

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/16/2023	
NAME OF PROVIDER OR SUPPLIER INDEPENDENCE VILLAGE OF FISHERS EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 12950 TALBLICK STREET, FISHERS, , 46037					
(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 IN00401007. Complaint IN00401007 - Substantiated. State deficiencies related to the allegations are cited at R091, R240 and R354. Survey dates: February 15 and 16, 2023 Facility number: 013945 Residential Census: 67 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 20, 2023	R 0000					
R 0091	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(h)(1-4) (h) The facility shall establish and	R 0091	. What corrective action(s) will be accomplished for those residents found to have			03/10/2023	

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implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. 2. The clinical record for Resident D was reviewed on 2/15/23 at 1:53 p.m. Her diagnoses included, but were not limited to, depression and hypertension. The 1/10/23 Level of Care Evaluation indicated Resident D did not transfer independently, needed staff assistance to transfer, and had fallen in the last 3 months The 12/28/22, 7:12 a.m. nurse's note read, "[Name of Resident D] was found lying in supine position on floor at bedside. It appears [name of Resident D] was having an episode of muscle spasms and tremors that caused her to fall out of the bed. No apparent injury noted at this time. [Name of Resident D] alert to self, able to follow some commands, denies pain/discomfort, denies hitting	been affected by the deficient practice; By in-servicing Wellness Staff regarding the facility's Fall Policy & Procedure, Residents who have fallen or are at risk for falls will have interventions that may decrease the risk for repetitive falls and/or reasons of why falls may be happening will be identified to assist in decreasing further risk of falls. . 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; A review of falls that have happened in last 30 days will be done and steps using the Fall Policy & Procedure will be used to ensure that the residents have not been affected by the alleged deficient practice by March 15th, 2023. Review to be done by the Wellness Director/designee.	
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head. ROM to all extremities WNL [within normal limits,] as per her normal. B/P [blood pressure] 149/97, P [pulse] 60, Temp [temperature] 97.3, r [respirations]16, O2 [oxygen]96% RA [room air.]"

The 1/2/23, 10:32 p.m. progress note read, "at 10:20PM was found on floor next to bed without injury and no complaints of pain. Triage notified Vital are B/P 111/57 Pulse 60 temp 98.2 o2 sat 97 respirations 16. Resident was toileted and is in bed. Will monitor throughout the night as advised by triage nurse."

The 1/2/23, 11:00 p.m. progress note read, "Fall Follow up Date/Time of Incident: 1/2/23 1035 pm. Description: Resident found lying at bedside on her left side. No injury apparent. Resident unable to account for events leading to fall . Denies pain, denies hitting head. Resident assisted up and back to bed by staff. Vitals WNL. ROM [range of motion] WNL. Close monitoring post fall for safety/changes. Actions (Intervention if a fall): Close monitoring post fall. Notification: PCP [primary care physician,] Family, WD [Wellness Director.]"

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

A Fall Tracker will be initiated where all falls will be logged. The tracker will include each fall, date of fall along with intervention put into place. The Fall Tracker will be updated daily by the Wellness Director. Falls will be reviewed weekly with the Leadership staff that attend Weekly Clinical Meeting.

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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;

There were no incident logs in Resident D's clinical record regarding her 12/28/22 or 1/2/23 falls.

An interview was conducted with the DON (Director of Nursing) on 2/16/23 at 9:57 a.m. She indicated a progress note was documented after a resident fell and nursing was to do 72 hour charting after the fall. The DON reviewed the facility's fall policy at this time and indicated they did not use incident logs and was unsure what they were.

This State Tag relates to complaint IN00401007.

Based on interview and record review, the facility failed to follow the facility's fall policy regarding incident logs with post fall interventions for 2 of 3 residents reviewed for falls. (Resident B and D)

Findings include:

1. A fall policy was provided by the Director of Nursing on 2/15/23 at 1:24 p.m. It indicated "...1. Purpose. The purpose of the falls policy is to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of falls. 2. Prerequisites. Should the resident experience a fall, staff will provide or arrange for necessary emergency care, and follow up with service plan

A Weekly Fall Audit will be conducted during the Weekly Clinical meeting to ensure that all falls have been tracked and that the fall policy and procedure has been followed.

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By
what date the systemic changes will be completed:

The
Systemic changes will be implemented by March 10, 2023.

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updates needed. Resident record; incident log...4. Procedure...7...b. Staff complete the post fall documentation. c. The incident is recorded on the incident log with the post fall intervention..."

The clinical record for Resident B was reviewed on 2/15/23 at 12:00 p.m. The diagnosis for Resident B included, but was not limited to, dementia. The resident was admitted on 12/1/22 and discharged to another assisted living facility on 1/17/23.

A Saint Louis University Mental Status (Slums) assessment dated 11/30/22 indicated Resident B had dementia(cognitively impaired).

A hospital discharge summary report dated 12/1/22 indicated a recommendation of rehab following hospitalization due to gait disturbance.

A Morse fall assessment dated 12/1/22 indicated the resident was assessed on admission and scored as a high risk for falling. The assessment was conducted to "determine fall risk factors and target interventions to reduce risk." The assessment indicated Resident B does not use assisted device, but his gait was impaired. The assessment did not include documented interventions to reduce Resident

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B from falling.

A medical provider note dated 12/7/22 indicated the resident was seen due to a new patient. "...The facility requested PT/OT [physical therapy and occupational therapy]..."

A nursing progress note for Resident B dated 12/8/22 indicated "Resident returned to community after a Christmas light outing. While resident was ambulating at the lounge area, he lost his balance, and fell on his right side per the staff that witness fall..."

A nursing progress note for Resident B dated 12/11/22 indicated "res [resident] was eating dinner., when res stated he was trying to get up then slide off the chair,...nurse will notify family practice to send or for wheelchair, res will need device oto (sic) ambulate to prevent further fall or incidence.

An incident nursing note for Resident B dated 12/20/22 indicated "date/time of incident: 12/20/22 10:27 p.m.
Description: Resident found lying on left side in apt [apartment]...Resident stated he was going to restroom had a loss of balance and fell. Resident ambulating independently with no assistive device...Action (intervention if a fall): Call for assistance if

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needed for ambulating..."

A medical provider note dated 12/21/22 indicated "...He [Resident B] attempts to stand up during our visit with his walker, and is not able to get the strength to stand on his own. Staff notes that he often shuffles when going from sit to stand. Patient is reminded to ask for help when standing. PT has not been able to be started yet. Patient has had a fall in the last week...Goals for next week: start PT..."

A nursing progress note for Resident B dated 12/26/22, indicated "Resident had an unwitnessed fall early this morning...Resident voiced pain to back of neck, and left hip...Resident sent out to [name of hospital]..."

A service plan date initiated 12/30/22 for falls. It indicated the interventions were "is at risk for falls due to impaired balanced. Walks fast. Staff: Safety checks for falls..."

A nursing task form dated 12/15/22 indicated his safety needed: "Is at risk for falls due to impaired balance. Walks fast. Receives reminders/prompting/assistance during emergencies. Staff Managed: Does not know name, reason or time of medication. Staff Managed: Is unaware he

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need to take prescribed medications. Staff: Safety Checks for falls..."

A medical provider 1/4/23 indicated the resident was seen. The resident gait was the following: "...tandem walking: unsteady patient shuffles his feet, not completing a full swing before his foot touches the ground. often sliding his shoes....the facility requested PT/OT for reduction of falls..."

A fall incident report was provided by the Director of Nursing on 12/16/23 at 8:35 a.m. It indicated Resident B had fallen on 12/8/22, 12/20/22 and 12/26/22. The fall report did not include Resident B's fall on 12/11/22.

The resident's clinical record did not include incident logs nor post fall documentation that included fall interventions for Resident B's falls that occurred on 12/8/22, 12/11/22, 12/20/22 and 12/26/22.

An interview was conducted with the Director of Nursing on 12/16/23 at 10:00 a.m. She indicated she was unsure why there was a delay with Resident B starting physical therapy services. The nursing task form was all the interventions or reminders to assist the staff with care of the resident. The fall interventions put in place would

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be in the safety section in the task form and in the fall service plan. After reviewing of the facility fall policy, she indicated the staff do not utilize incident logs that includes post fall documentation per the policy. She was not sure what that was. The Director of Nursing was unable to provide post fall documentation for Resident B's falls and was unaware Resident B had fallen on 12/11/22. The resident did have a walker, but he was not consistent with using it. She was unsure when the walker was brought into the facility for his use.

An interview was conducted with Resident B's Representative on 2/16/23 at 12:30 p.m. Resident B was admitted to the facility on 12/1/22 from the hospital, and he had orders the resident was to receive PT/OT/DT therapy. Resident B had 4 falls while in the facility and had not received the therapy services as he needed. The nursing staff had been asked about the therapy services, and the staff still had not started those services. The resident was discharged on 1/17/23.

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2. The clinical record for Resident D was reviewed on 2/15/23 at 1:53 p.m. Her diagnoses included, but were not limited to, depression and hypertension.

The 1/10/23 Level of Care Evaluation indicated Resident D did not transfer independently, needed staff assistance to transfer, and had fallen in the last 3 months

The 12/28/22, 7:12 a.m. nurse's note read, "[Name of Resident D] was found lying in supine position on floor at bedside. It appears [name of Resident D] was having an episode of muscle spasms and tremors that caused her to fall out of the bed. No apparent injury noted at this time. [Name of Resident D] alert to self, able to follow some commands, denies pain/discomfort, denies hitting head. ROM to all extremities WNL [within normal limits,] as per her normal. B/P [blood pressure] 149/97, P [pulse] 60, Temp [temperature] 97.3, r [respirations]16, O2 [oxygen]96% RA [room air.]"

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The 1/2/23, 11:00 p.m. progress note read, "Fall Follow up
Date/Time of Incident: 1/2/23
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There were no incident logs in Resident D's clinical record regarding her 12/28/22 or 1/2/23 falls.

An interview was conducted with the DON (Director of Nursing) on 2/16/23 at 9:57 a.m. She indicated a progress note was documented after a resident fell and nursing was to do 72 hour charting after the fall. The DON reviewed the facility's fall policy at this time and indicated they did not use incident logs and was unsure what they were.

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Based on interview and record review, the facility failed to follow the facility's fall policy regarding incident logs with post fall interventions for 2 of 3 residents reviewed for falls. (Resident B and D)

Findings include:

1. A fall policy was provided by the Director of Nursing on 2/15/23 at 1:24 p.m. It indicated "...1. Purpose. The purpose of the falls policy is to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of falls. 2. Prerequisites. Should the resident experience a fall, staff will provide or arrange for necessary emergency care, and follow up with service plan updates needed. Resident record; incident log...4. Procedure...7...b. Staff complete the post fall documentation. c. The incident is recorded on the incident log with the post fall intervention..."

The clinical record for Resident B was reviewed on 2/15/23 at 12:00 p.m. The diagnosis for Resident B included, but was not limited to, dementia. The resident was admitted on 12/1/22 and discharged to another assisted living facility on 1/17/23.

A Saint Louis University Mental Status (Slums) assessment

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dated 11/30/22 indicated Resident B had dementia(cognitively impaired).

A hospital discharge summary report dated 12/1/22 indicated a recommendation of rehab following hospitalization due to gait disturbance.

A Morse fall assessment dated 12/1/22 indicated the resident was assessed on admission and scored as a high risk for falling. The assessment was conducted to "determine fall risk factors and target interventions to reduce risk." The assessment indicated Resident B does not use assisted device, but his gait was impaired. The assessment did not include documented interventions to reduce Resident B from falling.

A medical provider note dated 12/7/22 indicated the resident was seen due to a new patient. "...The facility requested PT/OT [physical therapy and occupational therapy]..."

A nursing progress note for Resident B dated 12/8/22 indicated "Resident returned to community after a Christmas light outing. While resident was ambulating at the lounge area, he lost his balance, and fell on his right side per the staff that witness fall..."

A nursing progress note for Resident B dated 12/11/22

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indicated "res [resident] was eating dinner., when res stated he was trying to get up then slide off the chair,...nurse will notify family practice to send or for wheelchair, res will need device oto (sic) ambulate to prevent further fall or incidence.

An incident nursing note for Resident B dated 12/20/22 indicated "date/time of incident: 12/20/22 10:27 p.m.
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Resident ambulating independently with no assistive device...Action (intervention if a fall): Call for assistance if needed for ambulating..."

A medical provider note dated 12/21/22 indicated "...He [Resident B] attempts to stand up during our visit with his walker, and is not able to get the strength to stand on his own. Staff notes that he often shuffles when going from sit to stand. Patient is reminded to ask for help when standing. PT has not been able to be started yet. Patient has had a fall in the last week...Goals for next week: start PT..."

A nursing progress note for Resident B dated 12/26/22, indicated "Resident had an unwitnessed fall early this

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morning...Resident voiced pain to back of neck, and left hip...Resident sent out to [name of hospital]..."

A service plan date initiated 12/30/22 for falls. It indicated the interventions were "is at risk for falls due to impaired balanced. Walks fast. Staff: Safety checks for falls..."

A nursing task form dated 12/15/22 indicated his safety needed: "Is at risk for falls due to impaired balance. Walks fast. Receives reminders/prompting/assistance during emergencies. Staff Managed: Does not know name, reason or time of medication. Staff Managed: Is unaware he need to take prescribed medications. Staff: Safety Checks for falls..."

A medical provider 1/4/23 indicated the resident was seen. The resident gait was the following: "...tandem walking: unsteady patient shuffles his feet, not completing a full swing before his foot touches the ground. often sliding his shoes....the facility requested PT/OT for reduction of falls..."

A fall incident report was provided by the Director of Nursing on 12/16/23 at 8:35 a.m. It indicated Resident B had fallen on 12/8/22, 12/20/22 and 12/26/22. The fall report did not

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include Resident B's fall on 12/11/22.

The resident's clinical record did not include incident logs nor post fall documentation that included fall interventions for Resident B's falls that occurred on 12/8/22, 12/11/22, 12/20/22 and 12/26/22.

An interview was conducted with the Director of Nursing on 12/16/23 at 10:00 a.m. She indicated she was unsure why there was a delay with Resident B starting physical therapy services. The nursing task form was all the interventions or reminders to assist the staff with care of the resident. The fall interventions put in place would be in the safety section in the task form and in the fall service plan. After reviewing of the facility fall policy, she indicated the staff do not utilize incident logs that includes post fall documentation per the policy. She was not sure what that was. The Director of Nursing was unable to provide post fall documentation for Resident B's falls and was unaware Resident B had fallen on 12/11/22. The resident did have a walker, but he was not consistent with using it. She was unsure when the walker was brought into the facility for his use.

An interview was conducted with Resident B's

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Representative on 2/16/23 at 12:30 p.m. Resident B was admitted to the facility on 12/1/22 from the hospital, and he had orders the resident was to receive PT/OT/DT therapy. Resident B had 4 falls while in the facility and had not received the therapy services as he needed. The nursing staff had been asked about the therapy services, and the staff still had not started those services. The resident was discharged on 1/17/23.

2. The clinical record for Resident D was reviewed on 2/15/23 at 1:53 p.m. Her diagnoses included, but were not limited to, depression and hypertension.

The 1/10/23 Level of Care Evaluation indicated Resident D did not transfer independently, needed staff assistance to transfer, and had fallen in the last 3 months

The 12/28/22, 7:12 a.m. nurse's note read, "[Name of Resident D] was found lying in supine position on floor at bedside. It appears [name of Resident D] was having an episode of muscle spasms and tremors that caused her to fall out of the bed. No apparent injury noted at this time. [Name of Resident D] alert to self, able to follow some commands, denies pain/discomfort, denies hitting

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1035 pm. Description: Resident found lying at bedside on her left side. No injury apparent. Resident unable to account for events leading to fall . Denies pain, denies hitting head. Resident assisted up and back to bed by staff. Vitals WNL. ROM [range of motion] WNL. Close monitoring post fall for safety/changes. Actions (Intervention if a fall): Close monitoring post fall. Notification: PCP [primary care physician,] Family, WD [Wellness Director.']

There were no incident logs in Resident D's clinical record regarding her 12/28/22 or 1/2/23 falls.

An interview was conducted with the DON (Director of Nursing) on 2/16/23 at 9:57 a.m. She indicated a progress note was documented after a resident fell and nursing was to do 72 hour charting after the fall. The DON reviewed the facility's fall policy at this time and indicated they did not use incident logs and was unsure what they were.

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Based on interview and record review, the facility failed to follow the facility's fall policy regarding incident logs with post fall interventions for 2 of 3 residents reviewed for falls. (Resident B and D)

Findings include:

1. A fall policy was provided by the Director of Nursing on 2/15/23 at 1:24 p.m. It indicated "...1. Purpose. The purpose of the falls policy is to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of falls. 2. Prerequisites. Should the resident experience a fall, staff will provide or arrange for necessary emergency care, and follow up with service plan updates needed. Resident record; incident log...4. Procedure...7...b. Staff complete the post fall documentation. c. The incident is recorded on the incident log with the post fall intervention..."

The clinical record for Resident B was reviewed on 2/15/23 at 12:00 p.m. The diagnosis for Resident B included, but was not limited to, dementia. The resident was admitted on 12/1/22 and discharged to another assisted living facility on 1/17/23.

A Saint Louis University Mental Status (Slums) assessment

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dated 11/30/22 indicated Resident B had dementia(cognitively impaired).

A hospital discharge summary report dated 12/1/22 indicated a recommendation of rehab following hospitalization due to gait disturbance.

A Morse fall assessment dated 12/1/22 indicated the resident was assessed on admission and scored as a high risk for falling. The assessment was conducted to "determine fall risk factors and target interventions to reduce risk." The assessment indicated Resident B does not use assisted device, but his gait was impaired. The assessment did not include documented interventions to reduce Resident B from falling.

A medical provider note dated 12/7/22 indicated the resident was seen due to a new patient. "...The facility requested PT/OT [physical therapy and occupational therapy]..."

A nursing progress note for Resident B dated 12/8/22 indicated "Resident returned to community after a Christmas light outing. While resident was ambulating at the lounge area, he lost his balance, and fell on his right side per the staff that witness fall..."

A nursing progress note for Resident B dated 12/11/22

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indicated "res [resident] was eating dinner., when res stated he was trying to get up then slide off the chair,...nurse will notify family practice to send or for wheelchair, res will need device oto (sic) ambulate to prevent further fall or incidence.

An incident nursing note for Resident B dated 12/20/22 indicated "date/time of incident: 12/20/22 10:27 p.m.
Description: Resident found lying on left side in apt [apartment]...Resident stated he was going to restroom had a loss of balance and fell.
Resident ambulating independently with no assistive device...Action (intervention if a fall): Call for assistance if needed for ambulating..."

A medical provider note dated 12/21/22 indicated "...He [Resident B] attempts to stand up during our visit with his walker, and is not able to get the strength to stand on his own. Staff notes that he often shuffles when going from sit to stand. Patient is reminded to ask for help when standing. PT has not been able to be started yet. Patient has had a fall in the last week...Goals for next week: start PT..."

A nursing progress note for Resident B dated 12/26/22, indicated "Resident had an unwitnessed fall early this

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morning...Resident voiced pain to back of neck, and left hip...Resident sent out to [name of hospital]..."

A service plan date initiated 12/30/22 for falls. It indicated the interventions were "is at risk for falls due to impaired balanced. Walks fast. Staff: Safety checks for falls..."

A nursing task form dated 12/15/22 indicated his safety needed: "Is at risk for falls due to impaired balance. Walks fast. Receives reminders/prompting/assistance during emergencies. Staff Managed: Does not know name, reason or time of medication. Staff Managed: Is unaware he need to take prescribed medications. Staff: Safety Checks for falls..."

A medical provider 1/4/23 indicated the resident was seen. The resident gait was the following: "...tandem walking: unsteady patient shuffles his feet, not completing a full swing before his foot touches the ground. often sliding his shoes....the facility requested PT/OT for reduction of falls..."

A fall incident report was provided by the Director of Nursing on 12/16/23 at 8:35 a.m. It indicated Resident B had fallen on 12/8/22, 12/20/22 and 12/26/22. The fall report did not

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include Resident B's fall on 12/11/22.

The resident's clinical record did not include incident logs nor post fall documentation that included fall interventions for Resident B's falls that occurred on 12/8/22, 12/11/22, 12/20/22 and 12/26/22.

An interview was conducted with the Director of Nursing on 12/16/23 at 10:00 a.m. She indicated she was unsure why there was a delay with Resident B starting physical therapy services. The nursing task form was all the interventions or reminders to assist the staff with care of the resident. The fall interventions put in place would be in the safety section in the task form and in the fall service plan. After reviewing of the facility fall policy, she indicated the staff do not utilize incident logs that includes post fall documentation per the policy. She was not sure what that was. The Director of Nursing was unable to provide post fall documentation for Resident B's falls and was unaware Resident B had fallen on 12/11/22. The resident did have a walker, but he was not consistent with using it. She was unsure when the walker was brought into the facility for his use.

An interview was conducted with Resident B's

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	Representative on 2/16/23 at 12:30 p.m. Resident B was admitted to the facility on 12/1/22 from the hospital, and he had orders the resident was to receive PT/OT/DT therapy. Resident B had 4 falls while in the facility and had not received the therapy services as he needed. The nursing staff had been asked about the therapy services, and the staff still had not started those services. The resident was discharged on 1/17/23.			
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. Based on interview and record review, the facility failed to follow up on a therapy recommendation timely, administer a hypertension medication as ordered, obtain blood pressures standing and sitting as ordered and notify a medical provider of a resident's change of condition timely for 1 of 3 residents reviewed for falls, change in condition, and therapy services. (Resident B) Finding include: 1a. The clinical record for	R 0240	. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: By In-servicing Wellness Staff on ways to identify Changes in condition and following Physicians orders, residents who have had changes in condition from medical illness/conditions or falls will not have affects of decline related to not following interventions or physicians orders in a timely manner.	03/15/2023

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Resident B was reviewed on 2/15/23 at 12:00 p.m. The diagnosis for Resident B included, but was not limited to, dementia. The resident was admitted on 12/1/22 and discharged to another assisted living facility on 1/17/23.

A Saint Louis University Mental Status (Slums) assessment dated 11/30/22 indicated Resident B had dementia(cognitively impaired).

A hospital discharge summary report dated 12/1/22 indicated a recommendation of rehab following hospitalization due to gait disturbance.

A Morse fall assessment dated 12/1/22 indicated the resident was assessed on admission and scored as a high risk for falling. The assessment was conducted to "determine fall risk factors and target interventions to reduce risk." The assessment indicated Resident B does not use assisted device, but his gait was impaired.

A medical provider note dated 12/7/22 indicated the resident was seen due to a new patient. "...The facility requested PT/OT [physical therapy and occupational therapy]..."

A fall incident report indicated Resident B had falls on 12/8/22, 12/20/22 and 12/26/22.

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

All residents are at risk to be potentially affected by the same alleged deficient practice but to prevent from other residents potentially being affected the Wellness Director/designee will review the 24/72 hour shift report to identify any residents that have personal care needs that require the appropriate follow up to ensure that their Personal individual care needs are met.

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

During the Weekly clinical meeting the Wellness Director will follow up on any residents that had

A nursing progress note dated 12/11/22 indicated Resident B had fallen out of a chair that day.

The fall report did not include Resident B had a fall on 12/11/22.

A medical provider note dated 12/21/22 indicated "...He [Resident B] attempts to stand up during our visit with his walker, and is not able to get the strength to stand on his own. Staff notes that he often shuffles when going from sit to stand. Patient is reminded to ask for help when standing. PT has not been able to be started yet. Patient has had a fall in the last week...Goals for next week: start PT..."

A medical provider 1/4/23 indicated the resident was seen. The resident gait was the following: "...tandem walking: unsteady patient shuffles his feet, not completing a full swing before his foot touches the ground. often sliding his shoes....the facility requested PT/OT for reduction of falls..."

An interview was conducted with the Director of Nursing on 2/15/23 at 12:00 p.m. She indicated the nursing staff are responsible with getting the physician orders for residents to receive therapy services. Once the orders are given to therapy,

been identified on the daily review to ensure any changes in care needs have been completed and followed through.

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:

10% of resident total census will be audited/reviewed for any changes in condition or medical concerns that will include checking for any referrals or Physicians orders. The audit will be looking for timely follow up and the appropriate documentation within the residents chart. Audit will be done weekly for 4 weeks, then Bi-weekly for 4 weeks, then once a month for 3 months to determine if the process is consistently followed. If at that time the Quality Assurance threshold is greater than 95% for 3 months, the audit may be stopped as the systemic process that has been put in place has been determined to be successful.

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the therapy department was responsible for getting insurance information to provide those services.

An interview was conducted with Resident B's Representative on 2/16/23 at 12:30 p.m. Resident B was admitted to the facility on 12/1/22 from the hospital, and he had orders the resident was to receive PT/OT/DT therapy. Resident B had 4 falls while in the facility and had not received the therapy services. The nursing staff had been asked about the therapy services, and they still had not started those services.

An interview was conducted with Therapy Director 5 on 2/16/23 at 11:13 a.m. She indicated in the month of December, she was out of the facility for 4 weeks. She had not evaluated Resident B nor provided any therapy services to Resident B during his stay in the facility. Regional Therapy Director 6 had overseen the therapy department while she was gone. She was unable to provide any documentation regarding Resident B, because therapy had not provided any services to him.

An interview was conducted with the Certified Occupational Therapy Assistant 7 on 2/16/23 at 11:19 a.m. She indicated the

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By
what date the systemic changes will be completed

March 15, 2023.

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therapy staff received orders to provide therapy services to Resident B she believed after Christmas. The resident's family chose not to initiate the services. She was unable to provide the physician orders.

An interview was conducted with Regional Therapy Director 6 on 2/16/23 at 3:37 p.m. She indicated Resident B did not have orders for PT/OT on admission. Therapy Director 5 had went on vacation mid December. She was overseeing the therapy department at that time. If Therapy Director 5 had received the orders prior to leaving on vacation, she would have put them in. She can not recall exact date, but after Christmas does sound correct about when the therapy department did receive the orders from nursing to provide the services to Resident B. The therapy department did not have the resident's insurance information. The nursing staff do get the physician orders to start therapy, but she had learned during that time, it was the responsibility of therapy staff to received insurance information for the residents; nursing does not do that. She could not recall exact date, but did reach out to Resident B's Representative around 1/5/23 to start therapy services, and she had declined the services due to moving the resident to another assisted

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living.

1b. A pre-admission healthcare provider plan of care dated 11/30/22 indicated Resident B was to receive 225 milligrams of propafenone hypertension medication three times a day.

A hospital discharge summary report dated 12/1/22 indicated Resident B was to receive 425 milligrams of propafenone hypertension medications every 12 hours.

An order recap physician order report dated 12/1/22 - 1/31/23 indicated on 12/1/22 Resident B was to receive 225 milligrams of propafenone three times a day. The medication order was discontinued on 1/5/23. The reason documented as "order changed from ER [emergency room] discharged order."

A physician order dated 1/5/23 indicated Resident B was to receive 450 milligrams of propafenone three times a day. The order was discontinued on 1/9/23.

A physician order dated 1/9/23 indicated Resident B was to receive 425 milligrams of propafenone three times a day.

The December 2022 Medication Administration Record indicated Resident B had received the 225 milligrams of propafenone on 12/1/22 through 12/31/22

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three times a day except on 12/19/22 and 12/26/22 due to hospitalization.

The hospital discharge instructions dated 12/26/22 indicated Resident B was to receive 425 milligrams of propafenone every 12 hours.

The January 2023 Medication Administration Record indicated Resident B had received 450 milligrams propafenone on 1/5/23 through 1/9/23 three times a day except on the evening of 1/6/23, because of hospitalization. Resident B received 425 milligrams of propafenone three times a day from 1/9/23 through the morning of 1/17/23, because of resident's discharge.

The hospital discharge instructions dated 1/6/23 indicated the resident was to receive 425 milligrams of profenone every 12 hours.

The resident's clinical record did not have documentation or provider notes the physician orders were to change from the hospital discharge summary paperwork dated 12/1/22, to administer 425 milligrams of propafenone every 12 hours to the resident.

An interview was conducted with the Director of Nursing on 2/16/23 at 11:39 a.m. She indicated the pre-admission plan

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of care dated 11/30/22 was faxed over prior to admission with Resident B's medication. On admission, 12/1/22 after reviewing the medication list discharge summary, she indicated the nursing staff are to compare and clarify any discrepancies. There are checkmarks on the discharge summary medications which indicates to her the nursing staff had reviewed and compared what was received on 11/30/22 and 12/1/22. The nursing staff did document the emergency room had changed the order on 1/5/23, but was unable to find any documentation by hospital records nor a medical provider the propafenone dosage had changed.

A release of medications form dated 1/17/23 indicated on the discharge, Resident B had received 2 bottles of 425 milligrams of propafenone.

1c. A physician order dated 1/2/23 indicated staff was to obtain Resident B's blood pressures sitting and standing 3 times a day. The instructions by the provider were for the staff to take resident's blood pressure while sitting and then by standing. The order was discontinued on 1/9/23.

The January 2023 Medication Administration Record indicated the staff had not taken Resident

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B's blood pressure sitting and then standing three times a day as ordered on the following days and shifts:

1/2/23 at 7:30 p.m.,

1/3/23 at 1:30 p.m.,

1/4/23 at 1:30 p.m., and 7:30 p.m.,

1/5/23 at 7:30 a.m., 1:30 p.m., and 7:30 p.m.,

1/6/23 at 7:30 a.m., 1:30 p.m.,

1/7/23 at 7:30 a.m., 1:30 p.m.,

1/8/23 at 7:30 a.m., and

1/9/23 at 7:30 a.m., 7:30 p.m.

An interview was conducted with the Director of Nursing on 2/16/23 at 12:40 p.m. She indicated she had reviewed the blood pressures that were obtained, and she was unable to provide any additional blood pressures.

1d. A nursing progress note for Resident B dated 12/18/22 at 9:22 a.m., indicated "res [resident] has been lethargic, increase fatigue, assessed res, his 02 was 94, b/p [blood pressure] was 133/79 hr [heart rate] 81, res denied pain he stated he's feeling okay, res was sitting in a chair, he learned (sic) on one side. staff will keep on res for any change of

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condition.

Resident B's clinical record did not indicate the medical provider was notified of the resident's change of condition on 12/18/22.

A nursing progress note dated 12/19/22 at 5:10 p.m., indicated "Resident appeared lethargic, hard to arouse, wheeze like sound heard when he breaths, with chest congestion. Resident had fever of 100.3f [Fahrenheit] LOC [level of conscious] below baseline. Writer spoke to POA [Power of Attorney]. POA arrived to facility to visit resident. Writer sent resident out to [name of hospital]..."

A medical provider note dated 12/21/22 indicated "...Patient [Resident B] was sent to ER [emergency room] due to lethargy. He was diagnosed with influenza A..."

An interview was conducted with Resident B's Representative on 2/16/23 at 12:30 p.m. She indicated Resident B had been receiving companion care services by a health staff person in the past and was assisting Resident B's Representative to oversee the resident's care at the facility. The facility nursing staff had contacted Health Staff 9 on 12/19/22, and reported Resident B was lethargic with a low grade

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fever. Health Staff 9 went to the facility and assessed Resident B. The resident was sweating, lethargic, coughing and had a sore throat. The staff was not going to have the resident see a doctor, so Health Staff 9 had requested the resident to be sent to the hospital for evaluation. The resident had tested positive for the flu at the hospital.

An interview was conducted with the Director of Nursing on 12/16/23 at 12:40 p.m. She indicated the medical provider should be notified if a resident has had a change of condition. She was unable to provide hospital discharge summary from Resident B's 12/19/22 hospitalization. The staff should document in the progress notes if the medical provider was notified on 12/18/22. She was unable to provide documentation the medical provider was notified on 12/18/22 with Resident B' change of condition.

This State Tag relates to complaint IN00401007.

Based on interview and record review, the facility failed to follow up on a therapy recommendation timely, administer a hypertension medication as ordered, obtain blood pressures standing and sitting as ordered and notify a

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medical provider of a resident's change of condition timely for 1 of 3 residents reviewed for falls, change in condition, and therapy services. (Resident B)

Finding include:

1a. The clinical record for Resident B was reviewed on 2/15/23 at 12:00 p.m. The diagnosis for Resident B included, but was not limited to, dementia. The resident was admitted on 12/1/22 and discharged to another assisted living facility on 1/17/23.

A Saint Louis University Mental Status (Slums) assessment dated 11/30/22 indicated Resident B had dementia(cognitively impaired).

A hospital discharge summary report dated 12/1/22 indicated a recommendation of rehab following hospitalization due to gait disturbance.

A Morse fall assessment dated 12/1/22 indicated the resident was assessed on admission and scored as a high risk for falling. The assessment was conducted to "determine fall risk factors and target interventions to reduce risk." The assessment indicated Resident B does not use assisted device, but his gait was impaired.

A medical provider note dated 12/7/22 indicated the resident

was seen due to a new patient.
"...The facility requested PT/OT [physical therapy and occupational therapy]..."

A fall incident report indicated Resident B had falls on 12/8/22, 12/20/22 and 12/26/22.

A nursing progress note dated 12/11/22 indicated Resident B had fallen out of a chair that day.

The fall report did not include Resident B had a fall on 12/11/22.

A medical provider note dated 12/21/22 indicated "...He [Resident B] attempts to stand up during our visit with his walker, and is not able to get the strength to stand on his own. Staff notes that he often shuffles when going from sit to stand. Patient is reminded to ask for help when standing. PT has not been able to be started yet. Patient has had a fall in the last week...Goals for next week: start PT..."

A medical provider 1/4/23 indicated the resident was seen. The resident gait was the following: "...tandem walking: unsteady patient shuffles his feet, not completing a full swing before his foot touches the ground. often sliding his shoes....the facility requested PT/OT for reduction of falls..."

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An interview was conducted with the Director of Nursing on 2/15/23 at 12:00 p.m. She indicated the nursing staff are responsible with getting the physician orders for residents to receive therapy services. Once the orders are given to therapy, the therapy department was responsible for getting insurance information to provide those services.

An interview was conducted with Resident B's Representative on 2/16/23 at 12:30 p.m. Resident B was admitted to the facility on 12/1/22 from the hospital, and he had orders the resident was to receive PT/OT/DT therapy. Resident B had 4 falls while in the facility and had not received the therapy services. The nursing staff had been asked about the therapy services, and they still had not started those services.

An interview was conducted with Therapy Director 5 on 2/16/23 at 11:13 a.m. She indicated in the month of December, she was out of the facility for 4 weeks. She had not evaluated Resident B nor provided any therapy services to Resident B during his stay in the facility. Regional Therapy Director 6 had overseen the therapy department while she was gone. She was unable to provide any documentation

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regarding Resident B, because therapy had not provided any services to him.

An interview was conducted with the Certified Occupational Therapy Assistant 7 on 2/16/23 at 11:19 a.m. She indicated the therapy staff received orders to provide therapy services to Resident B she believed after Christmas. The resident's family chose not to initiate the services. She was unable to provide the physician orders.

An interview was conducted with Regional Therapy Director 6 on 2/16/23 at 3:37 p.m. She indicated Resident B did not have orders for PT/OT on admission. Therapy Director 5 had went on vacation mid December. She was overseeing the therapy department at that time. If Therapy Director 5 had received the orders prior to leaving on vacation, she would have put them in. She can not recall exact date, but after Christmas does sound correct about when the therapy department did receive the orders from nursing to provide the services to Resident B. The therapy department did not have the resident's insurance information. The nursing staff do get the physician orders to start therapy, but she had learned during that time, it was the responsibility of therapy staff to received insurance information

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for the residents; nursing does not do that. She could not recall exact date, but did reach out to Resident B's Representative around 1/5/23 to start therapy services, and she had declined the services due to moving the resident to another assisted living.

1b. A pre-admission healthcare provider plan of care dated 11/30/22 indicated Resident B was to receive 225 milligrams of propafenone hypertension medication three times a day.

A hospital discharge summary report dated 12/1/22 indicated Resident B was to receive 425 milligrams of propafenone hypertension medications every 12 hours.

An order recap physician order report dated 12/1/22 - 1/31/23 indicated on 12/1/22 Resident B was to receive 225 milligrams of propafenone three times a day. The medication order was discontinued on 1/5/23. The reason documented as "order changed from ER [emergency room] discharged order."

A physician order dated 1/5/23 indicated Resident B was to receive 450 milligrams of propafenone three times a day. The order was discontinued on 1/9/23.

A physician order dated 1/9/23 indicated Resident B was to

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receive 425 milligrams of propafenone three times a day.

The December 2022 Medication Administration Record indicated Resident B had received the 225 milligrams of propafenone on 12/1/22 through 12/31/22 three times a day except on 12/19/22 and 12/26/22 due to hospitalization.

The hospital discharge instructions dated 12/26/22 indicated Resident B was to receive 425 milligrams of propafenone every 12 hours.

The January 2023 Medication Administration Record indicated Resident B had received 450 milligrams propafenone on 1/5/23 through 1/9/23 three times a day except on the evening of 1/6/23, because of hospitalization. Resident B received 425 milligrams of propafenone three times a day from 1/9/23 through the morning of 1/17/23, because of resident's discharge.

The hospital discharge instructions dated 1/6/23 indicated the resident was to receive 425 milligrams of profenone every 12 hours.

The resident's clinical record did not have documentation or provider notes the physician orders were to change from the hospital discharge summary paperwork dated 12/1/22, to

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administer 425 milligrams of propafenone every 12 hours to the resident.

An interview was conducted with the Director of Nursing on 2/16/23 at 11:39 a.m. She indicated the pre-admission plan of care dated 11/30/22 was faxed over prior to admission with Resident B's medication. On admission, 12/1/22 after reviewing the medication list discharge summary, she indicated the nursing staff are to compare and clarify any discrepancies. There are checkmarks on the discharge summary medications which indicates to her the nursing staff had reviewed and compared what was received on 11/30/22 and 12/1/22. The nursing staff did document the emergency room had changed the order on 1/5/23, but was unable to find any documentation by hospital records nor a medical provider the propafenone dosage had changed.

A release of medications form dated 1/17/23 indicated on the discharge, Resident B had received 2 bottles of 425 milligrams of propafenone.

1c. A physician order dated 1/2/23 indicated staff was to obtain Resident B's blood pressures sitting and standing 3 times a day. The instructions by the provider were for the staff to

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take resident's blood pressure while sitting and then by standing. The order was discontinued on 1/9/23.

The January 2023 Medication Administration Record indicated the staff had not taken Resident B's blood pressure sitting and then standing three times a day as ordered on the following days and shifts:

1/2/23 at 7:30 p.m.,

1/3/23 at 1:30 p.m.,

1/4/23 at 1:30 p.m., and 7:30 p.m.,

1/5/23 at 7:30 a.m., 1:30 p.m., and 7:30 p.m.,

1/6/23 at 7:30 a.m., 1:30 p.m.,

1/7/23 at 7:30 a.m., 1:30 p.m.,

1/8/23 at 7:30 a.m., and

1/9/23 at 7:30 a.m., 7:30 p.m.

An interview was conducted with the Director of Nursing on 2/16/23 at 12:40 p.m. She indicated she had reviewed the blood pressures that were obtained, and she was unable to provide any additional blood pressures.

1d. A nursing progress note for Resident B dated 12/18/22 at 9:22 a.m., indicated "res [resident] has been lethargic,

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increase fatigue, assessed res, his 02 was 94, b/p [blood pressure] was 133/79 hr [heart rate] 81, res denied pain he stated he's feeling okay, res was sitting in a chair, he learned (sic) on one side. staff will keep on res for any change of condition.

Resident B's clinical record did not indicate the medical provider was notified of the resident's change of condition on 12/18/22.

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A medical provider note dated 12/21/22 indicated "...Patient [Resident B] was sent to ER [emergency room] due to lethargy. He was diagnosed with influenza A..."

An interview was conducted with Resident B's Representative on 2/16/23 at 12:30 p.m. She indicated Resident B had been receiving companion care services by a

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health staff person in the past and was assisting Resident B's Representative to oversee the resident's care at the facility. The facility nursing staff had contacted Health Staff 9 on 12/19/22, and reported Resident B was lethargic with a low grade fever. Health Staff 9 went to the facility and assessed Resident B. The resident was sweating, lethargic, coughing and had a sore throat. The staff was not going to have the resident see a doctor, so Health Staff 9 had requested the resident to be sent to the hospital for evaluation. The resident had tested positive for the flu at the hospital.

An interview was conducted with the Director of Nursing on 12/16/23 at 12:40 p.m. She indicated the medical provider should be notified if a resident has had a change of condition. She was unable to provide hospital discharge summary from Resident B's 12/19/22 hospitalization. The staff should document in the progress notes if the medical provider was notified on 12/18/22. She was unable to provide documentation the medical provider was notified on 12/18/22 with Resident B' change of condition.

This State Tag relates to complaint IN00401007.

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R 0354	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(g)(1-7) (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. 2. The clinical record for Resident D was reviewed on 2/15/23 at 1:53 p.m. Her diagnoses included, but were not limited to, depression and hypertension.	R 0354	. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No harm has been identified from not using a transfer form but residents' could potentially not receive continuity of care when transferred to the hospital by not having the necessary information that would be provided on the transfer form. . 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 A review of residents who have transferred to the hospital in the last 30 days will be reviewed to identify if any residents did not receive the appropriate care.	03/10/2023
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FORM APPROVED

OMB NO. 0938-0391

The 1/5/23, 2:39 p.m. nurse's note read, "Resident voiced pain to right hip area. Grimacing, and holding onto the area. No bruises, no redness, not warm to touch, or any skin concern noted during assessment. Resident's son [name of Resident D's son] was present, and he made a decision to take resident to ER [emergency room] for evaluation, and treatment."

There was no information in the clinical record to indicate a transfer form was sent to the hospital when Resident D was transferred there on 1/5/23.

An interview was conducted with the DON (Director of Nursing) on 2/16/23 at 9:57 a.m. She indicated the facility did not use transfer forms when a resident was sent to the hospital. They just sent them with a list of medications and their face sheet, which did not include the name of the receiving institution, date of transfer, resident's personal property when transferred to an acute care facility, nurse's notes related to the resident's functional abilities and physical limitation, nursing care, condition on transfer, and date of chest x-ray and skin test for tuberculosis.

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

An In-Service to be provided to Wellness staff regarding the process of transferring residents to the acute hospital and the documentation. In-service to be done on 3/9/23.

When a resident is sent out to the acute setting for care staff will place a copy of the transfer form to the Wellness Director. The Wellness Director will review the copy of the transfer form that was used when sending residents out.

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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:

A monthly Quality Assurance Audit will be conducted to review all

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This State Tag relates to complaint IN00401007.

Based on interview and record review, the facility failed to utilize a transfer form when residents were sent to the hospital that included: name of receiving institution and date of transfer, resident's personal property when transferred to an acute care facility, nurse's notes related to resident's functional abilities and physical limitation, nursing care, condition on transfer, and date of chest x-ray and skin test for tuberculosis for 2 of 3 residents reviewed for change of condition. (Residents' B and D)

Findings include:

1. The clinical record for Resident B was reviewed on 2/15/23 at 12:00 p.m. The diagnosis for Resident B included, but was not limited to, dementia. The resident was admitted on 12/1/22 and discharged to another assisted living facility on 1/17/23.

A nursing progress note dated 12/19/22 at 5:10 p.m., indicated "Resident appeared lethargic, hard to arouse, wheeze like sound heard when he breaths, with chest congestion. Resident had fever of 100.3f [Fahrenheit] LOC [level of conscious] below baseline. Writer spoke to POA [Power of Attorney]. POA

residents that went to the acute, looking for the Transfer form with the necessary information. The monthly audit will be done every month until the facility Quality Assurance Audit is at 100% three consecutive months.

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By
what date the systemic changes will be completed.

March 10, 2023.

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arrived to facility to visit resident. Writer sent resident out to [name of hospital]..."

A nursing progress note for Resident B dated 12/26/22, indicated "Resident had an unwitnessed fall early this morning...Resident voiced pain to back of neck, and left hip...Resident sent out to [name of hospital]..."

Resident B's clinical record did not have transfer discharge documentation for the resident discharge to the hospital on 12/19/22 and 12/26/22.

An interview was conducted with the Director of Nursing on 2/16/23 at 9:57 a.m. She indicated the staff does not utilize a transfer form to send out a resident to another health institution. The resident's face sheet and the medication list sheet are the only documents that are sent out with the resident.

Resident B's face sheet was provided by the Director of Nursing on 2/16/23 at 10:30 a.m. It did not include the following information: name of receiving institution and date of transfer, resident's personal property when transferred to an acute care facility, nurse's notes related to resident's functional abilities and physical limitation, nursing care, condition on

transfer, and date of chest x-ray and skin test for tuberculosis.

2. The clinical record for Resident D was reviewed on 2/15/23 at 1:53 p.m. Her diagnoses included, but were not limited to, depression and hypertension.

The 1/5/23, 2:39 p.m. nurse's note read, "Resident voiced pain to right hip area. Grimacing, and holding onto the area. No bruises, no redness, not warm to touch, or any skin concern noted during assessment. Resident's son [name of Resident D's son] was present, and he made a decision to take resident to ER [emergency room] for evaluation, and treatment."

There was no information in the clinical record to indicate a transfer form was sent to the hospital when Resident D was transferred there on 1/5/23.

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acute care facility, nurse's notes related to the resident's functional abilities and physical limitation, nursing care, condition on transfer, and date of chest x-ray and skin test for tuberculosis.

This State Tag relates to complaint IN00401007.

Based on interview and record review, the facility failed to utilize a transfer form when residents were sent to the hospital that included: name of receiving institution and date of transfer, resident's personal property when transferred to an acute care facility, nurse's notes related to resident's functional abilities and physical limitation, nursing care, condition on transfer, and date of chest x-ray and skin test for tuberculosis for 2 of 3 residents reviewed for change of condition. (Residents' B and D)

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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
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