m., while the MCM was talking with QMA 9 on the phone regarding another resident being sent out to the hospital, QMA 9 informed her Resident B was worse than he had been earlier in the shift when the staff checked on him. The MCM indicated she thought QMA 9 was a nurse not a QMA, so after QMA 9 kept telling her he was getting worse, she told			

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During an interview, on 2/11/22 at 12:40 p.m., the son indicated Resident B lived on the Memory Care unit at the facility. He fell on 1/31/22, sometime during the nightshift and staff left him on the floor until approximately 9:00 a.m., when the Fire department was called to assist him off the floor. He was assisted to bed, cleaned up, assessed for injuries and ate breakfast. On 2/1/22 at approximately 4:30 a.m., the son received a call indicating the resident was being sent to the hospital because he was in pain. While at the hospital, he was told by the Emergency Room (ER) staff, Resident B had numerous open wounds, a laceration, and bruising to his wrists, ankles, abdomen, knees and shoulders. The ER Doctor indicated the open wounds and blisters appeared to be "burn wounds," which may have

	occurred from where the resident attempted to get himself up, off the floor, after he fell, and laid there for an extended amount of time on 1/31/22. The son was not informed of the new areas, by the facility prior to going to the hospital. Resident B was admitted to the hospital for his injuries and he remained at the hospital as of 2/10/22. The ER Doctor indicated he did not feel it was safe for Resident B to be taken back to the facility he came from. He was not informed by the resident's physician, at the facility, the resident's bed was too short for him and he had no idea he needed another bed. During an interview, on 2/11/22 at 2:11 p.m., CNA 8 indicated she worked on 1/31/22 to 2/1/22 from 10:00 p.m. to 6:00 a.m. She notified QMA 9, on 2/1/22 at approximately 3:30 a.m., regarding a "blister looking" wound on Resident B's abdomen, a scrap on his left knee, the back of his right shoulder, right forearm and hand was skinned. She had never observed him lay himself on the floor. His left knee was painful at the kneecap and he was unable to move. She had checked on Resident B two other times during her shift, but she did not know the exact times. The evening shift had told her in report they could not get			

	the resident's brief up all the way because of he complained of pain to his left knee. She would always make sure she had assistance when she provided care for him because she was short. He could sit up in bed and stand up with his walker, but he was not able to do either that night due to he complained of pain to his left knee. During an interview, on 2/11/22 at 3:17 p.m., the Interim ED and Interim DON were in attendance. The Interim ED indicated QMA 9 did not report the open areas she observed on Resident B on 2/1/22, to her, instead she reported the concerns to the MCM. The Interim ED indicated she did not report the wounds of unknown origin or the event of the resident found lying on the floor for an undetermined amount of time to the state and she did not investigate the cause of the wounds of unknown origin. She should have reported the wounds and investigated them when she became aware of them. On the morning of 1/31/22, QMA 11 should have called one of the three Nurses on call when she found Resident B on the floor, for further instructions on what she should have done. There were no documentation, the physician followed up with the son regarding the bed. The staff			

	indicated he had laid himself on the floor. As far as she knew, the son was not called in an attempt to get him off the floor. The son would have come out to try to get him off the floor and the staff should have called him. There was no documentation for any of the events, which occurred for the night shift or dayshift on 1/31/22. After being shown the Service Plan of Resident B's, the Interim ED indicated there was no interventions for falls, the resident placed himself on the floor, the resident preferred to sleep on the floor versus his bed or his bed was not appropriate for him due to his feet hung off the side of the bed. The MCM should not have instructed QMA 9 to send Resident B to the hospital. By giving QMA 9 those kind of instructions, she was working outside her scope of practice as a Memory Care Manager. The Interim ED indicated QMA 11 documented on the progress note, dated 2/1/22 at 4:25 a.m., that she instructed her to send Resident B to the hospital and this was incorrect, it was the MCM who instructed her to send him to the hospital. QMA 11 documented incorrectly. A current facility policy, titled "Resident Fall Response," dated 9/1/2016 and provided by the Interim ED on 2/10/22 at 4:18 p.m., indicated "Policy: To			

	provide the staff guidance on responding to resident falls. Process: Assess Situation: Communicate with the resident and ask if he or she is in any pan and, if so, the location of the pain. Do not move the resident. Make the resident as comfortable as possible; use pillows and blankets as needed...Assess resident's discomfort...Perform a brief check of the resident to include feeling elbows, shoulders, back, hips and knees. If the resident is suspected to have struck their head or the resident was witnessed striking their head (even if no any [sic] injuries are noted), IMMEDIATELY CALL 9-1-1. Emergency personnel should be informed that the resident needs to be assessed for a possible closed head injury. If the check reveals painful areas or bumps, or if his/her limbs are in an unnatural position, encourage the resident to remain on the floor until an ambulance arrives...Notify the Care Services Manager for further instructions. The Care Service Manager will: Decide whether transporting the resident to the hospital is/is not necessary. Ask for additional instructions. Direct staff to call to 9-1-1. Staff should follow instructions and be prepared to report observations (including vital signs) and information to emergency dispatcher. Direct staff to arrange non-emergency			

	transportation to the hospital. Staff should follow instructions on how to arrange with hospital. If unable to reach the Care Service Manager or executive Director, call 9-1-1 immediately. Again, report observations (including vital signs) and information reported by the resident...Await Help...Do not, unless absolutely necessary, leave the resident alone until emergency assistance arrives...Documentation: Complete appropriate documentation following established procedures. Remedial measures taken to ensure resident safety (i.e. frequent checks, Short Term Health Monitor Physical Therapy assessment, etc.). Measurement to prevent further falls to be added to Short Term Health Monitor and/or Negotiated Service Agreement. Reporting: Follow the Enivant Incident Reporting Guidelines for additional notifications that may be required. In addition, the Executive Director and/or Care Services Manager is responsible for following state-specific reporting guidelines." This Residential tag relates to Complaint IN00372446.			
R 0090	Administration and Management - Deficiency	R 0090	**R 090 Administration and Management – Deficiency**	03/13/2022

	410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.		**1.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B was discharged to St. Vincent hospital effective 2/1/2022. Effective 2/15/2022, LPN 3 no longer provide services in the community. reported to IDOH on 3/1/2022 by the RDCS. The ED was re-educated on 2/11/2022 by the RDCS on investigation and reporting of unusual occurrence that directly threatens the welfare, safety, or health of a resident, including wounds of unknown origin. **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** An audit of current resident service notes for the last 30 days and skin assessments of memory care residents was completed on 3/1-3/2/2022 by the RDCS and the CSM to ensure an unusual occurrence that directly threatens the welfare, safety, or health of a residents is investigated and reported to IDOH. No concerns	

	(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on interview and record review, the facility failed to investigate and report wounds of unknown origin to the Indiana Department of Health for 1 of 3 residents being reviewed for accidents (Resident B). Findings include: A confidential interview was conducted during the course of the survey. The Confidential Interviewee indicated an EMS (Emergency Management Services) crew responded to a call for a resident who needed		identified. **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Current staff was re-educated on 3/2/2022 by the RDO the need to report to the ED or CSM an unusual occurrence that directly threatens the welfare, safety, or health of a resident, including wounds of unknown origin. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Effective 3/7/2022, the ED or designee will audit 5 random medical records in which the service notes from 3/2/2022 onward will be reviewed to determine if an unusual occurrence, including wound of unknown origin, has been investigated and reported. These audits will occur weekly times 3 months. Audits will be reviewed at monthly QI meeting. The QI Committee will determine if continued interviews are necessary based	

	assistance off the floor on 1/31/22 at 9:50 a.m. The resident (Resident B) was located on the Memory Care unit and the EMS crew had been to this particular facility multiple times prior to assist the resident off the floor. When the EMS crew found the resident, he was found with vomit and feces on him. None of the staff who were working "seemed" to know what had happened or when it happened with the resident. The EMS crew was never able to determine who called 911 and asked for assistance to get the resident off the floor. The EMS crew assisted the resident back to bed and the facility staff indicated they would clean the resident up. There was no ambulance dispatched to the facility at that time because the call came across as a lift assist. There were no injuries at that time. Due to the EMS crew working 24 hour shifts, later in their shift on 2/1/22 at 4:00 a.m., they were called back out to the same facility for the same resident (Resident B) for other medical complaints and he was transported to the hospital. The same EMS crew who came out to assist him on 1/31/22, came back out on 2/1/22 at 4:30 a.m. The ambulance and fire engine was sent out to the facility on this call because the call was		on 3 consecutive months. Monitoring will be on-going	

	sent out as a fall with an injured person. Resident B complained to the EMS crew about an abrasion on his left knee, swelling to this left knee and complaints of right shoulder pain. The EMS crew had concerns because the staff had called at 4:00 a.m., on 2/1/22, and the staff who came into the room indicated she had been on duty since 10:00 p.m., on 1/31/22, but she had just now made her rounds into Resident B's room. The EMS crew was concerned the staff had waited since 10:00 p.m., before making rounds on Resident B. During an interview, on 2/10/22 at 8:15 a.m., with the Interim ED (Executive Director) and Interim DON (Director of Nursing) in attendance. The Interim ED indicated Resident B fell and got an abrasion to his left knee on the night shift of 1/31/22. The paramedics came immediately to assist him off the floor. Staff indicated he would put himself on the floor and the medics and firemen would have to come and assist him back into bed. He would often put himself on the floor because his son bought him a new bed and he did not like the bed. He indicated to staff the bed was not comfortable and he preferred to lay on the floor. Three different staff members had checked on him prior to 911 being called and nothing			

	indicated at any of those times he had fallen. Nothing in his apartment was out of place, he was not injured, and every time a staff member checked on him, he indicated he was "fine" and he wanted to be left alone to sleep. On 2/1/22, night shift, Resident B was transported to the hospital by ambulance between 4:00 a.m. and 5:00 a.m. CNA 8 and QMA 9 were on duty on the Memory Care unit. CNA 8 noticed a skin condition change in Resident B and reported the change to QMA 9 on 2/1/22 at 12:30 a.m. His left knee had an abrasion without a scab and this change was reported to the ED by QMA 9. The next time CNA 8 checked on the resident and changed his brief on 2/1/22 at 4:00 a.m., he complained of pain. CNA 8 had to get assistance from another CNA to assist her to change his shirt and brief, which was out of the normal for Resident B. CNA 8 observed a blister on his stomach, an open skin area (area like a scrap) on the back of his right shoulder, an open skin area to his upper and outer inner arm, inner forearm and his hand had an open skin area with a scrap. CNA 8 went and got QMA 9. QMA 9 talked about Resident B's condition and the Memory Care Manager (MCM) told her to send him to the hospital on 2/1/22. The Interim			

	ED indicated she was the Nurse on call for the facility and she had no idea Resident B was being sent out to the hospital for emergent care. She was not informed of the resident being sent out until the MCM called the Interim ED on her way to the facility to discuss a phone call she had received from Resident B's son in the early morning. During an interview, on 2/10/22 at 11:32 a.m., the Interim ED was in attendance and showed this surveyor pictures off a cellphone Resident B's son sent to her of some of his wounds observed in the ER at the hospital. Four wound pictures were observed. The left knee open wound had no skin with a red wound bed and redness surrounding the wound. The abdomen picture was observed to have two yellow fluid filled blisters. The right shoulder picture was observed to have two open wound on the top front of his shoulder with a red wound bed and pieces of shredded skin around the edges. The right forearm picture was observed to have an open wound with a red wound bed with shredded skin with shredded skin along the edges. The MCM instructed QMA 9 to send Resident B to the hospital because of these new wounds and he was in pain on 2/1/22. Resident B's record was			

	reviewed on 2/10/22 at 12:00 p.m. Diagnoses included, but were not limited to, repeated falls, dementia, Type 2 diabetes mellitus, and depression. The resident's record included, but were not limited to, the following progress notes: On 2/1/22 at 4:25 a.m., while providing care and doing a transfer, Resident B was in severe pain. There were bruises of unknown origin on the resident's right shoulder, right hand, and left thigh. He was sent to the ER for evaluation as instructed by the ED. A document, untitled from the Pike Township Fire Department, dated 2/1/22, indicated Resident B's chief complaint was his right shoulder, left knee, and foot pain and his secondary complaint was his right abdomen and flank area. Under the comment section, a note was documented indicating the resident appeared to have burns to the upper right quadrant of his abdomen skin with a blister present. He had right flank and right back pain. He was uncooperative with the assessment and movement. He would not move his right arm to determine range of motion. His right anterior forearm had abrasions, which looked like a burn. The left medial knee had an abrasion with redness and			

	swelling and he had pain to his left foot and heel. The ambulance was dispatched to the facility for an injured person. Resident B was lying in bed. The staff indicated to the EMS crew they were making their rounds and found the resident with an abrasion to his left medial knee with swelling, redness and he was having pain. He also complained of pain in his left foot and heel. He complained of right shoulder pain and yelled when the front and back of it was touched. He had what "appeared" to be blistered burns to his upper right quadrant abdomen and right flank area with matching burns to the front right forearm. Another EMS crew was on scene indicating they were dispatched to this particular facility for this resident less than 24 hours ago for a lift assist and he was covered in feces and there was no staff present. The facility staff were not helpful in regards to the injuries the resident sustained. A document, titled "ER Triage Note," dated 2/1/22 at 5:19 a.m., indicated the chief complaint was fall with injury on 1/31/22 with left shoulder, left knee and right foot pain and swelling. He had an unwitnessed fall and sustained some burns to the right chest wall and right shoulder on the Memory Care unit at the facility			

	where he lived. There was nothing in the room for him to get burned on. EMS was called out for a lift assist 12 hours earlier and he was found n his own stool. He complained of constant, moderate and achy pain to his left knee, right ankle and right shoulder. He had dementia. He had swelling to his left knee and blistering to the right chest wall and the right shoulder. He needed a social work consult to discern his Memory Care situation and whether or not an APS (Adult Protective Services) report needed to be filed. He was not "safe to return to where he was living." A document, titled "Injury Identification Log" from the hospital, dated 2/1/22 at 1:00 p.m., indicated the resident had the following wounds upon admission to the ER: 1. Right anterior (front) shoulder, the area measured 8 cm (centimeters) x 6 cm. The area contained two wounds with a moist pink wound bed and the wound edges had abraded skin. 2. Right outer forearm, the area measured 2 cm x greater than 8 cm. The area contained three wounds and the wound bed was brown with jagged wound edges with abraded skin edges. 3. Right upper inner forearm,			

	the area measured approximately 8 cm x 8 cm. The area contained a wound, which measured 5 cm x 4 cm. The wound bed was beefy red with wound edges with abraded skin. The area was tender to palpation. 4. Right lower inner forearm, the area measured approximately 4 cm x 6 cm. The area contained an abrasion and multiple areas of yellow skin discoloration. 5. Right upper medial quadrant of abdomen, the area measured approximately 7 cm x 7.5 cm of pink skin discoloration with a serous fluid filled pocket of skin resembling a blister present. The area was tender with palpitations. 6. Right upper distant quadrant of abdomen, the area contained a serous fluid filled pocket of skin resembling a blister, an area of pink skin discoloration and the area was tender to palpations. 7. Left inner knee, the area measured approximately 6 cm x 6 cm. The area contained a wound with a yellow wound bed and abraded skin on the would edges. There was pink skin discoloration surrounding the wound. 8. Left upper thigh, he area measured approximately 4 cm x 6 cm and contained multiple			

abrasions.

A document, titled "Consult Note: Adult-Geriatric Medicine," from the hospital, dated 2/1/22 at 4:15 p.m., indicated the resident was brought to the ER from the facility he lived at by EMS after an unwitnessed fall on 1/31/22. EMS was at the facility twice on 1/31/22. The first time EMS went to the facility, Resident B was found in his own urine/feces and the staff needed EMS to assist lift him. The second time EMS went to the facility he was discovered down with new burns to his right arm and right chest which were not there when they were there the first time. Social work and Case Management were consulted. The Case Manager indicated the resident had suspicious burn marks on his chest, abdomen and shoulder and he would not be sent back to the facility. The resident had suspicious lesions from the facility and was unable to provide a history of events. There was a concern for neglect versus abuse at the facility. The physician in the ER was not comfortable sending the resident back to the facility and the son did not want his father to go back to the facility.

A document, titled "Consult Note-Adult Burn Visit," from the hospital, dated 2/1/22 at 6:57 p.m., indicated the resident was

	brought to the ER by way of EMS after an unwitnessed fall at the facility on 1/31/22. The wound team was consulted to evaluate his wounds as there was a concern his wounds were for burn injuries. The resident did not remember being exposed to any heat or dropping hot liquid on him. The EMS was called twice to the facility on 2/1/22, regarding the resident. The first time, he was found in his own urine and feces and needed EMS to assist lift him off the floor. EMS was called a second time and he was discovered down with new burns to his right arm and right chest which were not there earlier when EMS was there. The right arm wrist and forearm wounds had dark eschar. The right side antecubital and shoulder wounds "appear" to be a ruptured blister. The right shoulder wound "appear" to be a ruptured blister. The right abdominal area had a large blister, which was ruptured at the resident's bedside. All the wounds except the right wrist and forearm blanch easily. The resident did not remember sustaining any burns while at the facility. There was a question as to whether or not the resident was on the floor next to his bed for a considerable period of time. He had partial-thickness injuries to the left knee, right arm, right shoulder and right abdomen.			

	The areas on the right arm and abdomen blanched. The areas on the left leg and right wrist were deeper partial-thickness injuries and did not blanch. The treatment will include antibiotic ointment and Santyl to help lift the eschar away, but if that did not work, the resident would most likely have to have a surgical debridement in the operating room. During an interview, on 2/11/22 at 11:13 a.m., LPN 3 indicated she arrived to the facility between 7:15 a.m. and 7:20 a.m., on 1/31/22. She received report from QMA 11. She asked how the residents on the 3rd floor were and she was told Resident B laid himself on the floor at 1:00 a.m., and had been on the floor ever since then, because he was uncomfortable laying in his bed. QMA 11 indicated he had placed himself on the floor, but no one had witnessed the resident place himself on the floor according to the information given to LPN 3. At approximately 9:45 a.m., she decided to call 911 to have the EMS crew assist him off the floor. She did not call the EMS crew earlier because she was letting the resident exert his resident's rights and she did not want to infringe on his rights to lay on the floor if that was what he choose to do, but after laying on the floor for approximately nine hours, she indicated she			

	had to do something because he had been on the floor an excessive amount of time. After the EMS crew assisted him to bed, at approximately 10:00 a.m., on 1/31/22, she did a skin assessment and observed what "appeared" to be non-intact blisters (quarter sized open areas without skin covering them) to Resident B's right shin, right forearm, and on his left ankle by his left foot. She informed the son of the open areas she observed on the skin assessment she completed. LPN 3 did not notify Resident B's physician regarding the open areas she observed during the skin assessment she completed. LPN 3 indicated she did not document any of the events from 1/31/22, in the resident's medical record, but she was going to place a "late entry" piece of documentation in the resident's chart regarding the events. During an interview, on 2/11/22 at 11:54 a.m., the MCM indicated she was notified Resident B had skin areas by CNA 2 on 1/31/22, and she notified LPN 3 of those skin areas and she completed a skin assessment. On 2/1/22 at approximately 4:00 a.m., QMA 9 informed her Resident B was worse than he had been earlier in the shift when the staff checked on him. The MCM			

	indicated she told her to send the resident out to the hospital. She informed the Interim ED of Resident B being sent to the hospital after the resident's son called her to tell her he would be in the facility at 8:00 a.m., for a meeting to discuss his father's care. During an interview, on 2/11/22 at 12:40 p.m., the son indicated Resident B lived on the Memory Care unit at the facility. He fell on 1/31/22, sometime during the nightshift and staff left him on the floor until approximately 9:00 a.m., when the Fire department was called to assist him off the floor. He was assisted to bed, cleaned up, assessed for injuries and ate breakfast. On 2/1/22 at approximately 4:30 a.m., the son received a call indicating the resident was being sent to the hospital because he was in pain. While at the hospital, he was told by the Emergency Room (ER) staff, Resident B had numerous open wounds, a laceration and bruising to his wrists, ankles, abdomen, knees and shoulders. The ER Doctor indicated the open wounds and blisters appeared to be "burn wounds" which may have occurred from where the resident attempted to get himself up, off the floor, after he fell, and laid there for an extended amount of time on 1/31/22. The son was not			

	informed of the new areas, by the facility prior to going to the hospital. Resident B was admitted to the hospital for his injuries and he remained at the hospital as of 2/10/22. The ER Doctor indicated he did not feel it was safe for Resident B to be taken back to the facility he came from. During an interview, on 2/11/22 at 2:11 p.m., CNA 8 indicated she worked on 1/31/22 to 2/1/22 from 10:00 p.m. to 6:00 a.m. She notified QMA 9 on 2/1/22 at approximately 3:30 a.m., regarding a "blister looking" wound on Resident B's abdomen, a scrap on his left knee, the back of his right shoulder, right forearm and hand was skinned. She had never observed him lay himself on the floor. His left knee was painful at the kneecap and he was unable to move. CNA 8 indicated one of the EMS workers asked her if she was just then seeing the wounds on his body and she explained he had been in bed during her shift thus far and she had just taken off his shirt, so she had not seen those areas until that time. She had checked on Resident B two other times during her shift, but she did not know the exact times. The evening shift had told her in report they could not get the resident's brief up all the way because of he complained of pain to his left knee. She			

would always make sure she had assistance when she provided care for him because she was short. He could sit up in bed and stand up with his walker, but he was not able to do either that night due to he complained of pain to his left knee.

During an interview on 2/11/22 at 3:17 p.m., the Interim ED and Interim DON were in attendance. The Interim ED indicated QMA 9 did not report the open areas she observed on Resident B on 2/1/22, to her, instead she reported the concerns to the MCM. The Interim ED indicated she did not report the wounds of unknown origin or the event of the resident found lying on the floor for an undetermined amount of time to the state and she did not investigate the cause of the wounds of unknown origin. She should have reported the wounds and investigated them when she became aware of them. There was no documentation for any of the events, which occurred for the night shift or dayshift on 1/31/22.

A current policy, titled "Resident Fall Response," dated 9/1/2016 and provided by the Interim ED on 2/10/22 at 4:18 p.m., indicated "Policy: To provide the staff guidance on responding to resident falls. Process: Assess

	Situation: Communicate with the resident and ask if he or she is in any pan and, if so, the location of the pain. Do not move the resident. Make the resident as comfortable as possible; use pillows and blankets as needed...Assess resident's discomfort...Perform a brief check of the resident to include feeling elbows, shoulders, back, hips and knees. If the resident is suspected to have struck their head or the resident was witnessed striking their head (even if no any [sic] injuries are noted), IMMEDIATELY CALL 9-1-1. Emergency personnel should be informed that the resident needs to be assessed for a possible closed head injury. If the check reveals painful areas or bumps, or if his/her limbs are in an unnatural position, encourage the resident to remain on the floor until an ambulance arrives...Notify the Care Services Manager for further instructions. The Care Service Manager will: Decide whether transporting the resident to the hospital is/is not necessary. Ask for additional instructions. Direct staff to call to 9-1-1. Staff should follow instructions and be prepared to report observations (including vital signs) and information to emergency dispatcher. Direct staff to arrange non-emergency transportation to the hospital. Staff should follow instructions			

	on how to arrange with hospital. If unable to reach the Care Service Manager or executive Director, call 9-1-1 immediately. Again, report observations (including vital signs) and information reported by the resident...Await Help...Do not, unless absolutely necessary, leave the resident alone until emergency assistance arrives...Documentation: Complete appropriate documentation following established procedures. Remedial measures taken to ensure resident safety (i.e. frequent checks, Short Term Health Monitor Physical Therapy assessment, etc.). Measurement to prevent further falls to be added to Short Term Health Monitor and/or Negotiated Service Agreement. Reporting: Follow the Enivant Incident Reporting Guidelines for additional notifications that may be required. In addition, the Executive Director and/or Care Services Manager is responsible for following state-specific reporting guidelines." This Residential tag relates to Complaint IN00372446. Based on interview and record review, the facility failed to investigate and report wounds of unknown origin to the Indiana Department of Health for 1 of 3 residents being reviewed for			

	accidents (Resident B). Findings include: A confidential interview was conducted during the course of the survey. The Confidential Interviewee indicated an EMS (Emergency Management Services) crew responded to a call for a resident who needed assistance off the floor on 1/31/22 at 9:50 a.m. The resident (Resident B) was located on the Memory Care unit and the EMS crew had been to this particular facility multiple times prior to assist the resident off the floor. When the EMS crew found the resident, he was found with vomit and feces on him. None of the staff who were working "seemed" to know what had happened or when it happened with the resident. The EMS crew was never able to determine who called 911 and asked for assistance to get the resident off the floor. The EMS crew assisted the resident back to bed and the facility staff indicated they would clean the resident up. There was no ambulance dispatched to the facility at that time because the call came across as a lift assist. There were no injuries at that time. Due to the EMS crew working 24 hour shifts, later in their shift on 2/1/22 at 4:00 a.m., they			

	were called back out to the same facility for the same resident (Resident B) for other medical complaints and he was transported to the hospital. The same EMS crew who came out to assist him on 1/31/22, came back out on 2/1/22 at 4:30 a.m. The ambulance and fire engine was sent out to the facility on this call because the call was sent out as a fall with an injured person. Resident B complained to the EMS crew about an abrasion on his left knee, swelling to this left knee and complaints of right shoulder pain. The EMS crew had concerns because the staff had called at 4:00 a.m., on 2/1/22, and the staff who came into the room indicated she had been on duty since 10:00 p.m., on 1/31/22, but she had just now made her rounds into Resident B's room. The EMS crew was concerned the staff had waited since 10:00 p.m., before making rounds on Resident B. During an interview, on 2/10/22 at 8:15 a.m., with the Interim ED (Executive Director) and Interim DON (Director of Nursing) in attendance. The Interim ED indicated Resident B fell and got an abrasion to his left knee on the night shift of 1/31/22. The paramedics came immediately to assist him off the floor. Staff indicated he would put himself on the floor and the medics and firemen would have to come			

	and assist him back into bed. He would often put himself on the floor because his son bought him a new bed and he did not like the bed. He indicated to staff the bed was not comfortable and he preferred to lay on the floor. Three different staff members had checked on him prior to 911 being called and nothing indicated at any of those times he had fallen. Nothing in his apartment was out of place, he was not injured, and every time a staff member checked on him, he indicated he was "fine" and he wanted to be left alone to sleep. On 2/1/22, night shift, Resident B was transported to the hospital by ambulance between 4:00 a.m. and 5:00 a.m. CNA 8 and QMA 9 were on duty on the Memory Care unit. CNA 8 noticed a skin condition change in Resident B and reported the change to QMA 9 on 2/1/22 at 12:30 a.m. His left knee had an abrasion without a scab and this change was reported to the ED by QMA 9. The next time CNA 8 checked on the resident and changed his brief on 2/1/22 at 4:00 a.m., he complained of pain. CNA 8 had to get assistance from another CNA to assist her to change his shirt and brief, which was out of the normal for Resident B. CNA 8 observed a blister on his stomach, an open skin area			

	(area like a scrap) on the back of his right shoulder, an open skin area to his upper and outer inner arm, inner forearm and his hand had an open skin area with a scrap. CNA 8 went and got QMA 9. QMA 9 talked about Resident B's condition and the Memory Care Manager (MCM) told her to send him to the hospital on 2/1/22. The Interim ED indicated she was the Nurse on call for the facility and she had no idea Resident B was being sent out to the hospital for emergent care. She was not informed of the resident being sent out until the MCM called the Interim ED on her way to the facility to discuss a phone call she had received from Resident B's son in the early morning. During an interview, on 2/10/22 at 11:32 a.m., the Interim ED was in attendance and showed this surveyor pictures off a cellphone Resident B's son sent to her of some of his wounds observed in the ER at the hospital. Four wound pictures were observed. The left knee open wound had no skin with a red wound bed and redness surrounding the wound. The abdomen picture was observed to have two yellow fluid filled blisters. The right shoulder picture was observed to have two open wound on the top front of his shoulder with a red wound bed and pieces of shredded skin around the edges. The right			

	forearm picture was observed to have an open wound with a red wound bed with shredded skin with shredded skin along the edges. The MCM instructed QMA 9 to send Resident B to the hospital because of these new wounds and he was in pain on 2/1/22. Resident B's record was reviewed on 2/10/22 at 12:00 p.m. Diagnoses included, but were not limited to, repeated falls, dementia, Type 2 diabetes mellitus, and depression. The resident's record included, but were not limited to, the following progress notes: On 2/1/22 at 4:25 a.m., while providing care and doing a transfer, Resident B was in severe pain. There were bruises of unknown origin on the resident's right shoulder, right hand, and left thigh. He was sent to the ER for evaluation as instructed by the ED. A document, untitled from the Pike Township Fire Department, dated 2/1/22, indicated Resident B's chief complaint was his right shoulder, left knee, and foot pain and his secondary complaint was his right abdomen and flank area. Under the comment section, a note was documented indicating the resident appeared to have burns to the upper right			

	quadrant of his abdomen skin with a blister present. He had right flank and right back pain. He was uncooperative with the assessment and movement. He would not move his right arm to determine range of motion. His right anterior forearm had abrasions, which looked like a burn. The left medial knee had an abrasion with redness and swelling and he had pain to his left foot and heel. The ambulance was dispatched to the facility for an injured person. Resident B was lying in bed. The staff indicated to the EMS crew they were making their rounds and found the resident with an abrasion to his left medial knee with swelling, redness and he was having pain. He also complained of pain in his left foot and heel. He complained of right shoulder pain and yelled when the front and back of it was touched. He had what "appeared" to be blistered burns to his upper right quadrant abdomen and right flank area with matching burns to the front right forearm. Another EMS crew was on scene indicating they were dispatched to this particular facility for this resident less than 24 hours ago for a lift assist and he was covered in feces and there was no staff present. The facility staff were not helpful in regards to the injuries the resident sustained.			

	A document, titled "ER Triage Note," dated 2/1/22 at 5:19 a.m., indicated the chief complaint was fall with injury on 1/31/22 with left shoulder, left knee and right foot pain and swelling. He had an unwitnessed fall and sustained some burns to the right chest wall and right shoulder on the Memory Care unit at the facility where he lived. There was nothing in the room for him to get burned on. EMS was called out for a lift assist 12 hours earlier and he was found n his own stool. He complained of constant, moderate and achy pain to his left knee, right ankle and right shoulder. He had dementia. He had swelling to his left knee and blistering to the right chest wall and the right shoulder. He needed a social work consult to discern his Memory Care situation and whether or not an APS (Adult Protective Services) report needed to be filed. He was not "safe to return to where he was living." A document, titled "Injury Identification Log" from the hospital, dated 2/1/22 at 1:00 p.m., indicated the resident had the following wounds upon admission to the ER: 1. Right anterior (front) shoulder, the area measured 8 cm (centimeters) x 6 cm. The area contained two wounds with			

a moist pink wound bed and the wound edges had abraded skin.

2. Right outer forearm, the area measured 2 cm x greater than 8 cm. The area contained three wounds and the wound bed was brown with jagged wound edges with abraded skin edges.

3. Right upper inner forearm, the area measured approximately 8 cm x 8 cm. The area contained a wound, which measured 5 cm x 4 cm. The wound bed was beefy red with wound edges with abraded skin. The area was tender to palpation.

4. Right lower inner forearm, the area measured approximately 4 cm x 6 cm. The area contained an abrasion and multiple areas of yellow skin discoloration.

5. Right upper medial quadrant of abdomen, the area measured approximately 7 cm x 7.5 cm of pink skin discoloration with a serous fluid filled pocket of skin resembling a blister present. The area was tender with palpitations.

6. Right upper distant quadrant of abdomen, the area contained a serous fluid filled pocket of skin resembling a blister, an area of pink skin discoloration and the area was tender to palpations.

7. Left inner knee, the area

	measured approximately 6 cm x 6 cm. The area contained a wound with a yellow wound bed and abraded skin on the would edges. There was pink skin discoloration surrounding the wound. 8. Left upper thigh, he area measured approximately 4 cm x 6 cm and contained multiple abrasions. A document, titled "Consult Note: Adult-Geriatric Medicine," from the hospital, dated 2/1/22 at 4:15 p.m., indicated the resident was brought to the ER from the facility he lived at by EMS after an unwitnessed fall on 1/31/22. EMS was at the facility twice on 1/31/22. The first time EMS went to the facility, Resident B was found in his own urine/feces and the staff needed EMS to assist lift him. The second time EMS went to the facility he was discovered down with new burns to his right arm and right chest which were not there when they were there the first time. Social work and Case Management were consulted. The Case Manager indicated the resident had suspicious burn marks on his chest, abdomen and shoulder and he would not be sent back to the facility. The resident had suspicious lesions from the facility and was unable to provide a history of events. There was a concern for neglect			

	versus abuse at the facility. The physician in the ER was not comfortable sending the resident back to the facility and the son did not want his father to go back to the facility. A document, titled "Consult Note-Adult Burn Visit," from the hospital, dated 2/1/22 at 6:57 p.m., indicated the resident was brought to the ER by way of EMS after an unwitnessed fall at the facility on 1/31/22. The wound team was consulted to evaluate his wounds as there was a concern his wounds were for burn injuries. The resident did not remember being exposed to any heat or dropping hot liquid on him. The EMS was called twice to the facility on 2/1/22, regarding the resident. The first time, he was found in his own urine and feces and needed EMS to assist lift him off the floor. EMS was called a second time and he was discovered down with new burns to his right arm and right chest which were not there earlier when EMS was there. The right arm wrist and forearm wounds had dark eschar. The right side antecubital and shoulder wounds "appear" to be a ruptured blister. The right shoulder wound "appear" to be a ruptured blister. The right abdominal area had a large blister, which was ruptured at the resident's bedside. All the wounds except the right wrist			

	and forearm blanch easily. The resident did not remember sustaining any burns while at the facility. There was a question as to whether or not the resident was on the floor next to his bed for a considerable period of time. He had partial-thickness injuries to the left knee, right arm, right shoulder and right abdomen. The areas on the right arm and abdomen blanched. The areas on the left leg and right wrist were deeper partial-thickness injuries and did not blanch. The treatment will include antibiotic ointment and Santyl to help lift the eschar away, but if that did not work, the resident would most likely have to have a surgical debridement in the operating room. During an interview, on 2/11/22 at 11:13 a.m., LPN 3 indicated she arrived to the facility between 7:15 a.m. and 7:20 a.m., on 1/31/22. She received report from QMA 11. She asked how the residents on the 3rd floor were and she was told Resident B laid himself on the floor at 1:00 a.m., and had been on the floor ever since then, because he was uncomfortable laying in his bed. QMA 11 indicated he had placed himself on the floor, but no one had witnessed the resident place himself on the floor according to the information given to LPN 3. At approximately 9:45 a.m., she			

	decided to call 911 to have the EMS crew assist him off the floor. She did not call the EMS crew earlier because she was letting the resident exert his resident's rights and she did not want to infringe on his rights to lay on the floor if that was what he choose to do, but after laying on the floor for approximately nine hours, she indicated she had to do something because he had been on the floor an excessive amount of time. After the EMS crew assisted him to bed, at approximately 10:00 a.m., on 1/31/22, she did a skin assessment and observed what "appeared" to be non-intact blisters (quarter sized open areas without skin covering them) to Resident B's right shin, right forearm, and on his left ankle by his left foot. She informed the son of the open areas she observed on the skin assessment she completed. LPN 3 did not notify Resident B's physician regarding the open areas she observed during the skin assessment she completed. LPN 3 indicated she did not document any of the events from 1/31/22, in the resident's medical record, but she was going to place a "late entry" piece of documentation in the resident's chart regarding the events. During an interview, on 2/11/22 at 11:54 a.m., the MCM			

	indicated she was notified Resident B had skin areas by CNA 2 on 1/31/22, and she notified LPN 3 of those skin areas and she completed a skin assessment. On 2/1/22 at approximately 4:00 a.m., QMA 9 informed her Resident B was worse than he had been earlier in the shift when the staff checked on him. The MCM indicated she told her to send the resident out to the hospital. She informed the Interim ED of Resident B being sent to the hospital after the resident's son called her to tell her he would be in the facility at 8:00 a.m., for a meeting to discuss his father's care. During an interview, on 2/11/22 at 12:40 p.m., the son indicated Resident B lived on the Memory Care unit at the facility. He fell on 1/31/22, sometime during the nightshift and staff left him on the floor until approximately 9:00 a.m., when the Fire department was called to assist him off the floor. He was assisted to bed, cleaned up, assessed for injuries and ate breakfast. On 2/1/22 at approximately 4:30 a.m., the son received a call indicating the resident was being sent to the hospital because he was in pain. While at the hospital, he was told by the Emergency Room (ER) staff, Resident B had numerous open wounds, a laceration and bruising to his			

	wrists, ankles, abdomen, knees and shoulders. The ER Doctor indicated the open wounds and blisters appeared to be "burn wounds" which may have occurred from where the resident attempted to get himself up, off the floor, after he fell, and laid there for an extended amount of time on 1/31/22. The son was not informed of the new areas, by the facility prior to going to the hospital. Resident B was admitted to the hospital for his injuries and he remained at the hospital as of 2/10/22. The ER Doctor indicated he did not feel it was safe for Resident B to be taken back to the facility he came from. During an interview, on 2/11/22 at 2:11 p.m., CNA 8 indicated she worked on 1/31/22 to 2/1/22 from 10:00 p.m. to 6:00 a.m. She notified QMA 9 on 2/1/22 at approximately 3:30 a.m., regarding a "blister looking" wound on Resident B's abdomen, a scrap on his left knee, the back of his right shoulder, right forearm and hand was skinned. She had never observed him lay himself on the floor. His left knee was painful at the kneecap and he was unable to move. CNA 8 indicated one of the EMS workers asked her if she was just then seeing the wounds on his body and she explained he had been in bed during her shift			

	thus far and she had just taken off his shirt, so she had not seen those areas until that time. She had checked on Resident B two other times during her shift, but she did not know the exact times. The evening shift had told her in report they could not get the resident's brief up all the way because of he complained of pain to his left knee. She would always make sure she had assistance when she provided care for him because she was short. He could sit up in bed and stand up with his walker, but he was not able to do either that night due to he complained of pain to his left knee. During an interview on 2/11/22 at 3:17 p.m., the Interim ED and Interim DON were in attendance. The Interim ED indicated QMA 9 did not report the open areas she observed on Resident B on 2/1/22, to her, instead she reported the concerns to the MCM. The Interim ED indicated she did not report the wounds of unknown origin or the event of the resident found lying on the floor for an undetermined amount of time to the state and she did not investigate the cause of the wounds of unknown origin. She should have reported the wounds and investigated them when she became aware of them. There was no documentation for any of the			

	events, which occurred for the night shift or dayshift on 1/31/22. A current policy, titled "Resident Fall Response," dated 9/1/2016 and provided by the Interim ED on 2/10/22 at 4:18 p.m., indicated "Policy: To provide the staff guidance on responding to resident falls. Process: Assess Situation: Communicate with the resident and ask if he or she is in any pan and, if so, the location of the pain. Do not move the resident. Make the resident as comfortable as possible; use pillows and blankets as needed...Assess resident's discomfort...Perform a brief check of the resident to include feeling elbows, shoulders, back, hips and knees. If the resident is suspected to have struck their head or the resident was witnessed striking their head (even if no any [sic] injuries are noted), IMMEDIATELY CALL 9-1-1. Emergency personnel should be informed that the resident needs to be assessed for a possible closed head injury. If the check reveals painful areas or bumps, or if his/her limbs are in an unnatural position, encourage the resident to remain on the floor until an ambulance arrives...Notify the Care Services Manager for further instructions. The Care Service Manager will: Decide whether transporting the			

	resident to the hospital is/is not necessary. Ask for additional instructions. Direct staff to call to 9-1-1. Staff should follow instructions and be prepared to report observations (including vital signs) and information to emergency dispatcher. Direct staff to arrange non-emergency transportation to the hospital. Staff should follow instructions on how to arrange with hospital. If unable to reach the Care Service Manager or executive Director, call 9-1-1 immediately. Again, report observations (including vital signs) and information reported by the resident...Await Help...Do not, unless absolutely necessary, leave the resident alone until emergency assistance arrives...Documentation: Complete appropriate documentation following established procedures. Remedial measures taken to ensure resident safety (i.e. frequent checks, Short Term Health Monitor Physical Therapy assessment, etc.). Measurement to prevent further falls to be added to Short Term Health Monitor and/or Negotiated Service Agreement. Reporting: Follow the Enivant Incident Reporting Guidelines for additional notifications that may be required. In addition, the Executive Director and/or Care Services Manager is responsible for following state-specific reporting			

	guidelines." This Residential tag relates to Complaint IN00372446.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services	R 0217	**R 217 Evaluation – Deficiency** **1.** **What corrective action(s) will be accomplished for those residents found to** **have been affected by the deficient practice:** Resident B was discharged to St. Vincent hospital effective 2/1/2022. **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective** **action will be taken:** completed on 3/2/2022 by the RDCS to ensure the service plans reflect services provided for fall safety, interventions to reduce fall risk, and resident preferences. No concerns identified. **3 What measure will be put into place or what systemic changes the** **facility will make to ensure that the deficient practice does not recur:** The ED and Regional Care	03/13/2022

provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.

(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.

Based on interview and record review, the facility failed to update the service plan to reflect services provided for fall safety for 1 of 3 residents reviewed for service plans (Resident B).

Finding includes:

A confidential interview was conducted during the course of the survey. The Confidential Interviewee indicated an EMS (Emergency Management Services) crew responded to a call for a resident who needed assistance off the floor on 1/31/22 at 9:50 a.m. The resident (Resident B) was located on the Memory Care unit and the EMS crew had been to this particular facility multiple times prior to assist the resident off the floor. None of the staff who were working "seemed" to know what had happened or when it happened with the resident. The EMS crew assisted the resident back to bed. There was no ambulance

Specialist (RCS) were re-educated on 2/11/2022 by the RDCS toensure resident service plans reflect services provided for fall safety, interventions to reduce fall risk, and resident preferences.
Current staff were re-educated on 3/2/2022 by the RDO on the need toinform the ED or CSM of changes in services provided for fall safety, interventions for fall risk, and resident preferences to ensure resident service plans are updated.

4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:

Effective 3/7/2022, the ED or designee will audit 5 random service plansto ensure the service plans reflect services provided for fall safety, interventions to reduce fall risk, and resident preferences. These audits will occur weekly times 3 months. Audits will be reviewed at monthly QI meeting. The QI Committee will determine if continued interviews are necessary based on 3 consecutive months. Monitoring will be

	dispatched to the facility because the call came across as a lift assist. There were no injuries at that time. During an interview, on 2/10/22 at 4:30 p.m., CNA 2 indicated she met LPN 3 coming out of Resident B's room. LPN 3 indicated the resident was on the floor and she was going to call 911. CNA 2 indicated the resident told her, he did not fall, he laid himself on the floor as he frequently did at times. He slid himself onto the floor at times to sleep because he did not like the bed he had. CNA 2 indicated it was not unusual for Resident B to hang his feet from the edge of his bed because the bed length was too short for him. During an interview, on 2/10/22 at 8:15 a.m., with the Interim ED (Executive Director) and Interim DON (Director of Nursing) in attendance. The Interim ED indicated Resident B fell and got an abrasion to his left knee on the night shift of 1/31/22. He would often put himself on the floor because his son bought him a new bed and he did not like the bed. He indicated to the staff the bed was not comfortable and he preferred to lay on the floor. Resident B's record was reviewed on 2/10/22 at 12:00 p.m. Diagnoses included, but		on-going	

were not limited to, repeated falls, dementia, Type 2 diabetes mellitus, and depression.

A visit note from Resident B's physician, dated 12/10/21, indicated he had a difficult time sitting up during the assessment and was very weak. He was encouraged to participate in Physical Therapy (PT), so he could get stronger. He was at risk for falls, had generalized weakness and was sedentary, so the physician was recommending PT.

The resident's record included, but were not limited to, the following progress notes:

On 1/19/22 at 5:40 a.m., the resident was found on the floor during the staff's final check for their shift. He was sitting on his bottom and leaning on the bed facing the door. He indicated he slid from the bed when trying to get up.

On 1/29/22 at 12:00 p.m., the writer (Interim ED) was at home and she received a call from the charge nurse who indicated the resident had 2+ non-pitting bilateral edema. The physician's office was notified and indicated the resident had no diagnosis of CHF, however his bed was not long enough and his feet hang over the edge, which was likely contributing to the bilateral edema. The physician's

representative indicated they would notify Resident B's family regarding the need for a different bed and the resident would be seen during the next scheduled visit to the facility.

The Service Plan lacked fall interventions to prevent further falls, documentation indicating the resident preferred to lay on the floor to sleep due to his bed was uncomfortable to him, and that he placed himself on the floor at times and the EMS crew had to come to the facility to assist lift him back into bed.

During an interview, on 2/11/22 at 11:13 a.m., LPN 3 indicated she arrived somewhere between 7:15 a.m. and 7:20 a.m., on 1/31/22. She received report from QMA 11. She asked how the residents on the 3rd floor were and she was told Resident B laid himself on the floor at 1:00 a.m., and had been on the floor ever since then, because he was uncomfortable laying in his bed. QMA 11 indicated he had placed himself on the floor, but no one had witnessed the resident place himself on the floor according to the information given to LPN 3. At approximately 9:45 a.m., she decided to call 911 to have the EMS crew assist him off the floor. She did not call the EMS crew earlier because she was letting the resident exert his resident's rights and she did not

want to infringe on his rights to lay on the floor if that was what he choose to do, but after laying on the floor for approximately nine hours, she indicated she had to do something because he had been on the floor an excessive amount of time. She indicated she looked at the resident's Service Plan for his fall interventions and to see if he normally laid on the floor and refused to get up because this was only her second or third time taking care of him, but when she looked at it, his Service Plan did not have any of that information in it for her.

During an interview, on 2/11/22 at 3:17 p.m., the Interim ED and Interim DON were in attendance. After being shown the Service Plan of Resident B's, the Interim ED indicated there was no interventions for falls, that the resident placed himself on the floor, the resident preferred to sleep on the floor versus his bed or his bed was not appropriate for him due to his feet hung off the side of the bed. She indicated his service plan should have been updated with the fall interventions and the information regarding his bed.

This Residential tag relates to Complaint IN00372446.

Based on interview and record review, the facility failed to

update the service plan to reflect services provided for fall safety for 1 of 3 residents reviewed for service plans (Resident B).

Finding includes:

A confidential interview was conducted during the course of the survey. The Confidential Interviewee indicated an EMS (Emergency Management Services) crew responded to a call for a resident who needed assistance off the floor on 1/31/22 at 9:50 a.m. The resident (Resident B) was located on the Memory Care unit and the EMS crew had been to this particular facility multiple times prior to assist the resident off the floor. None of the staff who were working "seemed" to know what had happened or when it happened with the resident. The EMS crew assisted the resident back to bed. There was no ambulance dispatched to the facility because the call came across as a lift assist. There were no injuries at that time.

During an interview, on 2/10/22 at 4:30 p.m., CNA 2 indicated she met LPN 3 coming out of Resident B's room. LPN 3 indicated the resident was on the floor and she was going to call 911. CNA 2 indicated the resident told her, he did not fall, he laid himself on the floor as he

frequently did at times. He slid himself onto the floor at times to sleep because he did not like the bed he had. CNA 2 indicated it was not unusual for Resident B to hang his feet from the edge of his bed because the bed length was too short for him.

During an interview, on 2/10/22 at 8:15 a.m., with the Interim ED (Executive Director) and Interim DON (Director of Nursing) in attendance. The Interim ED indicated Resident B fell and got an abrasion to his left knee on the night shift of 1/31/22. He would often put himself on the floor because his son bought him a new bed and he did not like the bed. He indicated to the staff the bed was not comfortable and he preferred to lay on the floor.

Resident B's record was reviewed on 2/10/22 at 12:00 p.m. Diagnoses included, but were not limited to, repeated falls, dementia, Type 2 diabetes mellitus, and depression.

A visit note from Resident B's physician, dated 12/10/21, indicated he had a difficult time sitting up during the assessment and was very weak. He was encouraged to participate in Physical Therapy (PT), so he could get stronger. He was at risk for falls, had generalized weakness and was sedentary,

so the physician was recommending PT.

The resident's record included, but were not limited to, the following progress notes:

On 1/19/22 at 5:40 a.m., the resident was found on the floor during the staff's final check for their shift. He was sitting on his bottom and leaning on the bed facing the door. He indicated he slid from the bed when trying to get up.

On 1/29/22 at 12:00 p.m., the writer (Interim ED) was at home and she received a call from the charge nurse who indicated the resident had 2+ non-pitting bilateral edema. The physician's office was notified and indicated the resident had no diagnosis of CHF, however his bed was not long enough and his feet hang over the edge, which was likely contributing to the bilateral edema. The physician's representative indicated they would notify Resident B's family regarding the need for a different bed and the resident would be seen during the next scheduled visit to the facility.

The Service Plan lacked fall interventions to prevent further falls, documentation indicating the resident preferred to lay on the floor to sleep due to his bed was uncomfortable to him, and that he placed himself on the

floor at times and the EMS crew had to come to the facility to assist lift him back into bed.

During an interview, on 2/11/22 at 11:13 a.m., LPN 3 indicated she arrived somewhere between 7:15 a.m. and 7:20 a.m., on 1/31/22. She received report from QMA 11. She asked how the residents on the 3rd floor were and she was told Resident B laid himself on the floor at 1:00 a.m., and had been on the floor ever since then, because he was uncomfortable laying in his bed. QMA 11 indicated he had placed himself on the floor, but no one had witnessed the resident place himself on the floor according to the information given to LPN 3. At approximately 9:45 a.m., she decided to call 911 to have the EMS crew assist him off the floor. She did not call the EMS crew earlier because she was letting the resident exert his resident's rights and she did not want to infringe on his rights to lay on the floor if that was what he choose to do, but after laying on the floor for approximately nine hours, she indicated she had to do something because he had been on the floor an excessive amount of time. She indicated she looked at the resident's Service Plan for his fall interventions and to see if he normally laid on the floor and refused to get up because this was only her second or third

	time taking care of him, but when she looked at it, his Service Plan did not have any of that information in it for her. During an interview, on 2/11/22 at 3:17 p.m., the Interim ED and Interim DON were in attendance. After being shown the Service Plan of Resident B's, the Interim ED indicated there was no interventions for falls, that the resident placed himself on the floor, the resident preferred to sleep on the floor versus his bed or his bed was not appropriate for him due to his feet hung off the side of the bed. She indicated his service plan should have been updated with the fall interventions and the information regarding his bed. This Residential tag relates to Complaint IN00372446.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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