STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS AT NORTH WILLOW	1703 W 86TH STREET, INDIANAPOLIS, , 46260

(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 IN00364351. Complaint IN00364351 - Substantiated. State Residential Findings related to the allegations are cited at R0240. Survey date: October 20 and 21, 2021. Facility number: 013880 Residential Census: 97 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 28, 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	R 0240	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any	11/30/2021

needs and preferences.

Based on interview and record review, the facility failed to ensure new interventions were implemented after resident falls, and neurological checks were initiated and completed for 2 of 3 residents reviewed for Quality of Treatment (Resident B and C).

Findings include:

1. During a confidential interview, it was indicated, Resident B had recently had a steep decline in her health because she kept falling. It was indicated she had a fall which resulted in a broken arm, and when she came back, the facility indicated they could not keep an eye on her 24 hours a day 7 days a week. After her last fall, it took three days before she was sent to the emergency room (ER) where it was determined she had broken her hip, and she passed away a week later.

On 10/20/21 at 10:00 a.m., a medical record review was completed for Resident B. She was admitted to the facility with active diagnoses that included, but were not limited to, arthritis, osteoporosis, vitamin D deficiency and maculate degeneration (progressive eye disease that will ultimately cause blindness).

violation of regulation.

This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk
Review in lieu a Post Survey Review.

R-240

With regards to finding R240 Health Services 1717 Senior Living will;

***What corrective actions will be accomplished for those residents found
to have been affected by the finding:***

The nursing staff
will be reeducated on post fall assessments, fall interventions and neuro
checks.

	A nursing progress note, dated 4/3/21 at 10:35 p.m., indicated, Resident B had an unwitnessed fall, and was found on her knees next to her bed. Resident B indicated she rolled out of bed while sleeping and was unable to get herself up. Nursing staff assessed her and allowed her to sleep the remainder of the night in her recliner chair. The record lacked documentation that neuro checks had been implemented. A comprehensive nursing admission assessment and service plan, dated 4/5/21, indicated, Resident B independently walked with a rollator walker, no recent falls prior to her admission but was still considered a high fall risk with a score of 5, (5 or greater being considered a high fall risk) and required daily safety checks up to 12 times a day. A Nurse Practitioner (NP) progress note, dated, 5/31/21 at 10:18 a.m., indicated the nursing staff asked the NP to check on Resident B since she had reported some new knee pain. Resident B was lying in bed and crying due to severe knee pain in her right leg. Her family was present during the exam. Resident B indicated she fell once in her bathroom, then again while walking near her bed and had a lot of pain but		***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** No other residents were adversely affected. All residents had the potential to be adversely affected. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Nursing staff will be reeducated on post fall assessments including neuro checks and fall interventions. Falls will be reviewed during daily	

	had not called nursing staff for help. Resident B indicated she crawled back to her bed and called her family that morning. Upon exam, Resident B was crying/yelling in pain and held her right knee which was swollen. Due to her severe pain, it was decided to send Resident B out to the ER. A nursing progress note, dated 5/31/21 at 3:14 p.m., indicated Resident B was on her way back from the hospital, and her family member reported there were no acute findings, and no fractures. The NP gave new orders for Resident B to have PT (physical therapy) and OT (occupational therapy), and nursing implemented hourly safety checks. A nursing progress note, dated 6/5/21 at 7:07 a.m., indicated Resident B had a 4th fall. She was found on her knees in front of her walker after paging for assistance. Neuro checks were started, and her vital signs were within normal limits. No new fall interventions were documented. Several hours later on 6/5/21 at 2:49 p.m., Resident B complained of head pain, and she was sent to the ER. Later that evening, on 6/5/21 at 8:20 p.m., Resident B returned to the facility with no acute findings and no fractures. She		morning meeting to ensure proper reporting and documentation is complete, including neuro checks and interventions. . ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** Wellness Director or designee will review all resident falls ongoing to ensure interventions are put in place and neurological checks are completed and documented appropriately. Falls will be reviewed during daily morning meeting. This will be ongoing.	

	was assessed and complained of generalized pain A corresponding neurological flow sheet, dated 6/5/21, was started but was not continued after Resident B returned from the facility. A nursing progress note, dated 6/6/21 at 9:38 a.m., Resident B complained of dizziness. The dizziness was not noted on the neuro check flow sheet, and there was no indication the physician had been notified. A nursing progress note, dated 6/11/21 at 6:01 a.m., indicated Resident B had a 5th fall. She was found lying on her left side on the floor by her bed. She had been incontinent at the time of the fall and could not express what happened. Resident B complained of right shoulder pain and upon assessment she could not move her right arm. She was given Tylenol and neuro checks were started. A new order was received for an X-ray of her right shoulder and that was completed the same day at 10:12 a.m. Several hours later, the same day at 3:03 p.m., the X-ray results were received and revealed a fracture. Resident B was sent to the ER for evaluation and treatment. Resident B returned to the		***By what date the systemic changes will be completed:*** 11/30/21	

facility, on 6/11/21 at 9: 10 p.m., with a sling for her arm, and hourly checks through the night.

A corresponding neurological flow sheet, dated 6/11/21 was started, but was incomplete with only 1 of 22 rows filled in, and were not continued when she returned from the hospital.

A nursing progress note, dated 6/22/21 at 3:38 a.m., indicated Resident B had a 6th fall. She was found on her knees in front of her recliner. Neuro checks were started, and her vital signs were within normal limits. There was no new acute injury, but Resident B complained of pain her already affected arm. She was administered pain medication. No new fall interventions were indicated.

The corresponding neuro check flow sheet, dated 6/22/21 was nearly completed, but 1 row, and the last two sets of vitals were blank.

On 6/29/21 at 12:54 a.m., Resident B had a 7th fall. She was found on her apartment bathroom floor. Neuro checks were started, and her vital signs were within normal limits, but no new fall prevention interventions were indicated.

A couple hours later on, 6/29/21 at 3:19 a.m., Resident B had an 8th fall. She was found beside her bed and was brought to the

common area for closer monitoring.

The corresponding neuro check flow sheet, dated 6/29/21, was initiated but incomplete. There were 3 full rows blank and 4 other rows were incomplete.

A nursing progress note, dated 7/1/21 at 6:54 a.m., indicated Resident B had a 9th fall. She was heard screaming for help and was found on the floor near the bathroom. No new fall prevention interventions were indicated

The record lacked documentation that neuro checks had been initiated for the 7/1/21 fall.

A nursing progress note, dated 7/12/21 at 4:41 p.m., indicated Resident B had a 10th fall. She was found on the floor of her apartment. The progress note indicated neuro checks had been initiated, and her vital signs were within normal limits. No new fall prevention interventions were indicated.

The record lacked documentation that neuro checks had been initiated for the 7/12/21 fall.

A nursing progress note, dated 7/30/21 at 1:14 p.m., indicated Resident B refused care and needed redirection.

A nursing progress note, dated 8/20/21 at 10:39 p.m., indicated Resident B had displayed signs of increased confusion and tearfulness. Nursing aids reported, Resident B had been in her apartments undressed from the waist down and cried because she did not remember how or where her clothes go. Per report from the nursing aid, this was not the first time this type of behavior had been observed.

A nursing progress not, dated 8/27/21 at 7:07 p.m., indicated Resident B had an 11th (witnessed) fall. She leaned over in her chair as she attempted to stand on her own and fell. She was not witnessed to hit her head.

A nursing progress note, dated 8/27/21 at 10:37 p.m., indicated Resident B had attempted to walk, transfer herself, and tried to have other residents help her transfer from one seat to another, or from seated to standing.

A nursing progress note, dated 9/3/21 at 2:34 p.m., indicated Resident B was seen by the NP and started on an antibiotic for a urinary tract infection.

A nursing progress note, dated 9/17/21 at 4:10 p.m., indicated, Resident B was upset, she cried and wandered around the unit.

A nursing progress note, dated 9/21/21 at 9:08 p.m., indicated Resident B had a 12th fall. She was found lying on her right side in her apartment bathroom. At the time of the fall Resident B complained of pain in her right arm, (where the previous fracture had healed), and new pain in her back. A voicemail was left for the NP. There was no indication the NP called back, and no new orders were indicated.

A nursing progress note, dated 9/23/21 at 8:46 a.m., (approximately 35 hours after the fall), Resident B screamed out in pain and indicated her stomach hurt. The nurse gave her Tums. There was no indication the physician had been notified.

An NP progress note, dated 9/23/21 at 6:06 p.m. (approximately 48 hours after the fall) Resident B was seen for concerns related to her abdominal pain. Nursing staff reported that Resident B was in severe pain in the LLQ (left lower quadrant). She was given Tums with improvement. Upon exam, she was tired but denied any pain with palpation of her abdomen. She did recently sustain a fall on 9/21 and initially, she reported pain in her back and shoulder which had resolved the next day. At the time of the initial exam, a full set

of labs were ordered due to lethargy. Later in the afternoon, nursing staff noted resident had complained of hip/leg pain with transfer to bathroom and at that time, a STAT X-ray of pelvis and hips was ordered.

A nursing progress note, dated 9/24/21 at 9:26 a.m., indicated Resident B's X-ray results had been received and revealed a fracture to her right femoral hip. She had been observed earlier that morning crying in pain, but could not state where, and she did not eat breakfast. She was sent out via 911.

A comprehensive nursing admission assessment and service plan, dated 6/12/21 indicated, Resident B had no recent falls (by 6/12/21 Resident B had 6 falls) her fall risk score increased to an 8, and her daily safety check needs increased to 24 times a day.

During an interview on 10/21/21 at 10:15 a.m., The Memory Care Director (MCD) she was new to the facility but worked with Resident B and her family closely before she discharged. Resident B had dementia, and it seemed to have really progressed with her move into the secured memory care unit. She was always very busy and had a lot of falls. Resident B was on hourly checks, but the checks were not actually

marked off anywhere, but it was included as a part of the CNA (Certified Nursing Assistant) assignment sheets. The facility tried a couple different things for Resident B such as the BBET (Behavioral Based Ergonomic Therapy) which was also provided to all memory care residents if applicable. They rearranged her apartment to put Resident B's bed against the wall, and ordered a hospital bed, but the family and Resident did not like the bed, so it was sent back. Resident B had severe "Sundowning" syndrome, (a symptom of dementia where behaviors, anxiety, and stress levels increase, usually in the evening hours). Sometimes as early as after lunch she started to get more worked up and anxious. After a couple falls the IDT (interdisciplinary) team implemented a strategic visitation restriction for Resident B since she seemed to get more worked up after her family left from visits. Apart from being monitored 24/7, Resident B just kept falling. In the time that she worked with Resident B, the MCD indicated she had observed a noted decline in the resident's health and safety awareness and would probably have needed skilled care in the future.

During an interview on 10/21/21 at 2:32 p.m., with the

Administrator (ADM) and Director of Nursing (DON) present, the ADM indicated Resident B was very busy and not steady. She had several falls at her previous community. The ADM indicated the facility did not provide 24 hours 1 on 1 supervision, that families would have to provide sitter or home health aides to accommodate that kind of supervision. The ADM and DON indicated several interventions had been attempted such as: the apartment was rearranged, a new bed was ordered (but declined), strategic family visits, and hourly safety checks. At this time the DON reviewed the facilities internal "Fall Incident Report" tools for the above falls and indicated, she did not see that the physician had been notified of the Resident B's complaint of dizziness on 6/6/21, and that was especially important since it was after a fall. She

did not see on the internal documentation where new fall interventions had been attempted after the falls on: 6/5/21, 6/22/21, 7/1/21, and 7/12/21. Additionally, the DON indicated neuro checks should be completed, even if a resident was sent to the ER and returned within the neuro check follow up schedule, the neuro checks should be continued. The DON indicated neuro checks could

not be found for falls on 4/3/21, 5/31/21, 7/1/21, 7/12/21.

2. On 10/21/21 at 9:00 a.m., a medical record review for Resident C was completed.

A nursing progress note, dated 10/3/21 at 5:14 a.m., indicated Resident C was found on the floor outside a room with her back against the wall. She was able to follow directions and her range of motion was within normal limits. She was assisted off the floor into her wheelchair and into her room. no new fall prevention interventions were indicated.

The record lacked documentation that neuro checks had been implemented.

A nursing progress note, dated 10/7/21 at 9:49 p.m., indicated a loud crash and thud was heard. Resident C was found entangled in a walker and laying on her back. She suffered a small quarter-sized hematoma to her left temple. No new fall prevention interventions were indicated.

The record lacked documentation that neuro checks had been implemented.

A nursing progress note, dated 10/14/21 at 3:18 p.m., indicated Resident C was found sitting on her apartment floor. Her vital signs and initial neuro checks

were within normal limits and the resident was brought to the dining room. No new fall prevention interventions were indicated.

The record lacked documentation that neuro checks had been implemented.

On 10/20/21 at 3:15 p.m., the ADM provided a copy of current facility policy titled, "Fall Management Policy" dated 6/2014. The policy indicated, "It is the policy of this community to ensure the residents residing within the community maintain maximum physical functioning through the establishment of physical, environmental, and psychosocial guidelines. This includes ensuring the safety and comfort of the resident, assisting in continuity of care, and identifying any preventable injury related to falls... Any resident that has a fall within the community will have an Incident Report completed. The form initiated the investigation process and is to be completed by the licensed nurse prior to the end of the shift... initiate neuro checks if the resident has an unwitnessed fall or hits their head...seventy-two (72) hours follow up charting form will be initiated and documented on severity shift for 72 hours...."

On 10/20/21 at 3:15 p.m., the ADM provided a copy of current

facility policy titled, "Resident Service Plan" dated 6/2014. The policy indicated, "... service plans shall be reviewed and revised as appropriate and discussed by the resident and community as needs or desires change. Either the community or the resident may request a service plan review... The service plan is reviewed and revised every 6 months or following a change in condition and shall be signed and dated by the resident..."

On 10/20/21 at 3:15 p.m., the ADM provided a copy of current facility policy titled, "Resident Change in Health Status," dated 6/2014. The policy indicated, "... All symptoms and unusual sings will be communicated to the attending physician promptly. Routine changes are a minor change in physical and mental behavior, abnormal laboratory and x-ray results that are not life threatening. The nursing staff is responsible for notifications of physician and family or responsible party prior to end of assigned shift when a significant change in the resident's condition is noted...."

This State Residential Finding relates to Complaint IN00364351.

Based on interview and record review, the facility failed to ensure new interventions were

implemented after resident falls, and neurological checks were initiated and completed for 2 of 3 residents reviewed for Quality of Treatment (Resident B and C).

Findings include:

1. During a confidential interview, it was indicated, Resident B had recently had a steep decline in her health because she kept falling. It was indicated she had a fall which resulted in a broken arm, and when she came back, the facility indicated they could not keep an eye on her 24 hours a day 7 days a week. After her last fall, it took three days before she was sent to the emergency room (ER) where it was determined she had broken her hip, and she passed away a week later.

On 10/20/21 at 10:00 a.m., a medical record review was completed for Resident B. She was admitted to the facility with active diagnoses that included, but were not limited to, arthritis, osteoporosis, vitamin D deficiency and maculate degeneration (progressive eye disease that will ultimately cause blindness).

A nursing progress note, dated 4/3/21 at 10:35 p.m., indicated, Resident B had an unwitnessed fall, and was found on her knees next to her bed. Resident

B indicated she rolled out of bed while sleeping and was unable to get herself up. Nursing staff assessed her and allowed her to sleep the remainder of the night in her recliner chair.

The record lacked documentation that neuro checks had been implemented.

A comprehensive nursing admission assessment and service plan, dated 4/5/21, indicated, Resident B independently walked with a rollator walker, no recent falls prior to her admission but was still considered a high fall risk with a score of 5, (5 or greater being considered a high fall risk) and required daily safety checks up to 12 times a day.

A Nurse Practitioner (NP) progress note, dated, 5/31/21 at 10:18 a.m., indicated the nursing staff asked the NP to check on Resident B since she had reported some new knee pain. Resident B was lying in bed and crying due to severe knee pain in her right leg. Her family was present during the exam. Resident B indicated she fell once in her bathroom, then again while walking near her bed and had a lot of pain but had not called nursing staff for help. Resident B indicated she crawled back to her bed and called her family that morning. Upon exam, Resident B was

crying/yelling in pain and held her right knee which was swollen. Due to her severe pain, it was decided to send Resident B out to the ER.

A nursing progress note, dated 5/31/21 at 3:14 p.m., indicated Resident B was on her way back from the hospital, and her family member reported there were no acute findings, and no fractures. The NP gave new orders for Resident B to have PT (physical therapy) and OT (occupational therapy), and nursing implemented hourly safety checks.

A nursing progress note, dated 6/5/21 at 7:07 a.m., indicated Resident B had a 4th fall. She was found on her knees in front of her walker after paging for assistance. Neuro checks were started, and her vital signs were within normal limits. No new fall interventions were documented.

Several hours later on 6/5/21 at 2:49 p.m., Resident B complained of head pain, and she was sent to the ER.

Later that evening, on 6/5/21 at 8:20 p.m., Resident B returned to the facility with no acute findings and no fractures. She was assessed and complained of generalized pain

A corresponding neurological flow sheet, dated 6/5/21, was started but was not continued

after Resident B returned from the facility.

A nursing progress note, dated 6/6/21 at 9:38 a.m., Resident B complained of dizziness. The dizziness was not noted on the neuro check flow sheet, and there was no indication the physician had been notified.

A nursing progress note, dated 6/11/21 at 6:01 a.m., indicated Resident B had a 5th fall. She was found lying on her left side on the floor by her bed. She had been incontinent at the time of the fall and could not express what happened. Resident B complained of right shoulder pain and upon assessment she could not move her right arm. She was given Tylenol and neuro checks were started.

A new order was received for an X-ray of her right shoulder and that was completed the same day at 10:12 a.m.

Several hours later, the same day at 3:03 p.m., the X-ray results were received and revealed a fracture. Resident B was sent to the ER for evaluation and treatment.

Resident B returned to the facility, on 6/11/21 at 9: 10 p.m., with a sling for her arm, and hourly checks through the night.

A corresponding neurological flow sheet, dated 6/11/21 was

started, but was incomplete with only 1 of 22 rows filled in, and were not continued when she returned from the hospital.

A nursing progress note, dated 6/22/21 at 3:38 a.m., indicated Resident B had a 6th fall. She was found on her knees in front of her recliner. Neuro checks were started, and her vital signs were within normal limits. There was no new acute injury, but Resident B complained of pain her already affected arm. She was administered pain medication. No new fall interventions were indicated.

The corresponding neuro check flow sheet, dated 6/22/21 was nearly completed, but 1 row, and the last two sets of vitals were blank.

On 6/29/21 at 12:54 a.m., Resident B had a 7th fall. She was found on her apartment bathroom floor. Neuro checks were started, and her vital signs were within normal limits, but no new fall prevention interventions were indicated.

A couple hours later on, 6/29/21 at 3:19 a.m., Resident B had an 8th fall. She was found beside her bed and was brought to the common area for closer monitoring.

The corresponding neuro check flow sheet, dated 6/29/21, was initiated but incomplete. There

were 3 full rows blank and 4 other rows were incomplete.

A nursing progress note, dated 7/1/21 at 6:54 a.m., indicated Resident B had a 9th fall. She was heard screaming for help and was found on the floor near the bathroom. No new fall prevention interventions were indicated

The record lacked documentation that neuro checks had been initiated for the 7/1/21 fall.

A nursing progress note, dated 7/12/21 at 4:41 p.m., indicated Resident B had a 10th fall. She was found on the floor of her apartment. The progress note indicated neuro checks had been initiated, and her vital signs were within normal limits. No new fall prevention interventions were indicated.

The record lacked documentation that neuro checks had been initiated for the 7/12/21 fall.

A nursing progress note, dated 7/30/21 at 1:14 p.m., indicated Resident B refused care and needed redirection.

A nursing progress note, dated 8/20/21 at 10:39 p.m., indicated Resident B had displayed signs of increased confusion and tearfulness. Nursing aids reported, Resident B had been

in her apartments undressed from the waist down and cried because she did not remember how or where her clothes go. Per report from the nursing aid, this was not the first time this type of behavior had been observed.

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A nursing progress note, dated 9/21/21 at 9:08 p.m., indicated Resident B had a 12th fall. She was found lying on her right side in her apartment bathroom. At the time of the fall Resident B

complained of pain in her right arm, (where the previous fracture had healed), and new pain in her back. A voicemail was left for the NP. There was no indication the NP called back, and no new orders were indicated.

A nursing progress note, dated 9/23/21 at 8:46 a.m., (approximately 35 hours after the fall), Resident B screamed out in pain and indicated her stomach hurt. The nurse gave her Tums. There was no indication the physician had been notified.

An NP progress note, dated 9/23/21 at 6:06 p.m. (approximately 48 hours after the fall) Resident B was seen for concerns related to her abdominal pain. Nursing staff reported that Resident B was in severe pain in the LLQ (left lower quadrant). She was given Tums with improvement. Upon exam, she was tired but denied any pain with palpation of her abdomen. She did recently sustain a fall on 9/21 and initially, she reported pain in her back and shoulder which had resolved the next day. At the time of the initial exam, a full set of labs were ordered due to lethargy. Later in the afternoon, nursing staff noted resident had complained of hip/leg pain with transfer to bathroom and at that time, a STAT X-ray of pelvis and

hips was ordered.

A nursing progress note, dated 9/24/21 at 9:26 a.m., indicated Resident B's X-ray results had been received and revealed a fracture to her right femoral hip. She had been observed earlier that morning crying in pain, but could not state where, and she did not eat breakfast. She was sent out via 911.

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(Behavioral Based Ergonomic Therapy) which was also provided to all memory care residents if applicable. They rearranged her apartment to put Resident B's bed against the wall, and ordered a hospital bed, but the family and Resident did not like the bed, so it was sent back. Resident B had severe "Sundowning" syndrome, (a symptom of dementia where behaviors, anxiety, and stress levels increase, usually in the evening hours). Sometimes as early as after lunch she started to get more worked up and anxious. After a couple falls the IDT (interdisciplinary) team implemented a strategic visitation restriction for Resident B since she seemed to get more worked up after her family left from visits. Apart from being monitored 24/7, Resident B just kept falling. In the time that she worked with Resident B, the MCD indicated she had observed a noted decline in the resident's health and safety awareness and would probably have needed skilled care in the future.

During an interview on 10/21/21 at 2:32 p.m., with the Administrator (ADM) and Director of Nursing (DON) present, the ADM indicated Resident B was very busy and not steady. She had several falls at her previous community.

	The ADM indicated the facility did not provide 24 hours 1 on 1 supervision, that families would have to provide sitter or home health aides to accommodate that kind of supervision. The ADM and DON indicated several interventions had been attempted such as: the apartment was rearranged, a new bed was ordered (but declined), strategic family visits, and hourly safety checks. At this time the DON reviewed the facilities internal "Fall Incident Report" tools for the above falls and indicated, she did not see that the physician had been notified of the Resident B's complaint of dizziness on 6/6/21, and that was especially important since it was after a fall. She did not see on the internal documentation where new fall interventions had been attempted after the falls on: 6/5/21, 6/22/21, 7/1/21, and 7/12/21. Additionally, the DON indicated neuro checks should be completed, even if a resident was sent to the ER and returned within the neuro check follow up schedule, the neuro checks should be continued. The DON indicated neuro checks could not be found for falls on 4/3/21, 5/31/21, 7/1/21, 7/12/21.			

2. On 10/21/21 at 9:00 a.m., a medical record review for Resident C was completed.

A nursing progress note, dated 10/3/21 at 5:14 a.m., indicated Resident C was found on the floor outside a room with her back against the wall. She was able to follow directions and her range of motion was within normal limits. She was assisted off the floor into her wheelchair and into her room. no new fall prevention interventions were indicated.

The record lacked documentation that neuro checks had been implemented.

A nursing progress note, dated 10/7/21 at 9:49 p.m., indicated a loud crash and thud was heard. Resident C was found entangled in a walker and laying on her back. She suffered a small quarter-sized hematoma to her left temple. No new fall prevention interventions were indicated.

The record lacked documentation that neuro checks had been implemented.

A nursing progress note, dated 10/14/21 at 3:18 p.m., indicated Resident C was found sitting on her apartment floor. Her vital signs and initial neuro checks were within normal limits and the resident was brought to the dining room. No new fall

prevention interventions were indicated.

The record lacked documentation that neuro checks had been implemented.

On 10/20/21 at 3:15 p.m., the ADM provided a copy of current facility policy titled, "Fall Management Policy" dated 6/2014. The policy indicated, "It is the policy of this community to ensure the residents residing within the community maintain maximum physical functioning through the establishment of physical, environmental, and psychosocial guidelines. This includes ensuring the safety and comfort of the resident, assisting in continuity of care, and identifying any preventable injury related to falls... Any resident that has a fall within the community will have an Incident Report completed. The form initiated the investigation process and is to be completed by the licensed nurse prior to the end of the shift... initiate neuro checks if the resident has an unwitnessed fall or hits their head...seventy-two (72) hours follow up charting form will be initiated and documented on severity shift for 72 hours...."

On 10/20/21 at 3:15 p.m., the ADM provided a copy of current facility policy titled, "Resident Service Plan" dated 6/2014. The policy indicated, "... service

	plans shall be reviewed and revised as appropriate and discussed by the resident and community as needs or desires change. Either the community or the resident may request a service plan review... The service plan is reviewed and revised every 6 months or following a change in condition and shall be signed and dated by the resident..." On 10/20/21 at 3:15 p.m., the ADM provided a copy of current facility policy titled, "Resident Change in Health Status," dated 6/2014. The policy indicated, "... All symptoms and unusual sings will be communicated to the attending physician promptly. Routine changes are a minor change in physical and mental behavior, abnormal laboratory and x-ray results that are not life threatening. The nursing staff is responsible for notifications of physician and family or responsible party prior to end of assigned shift when a significant change in the resident's condition is noted...." This State Residential Finding relates to Complaint IN00364351.				

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