

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE CARMEL		STREET ADDRESS, CITY, STATE, ZIP CODE 301 EXECUTIVE DR, CARMEL, , 46032			
(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 IN00394354. Complaint IN00394354 - Substantiated. State deficiencies related to the allegations were cited at R0052. Survey date: November 18, 2022 Facility number: 010416 Residential Census: 53 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review was completed on November 30, 2022.	R 0000			
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;	R 0052	This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or the proposed administrative penalty (with right	12/16/2022	

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- (2) physical abuse;
- (3) mental abuse;
- (4) corporal punishment;
- (5) neglect; and
- (6) involuntary seclusion.

Based on observation, interview and record review, the facility failed to ensure a cognitively impaired resident was free from neglect, related to the resident was not assessed for injuries by a licensed nurse, transferred immediately off the floor after a fall, was not fed dinner and he was not transported in a safe manner from his room to the lounge area after he was picked up off the floor for 1 of 3 residents reviewed for neglect. (Resident B) Resident B laid on the floor in his room for six hours after a fall.

Findings include:

Resident B's record was reviewed on 11/18/22 at 3:15 p.m. Diagnoses included, but were not limited to, major neurologist disorder with psychosis, dementia, degenerative joint disease, hypertension, and chronic kidney disease

The resident's record lacked documentation indicating he had fallen or was left on the

to correct) on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigating factors.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

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CNA 3 was terminated. LPN 5 was a contract labor associate and will no longer be utilized at the facility. Resident was assessed and found to have no injuries from fall or lying on the floor. POA and MD notified.

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?

Facility considers all residents with memory

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floor for six hours on 11/3/22.

A document, titled "Type of Alleged Incident: Video Content Concern from Safely You email," dated 11/7/22 and provided by the DNS on 11/18/22 at 3:30 p.m., indicated a notification was sent from Safely You (camera technology, software, and video monitoring/recording hardware to detect unwitnessed resident falls to determine the causes of falls) by email on 11/7/22 at 10:38 a.m., of the occurrence, which occurred on 11/3/22 at 3:56 p.m. The video showed Resident B scooted off the bed and fell back. At 5:06 p.m., CNA 3 came into the resident's room to check on him and left him on the floor. Resident B was left on the floor, in his room, for six hours.

The timeline of the events, which occurred on 11/3/22, indicated Resident B fell in his room, then the following events were when staff interacted with the resident during the six hours he was secluded and the care they provided for him according to the video footage the DNS observed and documented on 11/7/22 at 10:38 a.m.

At 4:55 p.m., CNA 3 brought Resident B into his room and placed him in bed. She placed a pillow on the floor next to his bed and walked out of the room.

impairment to be at a high risk for falls. All residents who were cared for by CNA 3 and LPN 5 are memory impaired and therefore at risk to be affected by deficient practice. 30 residents had the potential to be affected by deficient practice.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

CNA 3 employment has been terminated. LPN 5 is contract labor associate who will no longer be utilized at community. All associates inserviced on abuse, use of mechanical lifts and SafelyYou fall management program. All associates inserviced on post fall protocols including notifications to charge nurse for all falls, assessing residents post fall and transferring residents to a safe space after assessment.

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?

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After CNA 3 left the room, the resident got out of bed and onto the floor in a kneeling position next to the bed.

At 4:57 p.m., he attempted to stand up and fell. At that time, someone opened the door and looked in the room, then closed the door.

At 5:06 p.m., CNA 3 entered Resident B's room and placed the Hoyer lift machine and his wheelchair in the bathroom. She closed the bathroom door, then stood over Resident B for a few seconds, then walked to the doorway, while looking back at the resident. CNA 3 walked back over to the resident, then she turned him over onto his left side.

At 5:07 p.m., CNA 3 left the resident's room and shut the door behind her.

At 5:14 p.m., LPN 5 went into Resident B's room and gave him a drink of lemonade while he was laying on the floor, then she walked out of the room and came back into the room and gave him more lemonade to drink while standing/leaning over him. At that time, the resident's shirt was off him. At that time, LPN 5 did not know the resident had fallen.

Facility was able to self-identify deficient practice and take appropriate next steps to initiate investigation, terminate associates involved and report incident to appropriate entities. ED or designee will continue to monitor all falls and ensure fall protocols are followed on a daily basis. Facility will complete quality assurance audit 5x weekly for 4 weeks followed by 1x weekly for 4 weeks followed by 1x monthly until deficient practice is corrected.

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At 5:16 p.m., LPN 5 left the resident's room shutting his room door as she left the room.

At 5:22 p.m., someone opened the resident's door, then closed it without entering the room.

At 6:13 p.m., CNA 3 entered the resident's room and placed a comforter on the end of his bed, then she left the room, shutting his room door as she left the room. At that time, the resident's shirt remained off, while his brief and pants were now down, and he was laying up against the wall by the closet.

At 6:16 p.m., CNA 3 entered Resident B's room and placed clothes in his dresser and walked past the resident again, who was laying in the same position as before at 6:13 p.m. and walked out of his room.

At 6:17 p.m., CNA 3 returned to the resident's room to put clothes in the closet and dresser drawers.

At 6:18 p.m., CNA 3 donned gloves, sat down on the floor next to Resident B, cleaned him up, dressed him in fresh clothing, and placed a clean brief on him. Then she placed a pillow under his head, and he remained on the floor and CNA 3 left his room and shut his door at 6:28 p.m.

At 6:30 p.m., CNA 3 returned to

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the resident's room with more clothing, then left the room and shut his door.

At 7:15 p.m., LPN 5 opened and shut the resident's room door.

At 8:31 p.m., someone opened and shut the door. Resident B remained on the floor at that time.

At 10:05 p.m., someone walked into the doorway, then left the room.

At 10:43 p.m., CNA 2 came into the room, then left the room. She returned with a Hoyer lift sling and assisted Resident B off the floor with the Hoyer lift. She transported him out to the common area (lounge area) in the neighborhood in the Hoyer lift and placed him in a recliner and turned the TV on.

An interview statement, typed up by the DNS and dated as 11/7/22 at 5:43 p.m., indicated CNA 2 indicated she started making her rounds on the midnight shift on 11/3/22. Resident B was awake on the floor. She retrieved a Hoyer sling and used the Hoyer lift to lift him off the floor and transported him to the common area and placed him in a recliner. She covered him with a blanket and turned the TV on for him and he eventually fell asleep in the recliner.

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An interview statement, typed up by the DNS and dated as 11/8/22, indicated Concierge 7 indicated she "always" called the nurse first with a Safely You call, then if the nurse did not answer, she would call the CNA. She did not remember the evening of 11/3/22, whether Safely You called her and if the company did, who she notified, the nurse or the CNA.

A document, titled "Corrective Action," dated 11/9/22, indicated CNA 3 was terminated from her employment at the facility for a behavior, which was in violation of the facility's guidelines for appropriate conduct as outlined in the Associate Handbook. On 11/3/22, she was observed at 4:55 p.m., assisting a resident to bed, then the resident fell out of bed. At 5:06 p.m., she came into the resident's room, then left. At 6:10 p.m., she changed his brief and clothes and left him lying on the floor. Several times while the resident laid on the floor she walked into the resident's room but did not attempt to get him off the floor, back into bed or offer to put him into his wheelchair. These behaviors did not contribute to the facility's success and would not be tolerated.

A document, titled "Corrective Action," dated 11/10/22, indicated CNA 2 was written up for a first reminder for violating

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the facility's guidelines for appropriate conduct and health and safety policies. On 11/3/22, she was observed assisting a resident off the floor with a Hoyer lift by herself, when the policy states all lifts required two person assists for safety.

During a phone interview, on 11/18/22 at 3:14 p.m., CNA 3 indicated Resident B had fallen multiple times on 11/3/22. He fell out of his recliner. She had him in the dining room, at the table for dinner, and he became aggressive, trying to stand up and spitting on people sitting at his table. She took him to his room and laid him down on his mattress on his floor at approximately 5:00 p.m. Shortly after she laid him in his bed, she heard a "thump." He slept on a thick mattress on the floor now. A few weeks ago, his bed was removed because he kept falling out of his bed onto the floor. If he rolled out of bed now, he slept on the floor because his mattress was on the floor, and he would not stay on the mattress. She worked the day and evening shifts on 11/3/22. After she took the resident to his room, the nurse (LPN 5) who came on after 3:00 p.m., told her to leave him on the floor when he fell. She placed a pillow under his head and covered him with a blanket. She did not understand why she was fired when everyone who

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worked did the same thing, she did that evening. All the nurses tell the CNAs to leave him on the floor when he fell off his mattress. She thought maybe because he laid on the floor for six hours and the management staff felt it was an excessive amount of time to lay on the floor. This was his fourth time falling that particular day and she felt he was safer laying on the floor, then on his mattress. She checked on him during the entire time he laid on the floor. She placed the Hoyer lift machine and his wheelchair in the bathroom, so he would not get hurt on it because he was rolling all over the floor in his room. He had a catheter, and she gave him a partial bed bath on the floor to get him ready for bed, then she gave him a pillow and a blanket to cover up with.

During a phone interview, on 11/18/22 at 4:21 p.m., LPN 5 indicated Resident B's mattress to his bed was on the floor and this was where he slept. A few weeks ago, his bed was taken apart because he kept falling out of the bed. He rolls back and forth from his mattress to the floor, so she did not know what the difference was that day when the staff did not place him back on his mattress. The facility only counted resident falls from a wheelchair or a recliner, not from a mattress on the floor. Six hours on the floor

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was a normal day for Resident B to be on the floor. The CNAs and the nurses provide care to him on the floor when he was on his mattress. If he got off his mattress, they did not count it as a fall. The resident had Safely You set up in his room, which was supposed to call the nurse if he fell, and she was not notified of a fall for him. Safely You called on 11/3/22 at 10:40 p.m., while she was giving report to the midnight nurse following her, but she did not take the call since she was leaving. She had "never" told CNA 3 to leave the resident on the floor. She had told her to "Leave him down low" which meant leave him on his mattress, but not on the floor. She assumed he rolled onto the floor from his mattress, so she did not assess him for injuries from his fall. When asked if she viewed his fall on the computer. She indicated the nurses only have access to view those falls for one hour and most of the time when the nurses discovered the resident fell, the hour time frame was gone. She did not know he fell, so she did not call and ask the DNS to view the fall footage on the computer. She was informed by the DNS; she was not allowed to work at the facility anymore as a contractor. She had worked at the facility since June 2022 picking up 13-15 shifts a month. The DNS indicated she was not

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allowed to pick up shifts anymore because she did not do anything about Resident B laying on the floor, nor did she have CNA 3 do anything about the resident laying on the floor for six hours. He did not eat dinner because CNA 3 was serving dinner when he started spitting on other residents, so he was taken to his room because he could not be redirected to stop spitting. CNA 3 indicated to LPN 5 she held his plate because he was spitting at the dining room table.

During an interview, on 11/18/22 at 4:57 p.m., the DNS indicated the Safely You video fall program allows the facility to know when a resident falls. LPN 5 was not allowed to come back and work again because she did not do anything to assist the resident when she found out he was on the floor. She expected her to have assessed him, not knowing if he fell or not, and assist CNA 3 to place the resident in his wheelchair, recliner or back to bed. She was not notified by LPN 5 the resident was not fed dinner. CNA 3 was terminated for leaving Resident B on the floor for 6 hours. CNA 2 was written up for not using two people to assist him off the floor with the Hoyer lift. When she was asked if it was common practice for the CNAs to transport a resident from one area to another area

with the Hoyer lift, she indicated no. CNA 2 should not have used the Hoyer lift to transfer him from his room to the lounge area. She should have transferred him into a wheelchair to be transported to the lounge area.

A current policy, titled "Indiana Resident Rights," dated as revised 03/03 and provided by the DNS on 11/18/22 at 3:15 p.m., indicated "...Treatment with consideration, respect, and recognition of your dignity and individuality ...Freedom from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat medical symptoms. Freedom from sexual, physical, mental abuse, verbal abuse, corporal punishment, neglect and involuntary seclusion...."

A current policy, titled "Abuse, Neglect & Exploitation Policy," dated as revised on 5/2021 and provided by the DNS on 11/18/22 at 3:12 p.m., indicated "...Policy Detail 1. Definitions: a. 'Abuse' is defined in Indiana as a willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, anguish or deprivation by an individual of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well-being. Abuse

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may also include sexual abuse and verbal abuse...b. 'Neglect' is defined in Indiana as an act or omission which places a resident in a situation that may endanger the resident's life or health; abandoning or cruelly confining a resident; or depriving a resident or necessary support, including food, shelter and medical care...."

A current policy, titled "Mechanical Lift Policy," dated as revised on 4/2021 and provided by the DNS on 11/18/22 at 5:30 p.m., indicated "...B. Mechanical Lift Use...2. Mechanical lifts may be utilized in various areas of the community and must be used in a dignified, respectful manner, and with discretion when transferring a resident. The use of mechanical lifts shall follow manufacturer instructions and are not used to transport a resident. 4. Mechanical lifts shall be stored in inconspicuous and non-public areas of the community...."

A current policy, titled "Falls Management Policy," dated as revised on 2/2022 and provided by the DNS on 11/18/22 at 3:12 p.m., indicated "...Definition of a Fall: A fall refers to unintentionally coming to rest on the ground, floor, or to lower level either witnessed or unwitnessed, with or without

injury. Policy Detail...3. Resident falls are noted in the resident record and entered into the BAIRS system. 4. A post fall evaluation is completed after a resident fall, individualized interventions are considered, and the evaluation is a part of the resident record. 5. When a fall occurs...Document the resident fall/injuries, resident response, and interventions taken in the resident record, See Alert Charting Clinical Guideline...."

A current policy, titled "Safely You Fall Detection System," dated 5/2021 as revised on 5/2022 and provided by the DNS on 11/18/22 at 5:30 p.m., indicated "Policy Overview: Safely You utilizes artificial intelligence (AI) enabled camera technology/software and video monitoring/recording hardware to detect unwitnessed resident falls. Where available a community may utilize this technology as part of its Fall Management Program and offer to residents and their responsible parties. Definition of a Fall: A fall refers to unintentionally coming to rest on the ground, floor, or other lower level either witnessed or unwitnessed, with or without injury. Policy Detail...2. The community will review the technology with the resident/responsible party including: a. Cameras do not

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provide live access to the resident's room b. Cameras may not detect all falls. c. No audio is recorded and approximately 10 minutes pre/post fall is recorded...8. Community associates will be trained on response to the system. 9. Data collected from the review of recorded fall may be used to ascertain potential injury and/or causes of the fall. This data may be used in review of the resident's service plan...."

This State tag relates to Complaint IN00394354.

Based on observation, interview and record review, the facility failed to ensure a cognitively impaired resident was free from neglect, related to the resident was not assessed for injuries by a licensed nurse, transferred immediately off the floor after a fall, was not fed dinner and he was not transported in a safe manner from his room to the lounge area after he was picked up off the floor for 1 of 3 residents reviewed for neglect. (Resident B) Resident B laid on the floor in his room for six hours after a fall.

Findings include:

Resident B's record was reviewed on 11/18/22 at 3:15 p.m. Diagnoses included, but were not limited to, major neurologist disorder with

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psychosis, dementia,
degenerative joint disease,
hypertension, and chronic
kidney disease

The resident's record lacked
documentation indicating he
had fallen or was left on the
floor for six hours on 11/3/22.

A document, titled "Type of
Alleged Incident: Video Content
Concern from Safely You
email," dated 11/7/22 and
provided by the DNS on
11/18/22 at 3:30 p.m., indicated
a notification was sent from
Safely You (camera technology,
software, and video
monitoring/recording hardware
to detect unwitnessed resident
falls to determine the causes of
falls) by email on 11/7/22 at
10:38 a.m., of the occurrence,
which occurred on 11/3/22 at
3:56 p.m. The video showed
Resident B scooted off the bed
and fell back. At 5:06 p.m., CNA
3 came into the resident's room
to check on him and left him on
the floor. Resident B was left on
the floor, in his room, for six
hours.

The timeline of the events,
which occurred on 11/3/22,
indicated Resident B fell in his
room, then the following events
were when staff interacted with
the resident during the six hours
he was secluded and the care
they provided for him according
to the video footage the DNS

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observed and documented on
11/7/22 at 10:38 a.m.

At 4:55 p.m., CNA 3 brought Resident B into his room and placed him in bed. She placed a pillow on the floor next to his bed and walked out of the room. After CNA 3 left the room, the resident got out of bed and onto the floor in a kneeling position next to the bed.

At 4:57 p.m., he attempted to stand up and fell. At that time, someone opened the door and looked in the room, then closed the door.

At 5:06 p.m., CNA 3 entered Resident B's room and placed the Hoyer lift machine and his wheelchair in the bathroom. She closed the bathroom door, then stood over Resident B for a few seconds, then walked to the doorway, while looking back at the resident. CNA 3 walked back over to the resident, then she turned him over onto his left side.

At 5:07 p.m., CNA 3 left the resident's room and shut the door behind her.

At 5:14 p.m., LPN 5 went into Resident B's room and gave him a drink of lemonade while he was laying on the floor, then she walked out of the room and came back into the room and gave him more lemonade to drink while standing/leaning

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over him. At that time, the resident's shirt was off him. At that time, LPN 5 did not know the resident had fallen.

At 5:16 p.m., LPN 5 left the resident's room shutting his room door as she left the room.

At 5:22 p.m., someone opened the resident's door, then closed it without entering the room.

At 6:13 p.m., CNA 3 entered the resident's room and placed a comforter on the end of his bed, then she left the room, shutting his room door as she left the room. At that time, the resident's shirt remained off, while his brief and pants were now down, and he was laying up against the wall by the closet.

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remained on the floor and CNA 3 left his room and shut his door at 6:28 p.m.

At 6:30 p.m., CNA 3 returned to the resident's room with more clothing, then left the room and shut his door.

At 7:15 p.m., LPN 5 opened and shut the resident's room door.

At 8:31 p.m., someone opened and shut the door. Resident B remained on the floor at that time.

At 10:05 p.m., someone walked into the doorway, then left the room.

At 10:43 p.m., CNA 2 came into the room, then left the room. She returned with a Hoyer lift sling and assisted Resident B off the floor with the Hoyer lift. She transported him out to the common area (lounge area) in the neighborhood in the Hoyer lift and placed him in a recliner and turned the TV on.

An interview statement, typed up by the DNS and dated as 11/7/22 at 5:43 p.m., indicated CNA 2 indicated she started making her rounds on the midnight shift on 11/3/22. Resident B was awake on the floor. She retrieved a Hoyer sling and used the Hoyer lift to lift him off the floor and transported him to the common area and placed him in a

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recliner. She covered him with a blanket and turned the TV on for him and he eventually fell asleep in the recliner.

An interview statement, typed up by the DNS and dated as 11/8/22, indicated Concierge 7 indicated she "always" called the nurse first with a Safely You call, then if the nurse did not answer, she would call the CNA. She did not remember the evening of 11/3/22, whether Safely You called her and if the company did, who she notified, the nurse or the CNA.

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A document, titled "Corrective Action," dated 11/9/22, indicated CNA 3 was terminated from her employment at the facility for a behavior, which was in violation of the facility's guidelines for appropriate conduct as outlined in the Associate Handbook. On 11/3/22, she was observed at 4:55 p.m., assisting a resident to bed, then the resident fell out of bed. At 5:06 p.m., she came into the resident's room, then left. At 6:10 p.m., she changed his brief and clothes and left him lying on the floor. Several times while the resident laid on the floor she walked into the resident's room but did not attempt to get him off the floor, back into bed or offer to put him into his wheelchair. These behaviors did not contribute to the facility's success and would not be tolerated.

A document, titled "Corrective Action," dated 11/10/22, indicated CNA 2 was written up for a first reminder for violating the facility's guidelines for appropriate conduct and health and safety policies. On 11/3/22, she was observed assisting a resident off the floor with a Hoyer lift by herself, when the policy states all lifts required two person assists for safety.

During a phone interview, on 11/18/22 at 3:14 p.m., CNA 3 indicated Resident B had fallen multiple times on 11/3/22. He

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fell out of his recliner. She had him in the dining room, at the table for dinner, and he became aggressive, trying to stand up and spitting on people sitting at his table. She took him to his room and laid him down on his mattress on his floor at approximately 5:00 p.m. Shortly after she laid him in his bed, she heard a "thump." He slept on a thick mattress on the floor now. A few weeks ago, his bed was removed because he kept falling out of his bed onto the floor. If he rolled out of bed now, he slept on the floor because his mattress was on the floor, and he would not stay on the mattress. She worked the day and evening shifts on 11/3/22. After she took the resident to his room, the nurse (LPN 5) who came on after 3:00 p.m., told her to leave him on the floor when he fell. She placed a pillow under his head and covered him with a blanket. She did not understand why she was fired when everyone who worked did the same thing, she did that evening. All the nurses tell the CNAs to leave him on the floor when he fell off his mattress. She thought maybe because he laid on the floor for six hours and the management staff felt it was an excessive amount of time to lay on the floor. This was his fourth time falling that particular day and she felt he was safer laying on the floor, then on his mattress.

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She checked on him during the entire time he laid on the floor. She placed the Hoyer lift machine and his wheelchair in the bathroom, so he would not get hurt on it because he was rolling all over the floor in his room. He had a catheter, and she gave him a partial bed bath on the floor to get him ready for bed, then she gave him a pillow and a blanket to cover up with.

During a phone interview, on 11/18/22 at 4:21 p.m., LPN 5 indicated Resident B's mattress to his bed was on the floor and this was where he slept. A few weeks ago, his bed was taken apart because he kept falling out of the bed. He rolls back and forth from his mattress to the floor, so she did not know what the difference was that day when the staff did not place him back on his mattress. The facility only counted resident falls from a wheelchair or a recliner, not from a mattress on the floor. Six hours on the floor was a normal day for Resident B to be on the floor. The CNAs and the nurses provide care to him on the floor when he was on his mattress. If he got off his mattress, they did not count it as a fall. The resident had Safely You set up in his room, which was supposed to call the nurse if he fell, and she was not notified of a fall for him. Safely You called on 11/3/22 at 10:40 p.m., while she was giving

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report to the midnight nurse following her, but she did not take the call since she was leaving. She had "never" told CNA 3 to leave the resident on the floor. She had told her to "Leave him down low" which meant leave him on his mattress, but not on the floor. She assumed he rolled onto the floor from his mattress, so she did not assess him for injuries from his fall. When asked if she viewed his fall on the computer. She indicated the nurses only have access to view those falls for one hour and most of the time when the nurses discovered the resident fell, the hour time frame was gone. She did not know he fell, so she did not call and ask the DNS to view the fall footage on the computer. She was informed by the DNS; she was not allowed to work at the facility anymore as a contractor. She had worked at the facility since June 2022 picking up 13-15 shifts a month. The DNS indicated she was not allowed to pick up shifts anymore because she did not do anything about Resident B laying on the floor, nor did she have CNA 3 do anything about the resident laying on the floor for six hours. He did not eat dinner because CNA 3 was serving dinner when he started spitting on other residents, so he was taken to his room because he could not be redirected to stop spitting. CNA

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3 indicated to LPN 5 she held his plate because he was spitting at the dining room table.

During an interview, on 11/18/22 at 4:57 p.m., the DNS indicated the Safely You video fall program allows the facility to know when a resident falls. LPN 5 was not allowed to come back and work again because she did not do anything to assist the resident when she found out he was on the floor. She expected her to have assessed him, not knowing if he fell or not, and assist CNA 3 to place the resident in his wheelchair, recliner or back to bed. She was not notified by LPN 5 the resident was not fed dinner. CNA 3 was terminated for leaving Resident B on the floor for 6 hours. CNA 2 was written up for not using two people to assist him off the floor with the Hoyer lift. When she was asked if it was common practice for the CNAs to transport a resident from one area to another area with the Hoyer lift, she indicated no. CNA 2 should not have used the Hoyer lift to transfer him from his room to the lounge area. She should have transferred him into a wheelchair to be transported to the lounge area.

A current policy, titled "Indiana Resident Rights," dated as revised 03/03 and provided by the DNS on 11/18/22 at 3:15

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p.m., indicated "...Treatment with consideration, respect, and recognition of your dignity and individuality ...Freedom from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat medical symptoms. Freedom from sexual, physical, mental abuse, verbal abuse, corporal punishment, neglect and involuntary seclusion...."

A current policy, titled "Abuse, Neglect & Exploitation Policy," dated as revised on 5/2021 and provided by the DNS on 11/18/22 at 3:12 p.m., indicated "...Policy Detail 1. Definitions: a. 'Abuse' is defined in Indiana as a willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, anguish or deprivation by an individual of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well-being. Abuse may also include sexual abuse and verbal abuse...b. 'Neglect' is defined in Indiana as an act or omission which places a resident in a situation that may endanger the resident's life or health; abandoning or cruelly confining a resident; or depriving a resident or necessary support, including food, shelter and medical care...."

A current policy, titled "Mechanical Lift Policy," dated as revised on 4/2021 and provided by the DNS on 11/18/22 at 5:30 p.m., indicated "...B. Mechanical Lift Use...2. Mechanical lifts may be utilized in various areas of the community and must be used in a dignified, respectful manner, and with discretion when transferring a resident. The use of mechanical lifts shall follow manufacturer instructions and are not used to transport a resident. 4. Mechanical lifts shall be stored in inconspicuous and non-public areas of the community...."

A current policy, titled "Falls Management Policy," dated as revised on 2/2022 and provided by the DNS on 11/18/22 at 3:12 p.m., indicated "...Definition of a Fall: A fall refers to unintentionally coming to rest on the ground, floor, or to lower level either witnessed or unwitnessed, with or without injury. Policy Detail...3. Resident falls are noted in the resident record and entered into the BAIRS system. 4. A post fall evaluation is completed after a resident fall, individualized interventions are considered, and the evaluation is a part of the resident record. 5. When a fall occurs...Document the resident fall/injuries, resident response, and interventions taken in the resident record,

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See Alert Charting Clinical
Guideline...."

A current policy, titled "Safely
You Fall Detection System,"
dated 5/2021 as revised on
5/2022 and provided by the
DNS on 11/18/22 at 5:30 p.m.,
indicated "Policy Overview:
Safely You utilizes artificial
intelligence (AI) enabled camera
technology/software and video
monitoring/recording hardware
to detect unwitnessed resident
falls. Where available a
community may utilize this
technology as part of its Fall
Management Program and offer
to residents and their
responsible parties. Definition of
a Fall: A fall refers to
unintentionally coming to rest on
the ground, floor, or other lower
level either witnessed or
unwitnessed, with or without
injury. Policy Detail...2. The
community will review the
technology with the
resident/responsible party
including: a. Cameras do not
provide live access to the
resident's room b. Cameras
may not detect all falls. c. No
audio is recorded and
approximately 10 minutes
pre/post fall is recorded...8.
Community associates will be
trained on response to the
system. 9. Data collected from
the review of recorded fall may
be used to ascertain potential
injury and/or causes of the fall.
This data may be used in review

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of the resident's service plan...."

This State tag relates to
Complaint IN00394354.

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