STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG MEADOWS ASSISTED LIVING	7133 MEADOW TRAIL, BROWNSBURG, , 46112

(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 IN00357296. Complaint IN00357296 - Substantiated. State deficiencies related to the allegations are cited at R0240. Survey date: August 5, 2021 Facility number: 013356 Residential Census: 81 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 11, 2021.	R 0000		
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.	R 0240	**R240** **What corrective action(s) will be accomplished for those residents found to have been**	08/27/2021

	Based on interview and record, the facility failed to assess and wait for emergency transport before moving a resident after a fall with head injury for 1 of 3 residents reviewed for accidents (Resident RB). Finding includes: On 8/5/21 at 11:05 a.m., the administrator (ADM) provided an "Event Report" document, documentation of staffs' statements and an incident report of two falls, dated 7/1/21, for Resident RB. ADM indicated the resident's falls were in the closed dementia unit common area. Staff should have called 911 for emergency transport to the hospital since the resident had a fall with a head injury and staff should have left the resident where she had fallen instead of moving her. Licensed Practical Nurse (LPN) 4 was in charge of the unit and resigned from the facility after the accident. On 8/5/21 at 11:25 a.m., the Director of Nursing (DON) provided a document, titled "[Resident RB's name] timeline," indicated the document was a timeline of Resident RB's falls on 7/1/21. Resident had an initial fall, on 7/1/21 at 3:28 p.m., in the closed dementia unit common area. The resident was rocking back and forth in a		**affected by the deficient practice? 1) All direct care staff will be re-educated on fall procedure, including but not limited to assessing & waiting for emergency transport before moving a resident by August 25th, 2021. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 1) All residents have the potential to be affected by the alleged deficient practice. 2) All direct care still will complete falls skills validation check offs no later than August 27th, 2021. What measures will**	

stationary chair, fell forward and landed on the ground. The nurse assessed the resident and placed her back into the stationary chair. An aide sat with the resident and the resident continued to rock back and forth. The aide transferred the resident to a wheelchair. The resident began propelling self, fell forward towards the floor, and landed face down on the floor. LPN 4 briefly assessed Resident RB and relocated the resident to her apartment where a thorough assessment and vitals were completed. The DON indicated disciplinary action and termination was to be taken on LPN 4 due to not following the facility's fall protocol and procedures of moving an injured resident after a fall, but LPN 4 resigned before the termination could occur.

On 8/5/21 at 1:33 p.m. ADM indicated the facility did not have a fall procedure for what staff should do when a resident falls. A nurse should initiate neurological checks and vital signs where the resident fell. The resident should have had an assessment of vital signs and a neurological assessment prior to picking the resident up from the floor and moved to another location. Staff should have called 911 to send Resident RB to the emergency room, since the resident had sustained a head injury. ADM

be put into place or systemic changes you will make to ensure that the deficient practice does not reoccur?

1) **All nursing staff was re-educated by Director of Nursing on (August 25th, 2021) regarding fall procedure & interventions.**

2) **The Director of Nursing/Designee will be responsible for completing a falls skills validation check off with each direct care staff member no later than August 27th, 2021.**

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

1) **The Director of Nursing/ Designee will be responsible for completing a falls skills validation check off with each direct care staff member upon**

	indicated LPN4 was wrong to have instructed two Certified Nursing Assistant (CNA) staff move the resident after the initial fall from a chair and after the resident fell again from the wheelchair. LPN 4 called the daughter who did not answer, so she called the son who came to the facility. The resident was already in bed when the son arrived. The nurse was suspended and likely knew she was going to be terminated, decided to resign from the position. Resident RB did not communicate much but with the obvious injuries to her head and face was probably in pain from the falls. Following the incident the facility created fall instructions for staff, which indicated do not move the resident but initiate assessment where the resident fell. On 8/5/21 at 2:02 p.m., Resident RB's record was reviewed. Diagnoses included, but were not limited to, dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), anxiety, and overactive bladder. A progress note, dated 7/1/21 at 3:53 p.m., indicated Resident RB was sitting in her wheelchair in the common area. Resident		**hire.** 2) **The CQI Tool will be completed beginning (August 23rd, 2021). Fall review: will be reviewed the following business day 5 times weekly. The CQI will be completed 5 days weekly for 4 weeks. then 3 times weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing until 2 consecutive months of compliance (compliance is defined as 95% or greater)**	

RB leaned over in her wheelchair causing her to fall face first onto the ground. Resident RB was assessed for range of motion, vital signs, skin, and neurological checks. Resident RB had a bump to the center of her forehead of 7.0 centimeters (cm) in circumference and an abrasion to the right side of her forehead 3 cm x 1.5 cm. Resident RB's son transported the resident to the hospital. X-rays revealed the resident had sustained a C1 and C2 fractures (the first two cervical (neck) vertebra which supports the head).

LPN 4's statement for Resident RB's fall incident indicated LPN 4 observed Resident RB seated in a wheelchair leaned forward and rolled out of the wheelchair. LPN 4 assessed for injuries and vital signs with noted abrasion to the forehead and a bump in the center of the forehead. Resident RB was transferred to the wheelchair and then to bed for a complete nursing assessment.

LPN 5's statement for Resident RB's fall incident indicated, on 7/1/21 at approximately at 3:30 p.m., Resident RB was sitting in the common area in a chair and fell to the floor due to leaning too far forward and sustained an abrasion to the forehead. Two CNAs (CNA 6 and CNA 7) picked Resident RB up from the

floor and placed her back into the chair. LPN 5 obtained Resident RB's vital signs and cleansed the abrasion on the forehead.

CNA 6's statement for Resident RB's fall incident indicated on 7/1/21 after he had transferred Resident RB into her wheelchair due to her being uncomfortable in a regular chair, which had caused her previous fall. Resident RB propelled herself forward and managed to lean forward, became unstable and fell face first into the dry erase board and brown drawer. LPN 4 assessed the resident then instructed CNA 6 and CNA 7 to transfer Resident RB back into her wheelchair and then to her bed in the resident's apartment.

CNA 7's statement for Resident RB's fall incident indicated on 7/1/21 CNA 7 witnessed Resident RB fall out of the common area chair face first and had scraped her forehead. CNA 6 and LPN 5 assisted Resident RB back into the chair after the fall.

On 8/5/21 at 1:58 p.m., ADM indicated after Resident RB's fall incidents on 7/1/21, the facility had created a procedure document titled "Fall Instructions," to instruct/in-service staff on what to do for a resident after a fall with an injury. The undated "Fall

Instructions" document indicated, "...Assessed resident for injury, including range of motion and pain, initiate neurological checks, if a fall is unwitnessed or hit head...If significant injury is suspected DO NOT move resident, assign staff to stay with the resident and call 911...."

This State Residential finding related to Complaint IN00357296.

Based on interview and record, the facility failed to assess and wait for emergency transport before moving a resident after a fall with head injury for 1 of 3 residents reviewed for accidents (Resident RB).

Finding includes:

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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