| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING<br>B. WING | 04/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GRAND BROOK MEMORY CARE OF GREENWOOD | 2444 SOUTH STATE ROAD 135, GREENWOOD, , 46143 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES... | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION... | (X5) COMPLETION DATE |
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| R 0000 | INITIAL COMMENTS<br><br>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00372660.<br><br>Complaint IN00372660 - Substantiated. State deficiencies related to the allegations are cited at R0052.<br><br>Survey dates: April 26, 27, and 28, 2022<br><br>Facility number: 014426<br><br>Residential Census: 36<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed May 6, 2022. | R 0000 | 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 of any violation of regulation. | |
| R 0052 | Residents' Rights - Offense<br><br>410 IAC 16.2-5-1.2(v)(1-6)<br><br>(v) Residents have the right to be | R 0052 | Resident B, the Director of nursing has verified the presence of the updated care plan with the intervention of a fall mat. | 05/28/2022 |

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| | free from:<br><br>(1) sexual abuse;<br><br>(2) physical abuse;<br><br>(3) mental abuse;<br><br>(4) corporal punishment;<br><br>(5) neglect; and<br><br>(6) involuntary seclusion.<br><br>Based on interview and record review, the facility neglected to ensure supervision to prevent falls for residents which resulted in a hip fractures for 2 of 3 residents reviewed. (Resident B, Resident C)<br><br>Findings include:<br><br>1. On 4/26/22 at 11:30 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, senile degeneration of the brain, ataxia (impaired balance), left humerus fracture, and left hip fracture.<br><br>A review of Resident B's incident reports indicated the following:<br><br>-On 4/28/21 at 4:45 a.m., the resident had a fall in her bathroom which resulted in a bleeding head injury.<br><br>-On 5/4/21 at 2:15 a.m., the resident had a fall and was found lying on her floor. Bruising | | Resident C, the family was notified regarding the fall, the community advised that the resident be sent out via emergency services, however the family refused and wanted to pick the resident up themselves and take her to an urgent care. DON spoke with family and strongly urged them to take her to the ER if they were not going to let us send her out. Resident C has since passed away, no fall preventions needed.<br><br>Current community residents are at risk for the alleged practice of not implementing care planned interventions to reduce the risk of falls.<br><br>Current nursing staff will be in serviced by the ED and Director of Nursing, regarding interventions to reduce falls and the assurance that interventions remain in place. Newly hired nursing staff will receive in service education during orientation.<br><br>The DON and/or designee will observe residents/rooms weekly X 4 weeks and then monthly X 5 months, to validate that any interventions that are in place to reduce falls, according to resident care plan. The ED, DON and/or designee will review audit/monitors to identify patterns/trends and will adjust plan as needed to maintain compliance. Results of audit will be brought to QA Committee meeting for review/recommendations. | |

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| | was noted to the resident's back and buttocks.<br><br>-On 5/6/21 at 5:28 a.m., the resident had a fall and was found on her floor and sustained a skin tear to their back.<br><br>-On 5/14/21 at 5:00 a.m., the resident had a fall and was found on her floor.<br><br>-On 5/26/21 at 4:05 p.m., the resident had a fall and was found in her doorway.<br><br>-On 6/7/21 at 3:27 a.m., the resident was found on the floor next to the bed after a fall. She sustained a raised bruise to her forehead and a skin hear to her elbow.<br><br>-On 6/8/21 at 5:19 a.m., the resident was found on the floor next to the bed after a fall.<br><br>-On 6/10/21 at 10:16 a.m., the resident was found on the bathroom floor after a fall. She sustained a head injury.<br><br>-On 6/22/21 at 3:38 p.m., the resident was found on the floor after a fall. Her wheelchair was parked outside of her room and the walker was near the bed. The resident sustained a head injury.<br><br>-On 6/23/21 at 5:24 a.m., the resident had a fall in the common area. | | | |

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| | -On 7/7/21 at 1:09 p.m., the resident was found on the floor after a fall. The resident indicated she was searching for her spouse and she did not want her family to know about the fall so she did not look stupid.<br><br>-On 7/7/21 at 5:08 p.m., the resident had a fall in the common area and hit her head on a table. The resident sustained a head injury.<br><br>-On 7/7/21 at 9:34 p.m., the resident was found on the floor after a fall. The resident sustained a scratch to her back. This was the third fall the resident sustained on this day.<br><br>-On 7/11/21 at 11:21 p.m., the resident was found by staff on the floor after a fall.<br><br>-On 7/15/21 at 3:27 p.m., the resident was found by staff on the floor after a fall. The resident was resistant when reminded to use her walker and wheelchair.<br><br>-On 7/17/21 at 9:57 p.m., the resident was found by staff outside on the patio after a fall. The resident sustained a laceration to her face between her right eye and temple and bruising was noted to the right side her of face. | | | |

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| | -On 7/22/21 at 5:10 a.m., the resident was found in the hallway after a fall.<br><br>-On 7/23/21 at 3:16 p.m., the resident was found on the floor after a fall.<br><br>-On 7/27/21 at 12:24 a.m., the resident was found by staff on the floor after a fall. The resident sustained bruising to the back.<br><br>-On 7/27/21 at 7:34 a.m., the resident was found on the floor after a fall.<br><br>-On 7/30/21 at 6:52 a.m., the resident was found on the floor after a fall. The resident did not sustain visible injury, however, she did moan out in pain when put back to bed.<br><br>-On 7/31/21 at 5:32 a.m., the resident was found on the floor after a fall. The resident sustained bruising to her back and right side of buttocks.<br><br>-On 7/31/21 at 9:47 a.m., the resident fell in the common area as she was attempting to ambulate. The note indicated the resident had several falls within the last 30 days and already had injuries (head/scalp, face, etc.). | | | |

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| | -On 8/9/21 at 1:48 p.m., the resident was found on the floor by staff after a fall. The resident attempted to self transfer and missed the wheelchair.<br><br>-On 8/18/21 at 1:42 p.m., the resident had a fall after being restless and redirected several times by staff. The resident attempted to stand and the wheelchair rolled back, which caused the resident to land on her bottom.<br><br>-On 9/21/21 at 4:00 p.m., the resident fell while self ambulating in her bedroom. The resident was reminded multiple times throughout the shift and staff tried redirection. The resident sustained a head injury and verbally complained of pain.<br><br>-On 11/21/21 at 11:25 p.m., the resident was found on her bottom after a fall.<br><br>-On 12/19/21 at 1:00 a.m., the resident was found in her room after a fall. The resident sustained a head injury with laceration to the forehead and bridge of the nose. Steri strips were applied to the laceration. | | | |

-On 2/2/22 at 3:30 a.m., the resident was found in her bathroom after a fall. The resident complained of left hip pain during patient care. The resident sustained a left hip fracture which could not be treated.

-On 2/6/22 at 6:06 a.m., the resident was found on their floor after a fall.

The resident sustained 30 falls between 4/23/21 and 2/6/22.

Resident B's radiology report, dated 2/3/22, indicated the resident had a fractured left hip.

Resident B's service plan, dated 2/8/22 , indicated the resident had a poor mental health status, couple propel self at times in wheelchair, staff propelled resident to and from places, was ambulatory, and had a few falls; one resulted in sutures and another which caused a fracture to the left arm. Fall interventions included staff to intervene as necessary to assist the resident to remain safe while they ambulated and during transfers.

On 4/27/22 at 11:30 a.m., the Director of Nursing (DON) indicated Resident B had frequent falls. No fall follow-up reviews were completed, no RCA (root cause analysis) were completed, nor any IDT (interdisciplinary team) notes completed after the falls in an

attempt to find a probable cause of the falls. The DON indicated they did not know if falls were required to be reviewed for an assisted living facility.

2. On 4/26/22 at 11:00 a.m., the Director of Nursing (DON) indicated Resident C had a fall with a hip fracture.

On 4/26/22 at 12:52 p.m., Resident C's closed clinical record was reviewed. The diagnoses included, but were not limited to dementia, compression fracture, and left hip fracture.

The Pre-Admission Evaluation, dated 7/26/21, indicated Resident C had cognitive impairment; Alzheimer's/dementia; used a walker; had no falls in the past 30 days; had no falls in the past 60 days; walked on a regular basis; used walker for fall prevention; incontinent of bladder; required hands on assistance with toileting; required reminders/cueing with transfers; and required reminders/cueing for walking.

The Service Plan, dated 7/26/21, indicated Resident C had a diagnosis of dementia and required staff to provide appropriate interventions to assist resident's dementia diagnosis. The service plan lacked documentation of what

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| | appropriate interventions were required.<br><br>The Incident Report Log indicated the following:<br><br>-On 11/24/21 at 7:07 a.m., Resident C was found on the floor near her chair and walker.<br><br>-On 11/30/21 at 6:26 p.m., Resident C fell on her way to bed. She had no injuries.<br><br>The Initial Evaluation, dated 12/7/21, indicated Resident C had cognitive impairment; Alzheimer's/dementia; used a walker; had no falls in the past 30 days; had no falls in the past 60 days; walked on a regular basis; used walker for fall prevention; required no additional fall prevention measures; incontinent of bladder; required hands on assistance with toileting; required reminders/cueing with transfers; and required reminders/cueing for walking. The Initial Evaluation lacked documentation of Resident C's falls on 11/24/21 and 11/30/21. | | | |

The Service Plan, dated 12/7/21, indicated Resident C had diagnosis of dementia and required staff to provide appropriate interventions to assist resident's dementia diagnosis. The service plan lacked documentation of what appropriate interventions were required.

The Semi-Annual Evaluation, dated 12/17/21, indicated Resident C had cognitive impairment; Alzheimer's/dementia; used a walker; had no falls in the past 30 days; had no falls in the past 60 days; walked on a regular basis; used walker for fall prevention; required no additional fall prevention measures; incontinent of bladder; required hands on assistance with toileting; required reminders/cueing with transfers; and required reminders/cueing for walking. The Initial Evaluation lacked documentation of Resident C's falls on 11/24/21 and 11/30/21.

The Service Plan, dated 12/17/21, lacked documentation of interventions for falls.

The Incident Report Log indicated the following:

-On 12/28/21 at 6:00 p.m., Resident C was found on the floor in the common living area near her door.

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| | -On 3/25/22 at 1:58 p.m., around 5:00 a.m., Resident C was found laying on the floor on her left side. Her walker was knocked over next to her. Resident C complained of left hip pain and lower back pain. She was unable to move her left lower leg due to pain. She was assisted back to bed with 2 staff members.<br><br>The observation note, dated 3/25/22 at 10:14 a.m. indicated when staff went to assist Resident C with care in the morning, had "quite a bit of pain" in her lower back and left hip area. She was unable to ambulate and was extremely uncomfortable while sitting in her chair. She was assisted back to bed. She was unable to lift her left leg without assistance. Her family took Resident C to hospital for further evaluation. Family was notified.<br><br>The observation note, dated 3/25/22 at 12:45 p.m., indicated Resident C had a left hip fracture, lumbar vertebra compression fracture, and a bruise on her scalp. | | | |

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| | The Hospital After Visit Summary, dated 3/25/22, indicated Resident C had a sacrum fracture (lower back fracture); left pubic ramus fracture (pelvic fracture); and lumbar vertebra compression fracture (lumbar spine fracture).<br><br>The clinical record lacked documentation of evaluations to identify the possible causes of falls and lacked documentation of potential fall interventions after the falls.<br><br>During an interview on 4/27/22 at 11:30 a.m., the Director of Nursing indicated there were no documentation of evaluations to identify the possible causes of falls and no documentation potential fall interventions after the falls.<br><br>During an interview on 4/28/22 at 10:40 a.m., the Director of Nursing indicated when a resident falls during the night, the staff member will call her. If the resident had injuries, they would be sent to the emergency room for evaluation. When Resident C fell, she had complaints of pain and could not move her left leg. She was not sent to the emergency room until later in the morning.<br><br>On 4/27/22 at 2:45 p.m., the Executive Director provided the facility policy, "Resident Agreement," revised 2/20/18, | | | |

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| | and indicated it was the policy currently being used. A review of the policy indicated, "... Health Needs Which Grand Brook Memory Care Cannot Meet: Should the Resident need health services which cannot be provided ... Grand Brook Memory Care will immediately notify the Responsible Part to assist in transitioning the Resident to an appropriate care setting..." The policy further indicated, "...5. ASSUMPTION OF THE RISK/SHARED RISK ... there are some risks that are unavoidable in any community care setting, including but not limited to: wandering inside or outside of the Community (elopement); resident to resident altercation; loss of skin integrity; loss of personal, sentimental or monetary property; change in human intimacy behavior; dehydration; falls; later stage weight loss; disease progression..."<br><br>On 4/28/22 at 2:00 p.m., the Administrator provided the facility's policy, "Falls Prevention Protocol," undated, and indicated this was the policy currently being used by the facility. A review of the policy indicated, "....A resident who has had a serious fall, or who has fallen more than once in a four week period of time, should be evaluated in an attempt to identify the possible cause of the fall(s) and potential | | | |

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| | interventions that should be implemented....Use the information collected from the assessments to develop an intervention plan for the resident and make sure these interventions are listed on the resident's care plan..."<br><br>This Residential tag relates to the Complaint IN00372660.<br><br>Based on interview and record review, the facility neglected to ensure supervision to prevent falls for residents which resulted in a hip fractures for 2 of 3 residents reviewed. (Resident B, Resident C)<br><br>Findings include:<br><br>1. On 4/26/22 at 11:30 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, senile degeneration of the brain, ataxia (impaired balance), left humerus fracture, and left hip fracture.<br><br>A review of Resident B's incident reports indicated the following:<br><br>-On 4/28/21 at 4:45 a.m., the resident had a fall in her bathroom which resulted in a bleeding head injury.<br><br>-On 5/4/21 at 2:15 a.m., the resident had a fall and was found lying on her floor. Bruising was noted to the resident's back | | | |

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| | and buttocks.<br><br>-On 5/6/21 at 5:28 a.m., the resident had a fall and was found on her floor and sustained a skin tear to their back.<br><br>-On 5/14/21 at 5:00 a.m., the resident had a fall and was found on her floor.<br><br>-On 5/26/21 at 4:05 p.m., the resident had a fall and was found in her doorway.<br><br>-On 6/7/21 at 3:27 a.m., the resident was found on the floor next to the bed after a fall. She sustained a raised bruise to her forehead and a skin hear to her elbow.<br><br>-On 6/8/21 at 5:19 a.m., the resident was found on the floor next to the bed after a fall.<br><br>-On 6/10/21 at 10:16 a.m., the resident was found on the bathroom floor after a fall. She sustained a head injury.<br><br>-On 6/22/21 at 3:38 p.m., the resident was found on the floor after a fall. Her wheelchair was parked outside of her room and the walker was near the bed. The resident sustained a head injury.<br><br>-On 6/23/21 at 5:24 a.m., the resident had a fall in the common area.<br><br>-On 7/7/21 at 1:09 p.m., the | | | |

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| | resident was found on the floor after a fall. The resident indicated she was searching for her spouse and she did not want her family to know about the fall so she did not look stupid.<br><br>-On 7/7/21 at 5:08 p.m., the resident had a fall in the common area and hit her head on a table. The resident sustained a head injury.<br><br>-On 7/7/21 at 9:34 p.m., the resident was found on the floor after a fall. The resident sustained a scratch to her back. This was the third fall the resident sustained on this day.<br><br>-On 7/11/21 at 11:21 p.m., the resident was found by staff on the floor after a fall.<br><br>-On 7/15/21 at 3:27 p.m., the resident was found by staff on the floor after a fall. The resident was resistant when reminded to use her walker and wheelchair.<br><br>-On 7/17/21 at 9:57 p.m., the resident was found by staff outside on the patio after a fall. The resident sustained a laceration to her face between her right eye and temple and bruising was noted to the right side her of face.<br><br>-On 7/22/21 at 5:10 a.m., the resident was found in the hallway after a fall. | | | |

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| | -On 7/23/21 at 3:16 p.m., the resident was found on the floor after a fall.<br><br>-On 7/27/21 at 12:24 a.m., the resident was found by staff on the floor after a fall. The resident sustained bruising to the back.<br><br>-On 7/27/21 at 7:34 a.m., the resident was found on the floor after a fall.<br><br>-On 7/30/21 at 6:52 a.m., the resident was found on the floor after a fall. The resident did not sustain visible injury, however, she did moan out in pain when put back to bed.<br><br>-On 7/31/21 at 5:32 a.m., the resident was found on the floor after a fall. The resident sustained bruising to her back and right side of buttocks.<br><br>-On 7/31/21 at 9:47 a.m., the resident fell in the common area as she was attempting to ambulate. The note indicated the resident had several falls within the last 30 days and already had injuries (head/scalp, face, etc.).<br><br>-On 8/9/21 at 1:48 p.m., the resident was found on the floor by staff after a fall. The resident attempted to self transfer and missed the wheelchair.<br><br>-On 8/18/21 at 1:42 p.m., the resident had a fall after being restless and redirected several | | | |

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| | times by staff. The resident attempted to stand and the wheelchair rolled back, which caused the resident to land on her bottom.<br><br>-On 9/21/21 at 4:00 p.m., the resident fell while self ambulating in her bedroom. The resident was reminded multiple times throughout the shift and staff tried redirection. The resident sustained a head injury and verbally complained of pain.<br><br>-On 11/21/21 at 11:25 p.m., the resident was found on her bottom after a fall.<br><br>-On 12/19/21 at 1:00 a.m., the resident was found in her room after a fall. The resident sustained a head injury with laceration to the forehead and bridge of the nose. Steri strips were applied to the laceration.<br><br>-On 2/2/22 at 3:30 a.m., the resident was found in her bathroom after a fall. The resident complained of left hip pain during patient care. The resident sustained a left hip fracture which could not be treated.<br><br>-On 2/6/22 at 6:06 a.m., the resident was found on their floor after a fall.<br><br>The resident sustained 30 falls between 4/23/21 and 2/6/22.<br><br>Resident B's radiology report, | | | |

dated 2/3/22, indicated the resident had a fractured left hip.

Resident B's service plan, dated 2/8/22 , indicated the resident had a poor mental health status, couple propel self at times in wheelchair, staff propelled resident to and from places, was ambulatory, and had a few falls; one resulted in sutures and another which caused a fracture to the left arm. Fall interventions included staff to intervene as necessary to assist the resident to remain safe while they ambulated and during transfers.

On 4/27/22 at 11:30 a.m., the Director of Nursing (DON) indicated Resident B had frequent falls. No fall follow-up reviews were completed, no RCA (root cause analysis) were completed, nor any IDT (interdisciplinary team) notes completed after the falls in an attempt to find a probable cause of the falls. The DON indicated they did not know if falls were required to be reviewed for an assisted living facility.

2. On 4/26/22 at 11:00 a.m., the Director of Nursing (DON) indicated Resident C had a fall with a hip fracture.

On 4/26/22 at 12:52 p.m., Resident C's closed clinical record was reviewed. The diagnoses included, but were not limited to dementia,

compression fracture, and left hip fracture.

The Pre-Admission Evaluation, dated 7/26/21, indicated Resident C had cognitive impairment; Alzheimer's/dementia; used a walker; had no falls in the past 30 days; had no falls in the past 60 days; walked on a regular basis; used walker for fall prevention; incontinent of bladder; required hands on assistance with toileting; required reminders/cueing with transfers; and required reminders/cueing for walking.

The Service Plan, dated 7/26/21, indicated Resident C had a diagnosis of dementia and required staff to provide appropriate interventions to assist resident's dementia diagnosis. The service plan lacked documentation of what appropriate interventions were required.

The Incident Report Log indicated the following:

-On 11/24/21 at 7:07 a.m., Resident C was found on the floor near her chair and walker.

-On 11/30/21 at 6:26 p.m., Resident C fell on her way to bed. She had no injuries.

The Initial Evaluation, dated 12/7/21, indicated Resident C had cognitive impairment;

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| | Alzheimer's/dementia; used a walker; had no falls in the past 30 days; had no falls in the past 60 days; walked on a regular basis; used walker for fall prevention; required no additional fall prevention measures; incontinent of bladder; required hands on assistance with toileting; required reminders/cueing with transfers; and required reminders/cueing for walking. The Initial Evaluation lacked documentation of Resident C's falls on 11/24/21 and 11/30/21.<br><br>The Service Plan, dated 12/7/21, indicated Resident C had diagnosis of dementia and required staff to provide appropriate interventions to assist resident's dementia diagnosis. The service plan lacked documentation of what appropriate interventions were required.<br><br>The Semi-Annual Evaluation, dated 12/17/21, indicated Resident C had cognitive impairment; Alzheimer's/dementia; used a walker; had no falls in the past 30 days; had no falls in the past 60 days; walked on a regular basis; used walker for fall prevention; required no additional fall prevention measures; incontinent of bladder; required hands on assistance with toileting; required reminders/cueing with | | | |

transfers; and required reminders/cueing for walking. The Initial Evaluation lacked documentation of Resident C's falls on 11/24/21 and 11/30/21.

The Service Plan, dated 12/17/21, lacked documentation of interventions for falls.

The Incident Report Log indicated the following:

-On 12/28/21 at 6:00 p.m., Resident C was found on the floor in the common living area near her door.

-On 3/25/22 at 1:58 p.m., around 5:00 a.m., Resident C was found laying on the floor on her left side. Her walker was knocked over next to her. Resident C complained of left hip pain and lower back pain. She was unable to move her left lower leg due to pain. She was assisted back to bed with 2 staff members.

The observation note, dated 3/25/22 at 10:14 a.m. indicated when staff went to assist Resident C with care in the morning, had "quite a bit of pain" in her lower back and left hip area. She was unable to ambulate and was extremely uncomfortable while sitting in her chair. She was assisted back to bed. She was unable to lift her left leg without assistance. Her family took Resident C to hospital for further

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| | evaluation. Family was notified.<br><br>The observation note, dated 3/25/22 at 12:45 p.m., indicated Resident C had a left hip fracture, lumbar vertebra compression fracture, and a bruise on her scalp.<br><br>The Hospital After Visit Summary, dated 3/25/22, indicated Resident C had a sacrum fracture (lower back fracture); left pubic ramus fracture (pelvic fracture); and lumbar vertebra compression fracture (lumbar spine fracture).<br><br>The clinical record lacked documentation of evaluations to identify the possible causes of falls and lacked documentation of potential fall interventions after the falls.<br><br>During an interview on 4/27/22 at 11:30 a.m., the Director of Nursing indicated there were no documentation of evaluations to identify the possible causes of falls and no documentation potential fall interventions after the falls.<br><br>During an interview on 4/28/22 at 10:40 a.m., the Director of Nursing indicated when a resident falls during the night, the staff member will call her. If the resident had injuries, they would be sent to the emergency room for evaluation. When Resident C fell, she had complaints of pain and could not | | | |

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| | move her left leg. She was not sent to the emergency room until later in the morning.<br><br>On 4/27/22 at 2:45 p.m., the Executive Director provided the facility policy, "Resident Agreement," revised 2/20/18, and indicated it was the policy currently being used. A review of the policy indicated, "... Health Needs Which Grand Brook Memory Care Cannot Meet: Should the Resident need health services which cannot be provided ... Grand Brook Memory Care will immediately notify the Responsible Part to assist in transitioning the Resident to an appropriate care setting..." The policy further indicated, "...5. ASSUMPTION OF THE RISK/SHARED RISK ... there are some risks that are unavoidable in any community care setting, including but not limited to: wandering inside or outside of the Community (elopement); resident to resident altercation; loss of skin integrity; loss of personal, sentimental or monetary property; change in human intimacy behavior; dehydration; falls; later stage weight loss; disease progression..."<br><br>On 4/28/22 at 2:00 p.m., the Administrator provided the facility's policy, "Falls Prevention Protocol," undated, and indicated this was the policy currently being used by the | | | |

facility. A review of the policy indicated, "....A resident who has had a serious fall, or who has fallen more than once in a four week period of time, should be evaluated in an attempt to identify the possible cause of the fall(s) and potential interventions that should be implemented....Use the information collected from the assessments to develop an intervention plan for the resident and make sure these interventions are listed on the resident's care plan..."

This Residential tag relates to the Complaint IN00372660.

Based on interview and record review, the facility neglected to ensure supervision to prevent falls for residents which resulted in a hip fractures for 2 of 3 residents reviewed. (Resident B, Resident C)

Findings include:

1. On 4/26/22 at 11:30 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, senile degeneration of the brain, ataxia (impaired balance), left humerus fracture, and left hip fracture.

A review of Resident B's incident reports indicated the following:

-On 4/28/21 at 4:45 a.m., the

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| | resident had a fall in her bathroom which resulted in a bleeding head injury.<br><br>-On 5/4/21 at 2:15 a.m., the resident had a fall and was found lying on her floor. Bruising was noted to the resident's back and buttocks.<br><br>-On 5/6/21 at 5:28 a.m., the resident had a fall and was found on her floor and sustained a skin tear to their back.<br><br>-On 5/14/21 at 5:00 a.m., the resident had a fall and was found on her floor.<br><br>-On 5/26/21 at 4:05 p.m., the resident had a fall and was found in her doorway.<br><br>-On 6/7/21 at 3:27 a.m., the resident was found on the floor next to the bed after a fall. She sustained a raised bruise to her forehead and a skin hear to her elbow.<br><br>-On 6/8/21 at 5:19 a.m., the resident was found on the floor next to the bed after a fall.<br><br>-On 6/10/21 at 10:16 a.m., the resident was found on the bathroom floor after a fall. She sustained a head injury.<br><br>-On 6/22/21 at 3:38 p.m., the resident was found on the floor after a fall. Her wheelchair was parked outside of her room and the walker was near the bed. | | | |

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| | The resident sustained a head injury.<br><br>-On 6/23/21 at 5:24 a.m., the resident had a fall in the common area.<br><br>-On 7/7/21 at 1:09 p.m., the resident was found on the floor after a fall. The resident indicated she was searching for her spouse and she did not want her family to know about the fall so she did not look stupid.<br><br>-On 7/7/21 at 5:08 p.m., the resident had a fall in the common area and hit her head on a table. The resident sustained a head injury.<br><br>-On 7/7/21 at 9:34 p.m., the resident was found on the floor after a fall. The resident sustained a scratch to her back. This was the third fall the resident sustained on this day.<br><br>-On 7/11/21 at 11:21 p.m., the resident was found by staff on the floor after a fall.<br><br>-On 7/15/21 at 3:27 p.m., the resident was found by staff on the floor after a fall. The resident was resistant when reminded to use her walker and wheelchair.<br><br>-On 7/17/21 at 9:57 p.m., the resident was found by staff outside on the patio after a fall. The resident sustained a laceration to her face between | | | |

her right eye and temple and bruising was noted to the right side her of face.

-On 7/22/21 at 5:10 a.m., the resident was found in the hallway after a fall.

-On 7/23/21 at 3:16 p.m., the resident was found on the floor after a fall.

-On 7/27/21 at 12:24 a.m., the resident was found by staff on the floor after a fall. The resident sustained bruising to the back.

-On 7/27/21 at 7:34 a.m., the resident was found on the floor after a fall.

-On 7/30/21 at 6:52 a.m., the resident was found on the floor after a fall. The resident did not sustain visible injury, however, she did moan out in pain when put back to bed.

-On 7/31/21 at 5:32 a.m., the resident was found on the floor after a fall. The resident sustained bruising to her back and right side of buttocks.

-On 7/31/21 at 9:47 a.m., the resident fell in the common area as she was attempting to ambulate. The note indicated the resident had several falls within the last 30 days and already had injuries (head/scalp, face, etc.).

-On 8/9/21 at 1:48 p.m., the

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| | resident was found on the floor by staff after a fall. The resident attempted to self transfer and missed the wheelchair.<br><br>-On 8/18/21 at 1:42 p.m., the resident had a fall after being restless and redirected several times by staff. The resident attempted to stand and the wheelchair rolled back, which caused the resident to land on her bottom.<br><br>-On 9/21/21 at 4:00 p.m., the resident fell while self ambulating in her bedroom. The resident was reminded multiple times throughout the shift and staff tried redirection. The resident sustained a head injury and verbally complained of pain.<br><br>-On 11/21/21 at 11:25 p.m., the resident was found on her bottom after a fall.<br><br>-On 12/19/21 at 1:00 a.m., the resident was found in her room after a fall. The resident sustained a head injury with laceration to the forehead and bridge of the nose. Steri strips were applied to the laceration.<br><br>-On 2/2/22 at 3:30 a.m., the resident was found in her bathroom after a fall. The resident complained of left hip pain during patient care. The resident sustained a left hip fracture which could not be treated. | | | |

-On 2/6/22 at 6:06 a.m., the resident was found on their floor after a fall.

The resident sustained 30 falls between 4/23/21 and 2/6/22.

Resident B's radiology report, dated 2/3/22, indicated the resident had a fractured left hip.

Resident B's service plan, dated 2/8/22 , indicated the resident had a poor mental health status, couple propel self at times in wheelchair, staff propelled resident to and from places, was ambulatory, and had a few falls; one resulted in sutures and another which caused a fracture to the left arm. Fall interventions included staff to intervene as necessary to assist the resident to remain safe while they ambulated and during transfers.

On 4/27/22 at 11:30 a.m., the Director of Nursing (DON) indicated Resident B had frequent falls. No fall follow-up reviews were completed, no RCA (root cause analysis) were completed, nor any IDT (interdisciplinary team) notes completed after the falls in an attempt to find a probable cause of the falls. The DON indicated they did not know if falls were required to be reviewed for an assisted living facility.

2. On 4/26/22 at 11:00 a.m., the Director of Nursing (DON) indicated Resident C had a fall

with a hip fracture.

On 4/26/22 at 12:52 p.m., Resident C's closed clinical record was reviewed. The diagnoses included, but were not limited to dementia, compression fracture, and left hip fracture.

The Pre-Admission Evaluation, dated 7/26/21, indicated Resident C had cognitive impairment; Alzheimer's/dementia; used a walker; had no falls in the past 30 days; had no falls in the past 60 days; walked on a regular basis; used walker for fall prevention; incontinent of bladder; required hands on assistance with toileting; required reminders/cueing with transfers; and required reminders/cueing for walking.

The Service Plan, dated 7/26/21, indicated Resident C had a diagnosis of dementia and required staff to provide appropriate interventions to assist resident's dementia diagnosis. The service plan lacked documentation of what appropriate interventions were required.

The Incident Report Log indicated the following:

-On 11/24/21 at 7:07 a.m., Resident C was found on the floor near her chair and walker.

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| | -On 11/30/21 at 6:26 p.m., Resident C fell on her way to bed. She had no injuries.<br><br>The Initial Evaluation, dated 12/7/21, indicated Resident C had cognitive impairment; Alzheimer's/dementia; used a walker; had no falls in the past 30 days; had no falls in the past 60 days; walked on a regular basis; used walker for fall prevention; required no additional fall prevention measures; incontinent of bladder; required hands on assistance with toileting; required reminders/cueing with transfers; and required reminders/cueing for walking. The Initial Evaluation lacked documentation of Resident C's falls on 11/24/21 and 11/30/21.<br><br>The Service Plan, dated 12/7/21, indicated Resident C had diagnosis of dementia and required staff to provide appropriate interventions to assist resident's dementia diagnosis. The service plan lacked documentation of what appropriate interventions were required.<br><br>The Semi-Annual Evaluation, dated 12/17/21, indicated Resident C had cognitive impairment; Alzheimer's/dementia; used a walker; had no falls in the past 30 days; had no falls in the past 60 days; walked on a regular | | | |

basis; used walker for fall prevention; required no additional fall prevention measures; incontinent of bladder; required hands on assistance with toileting; required reminders/cueing with transfers; and required reminders/cueing for walking. The Initial Evaluation lacked documentation of Resident C's falls on 11/24/21 and 11/30/21.

The Service Plan, dated 12/17/21, lacked documentation of interventions for falls.

The Incident Report Log indicated the following:

-On 12/28/21 at 6:00 p.m., Resident C was found on the floor in the common living area near her door.

-On 3/25/22 at 1:58 p.m., around 5:00 a.m., Resident C was found laying on the floor on her left side. Her walker was knocked over next to her. Resident C complained of left hip pain and lower back pain. She was unable to move her left lower leg due to pain. She was assisted back to bed with 2 staff members.

The observation note, dated 3/25/22 at 10:14 a.m. indicated when staff went to assist Resident C with care in the morning, had "quite a bit of pain" in her lower back and left hip area. She was unable to

ambulate and was extremely uncomfortable while sitting in her chair. She was assisted back to bed. She was unable to lift her left leg without assistance. Her family took Resident C to hospital for further evaluation. Family was notified.

The observation note, dated 3/25/22 at 12:45 p.m., indicated Resident C had a left hip fracture, lumbar vertebra compression fracture, and a bruise on her scalp.

The Hospital After Visit Summary, dated 3/25/22, indicated Resident C had a sacrum fracture (lower back fracture); left pubic ramus fracture (pelvic fracture); and lumbar vertebra compression fracture (lumbar spine fracture).

The clinical record lacked documentation of evaluations to identify the possible causes of falls and lacked documentation of potential fall interventions after the falls.

During an interview on 4/27/22 at 11:30 a.m., the Director of Nursing indicated there were no documentation of evaluations to identify the possible causes of falls and no documentation potential fall interventions after the falls.

During an interview on 4/28/22 at 10:40 a.m., the Director of Nursing indicated when a

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| | resident falls during the night, the staff member will call her. If the resident had injuries, they would be sent to the emergency room for evaluation. When Resident C fell, she had complaints of pain and could not move her left leg. She was not sent to the emergency room until later in the morning. | | | |

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| | On 4/27/22 at 2:45 p.m., the Executive Director provided the facility policy, "Resident Agreement," revised 2/20/18, and indicated it was the policy currently being used. A review of the policy indicated, "... Health Needs Which Grand Brook Memory Care Cannot Meet: Should the Resident need health services which cannot be provided ... Grand Brook Memory Care will immediately notify the Responsible Part to assist in transitioning the Resident to an appropriate care setting..." The policy further indicated, "...5. ASSUMPTION OF THE RISK/SHARED RISK ... there are some risks that are unavoidable in any community care setting, including but not limited to: wandering inside or outside of the Community (elopement); resident to resident altercation; loss of skin integrity; loss of personal, sentimental or monetary property; change in human intimacy behavior; dehydration; falls; later stage weight loss; disease progression..."<br><br>On 4/28/22 at 2:00 p.m., the Administrator provided the facility's policy, "Falls Prevention Protocol," undated, and indicated this was the policy currently being used by the facility. A review of the policy indicated, "....A resident who has had a serious fall, or who has fallen more than once in a | | | |

four week period of time, should be evaluated in an attempt to identify the possible cause of the fall(s) and potential interventions that should be implemented....Use the information collected from the assessments to develop an intervention plan for the resident and make sure these interventions are listed on the resident's care plan..."

This Residential tag relates to the Complaint IN00372660.

Based on interview and record review, the facility neglected to ensure supervision to prevent falls for residents which resulted in a hip fractures for 2 of 3 residents reviewed. (Resident B, Resident C)

Findings include:

1. On 4/26/22 at 11:30 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, senile degeneration of the brain, ataxia (impaired balance), left humerus fracture, and left hip fracture.

A review of Resident B's incident reports indicated the following:

-On 4/28/21 at 4:45 a.m., the resident had a fall in her bathroom which resulted in a bleeding head injury.

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| | -On 5/4/21 at 2:15 a.m., the resident had a fall and was found lying on her floor. Bruising was noted to the resident's back and buttocks.<br><br>-On 5/6/21 at 5:28 a.m., the resident had a fall and was found on her floor and sustained a skin tear to their back.<br><br>-On 5/14/21 at 5:00 a.m., the resident had a fall and was found on her floor.<br><br>-On 5/26/21 at 4:05 p.m., the resident had a fall and was found in her doorway.<br><br>-On 6/7/21 at 3:27 a.m., the resident was found on the floor next to the bed after a fall. She sustained a raised bruise to her forehead and a skin hear to her elbow.<br><br>-On 6/8/21 at 5:19 a.m., the resident was found on the floor next to the bed after a fall.<br><br>-On 6/10/21 at 10:16 a.m., the resident was found on the bathroom floor after a fall. She sustained a head injury.<br><br>-On 6/22/21 at 3:38 p.m., the resident was found on the floor after a fall. Her wheelchair was parked outside of her room and the walker was near the bed. The resident sustained a head injury.<br><br>-On 6/23/21 at 5:24 a.m., the | | | |

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| | resident had a fall in the common area.<br><br>-On 7/7/21 at 1:09 p.m., the resident was found on the floor after a fall. The resident indicated she was searching for her spouse and she did not want her family to know about the fall so she did not look stupid.<br><br>-On 7/7/21 at 5:08 p.m., the resident had a fall in the common area and hit her head on a table. The resident sustained a head injury.<br><br>-On 7/7/21 at 9:34 p.m., the resident was found on the floor after a fall. The resident sustained a scratch to her back. This was the third fall the resident sustained on this day.<br><br>-On 7/11/21 at 11:21 p.m., the resident was found by staff on the floor after a fall.<br><br>-On 7/15/21 at 3:27 p.m., the resident was found by staff on the floor after a fall. The resident was resistant when reminded to use her walker and wheelchair.<br><br>-On 7/17/21 at 9:57 p.m., the resident was found by staff outside on the patio after a fall. The resident sustained a laceration to her face between her right eye and temple and bruising was noted to the right side her of face. | | | |

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| | -On 7/22/21 at 5:10 a.m., the resident was found in the hallway after a fall.<br><br>-On 7/23/21 at 3:16 p.m., the resident was found on the floor after a fall.<br><br>-On 7/27/21 at 12:24 a.m., the resident was found by staff on the floor after a fall. The resident sustained bruising to the back.<br><br>-On 7/27/21 at 7:34 a.m., the resident was found on the floor after a fall.<br><br>-On 7/30/21 at 6:52 a.m., the resident was found on the floor after a fall. The resident did not sustain visible injury, however, she did moan out in pain when put back to bed.<br><br>-On 7/31/21 at 5:32 a.m., the resident was found on the floor after a fall. The resident sustained bruising to her back and right side of buttocks.<br><br>-On 7/31/21 at 9:47 a.m., the resident fell in the common area as she was attempting to ambulate. The note indicated the resident had several falls within the last 30 days and already had injuries (head/scalp, face, etc.). | | | |

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| | -On 8/9/21 at 1:48 p.m., the resident was found on the floor by staff after a fall. The resident attempted to self transfer and missed the wheelchair.<br><br>-On 8/18/21 at 1:42 p.m., the resident had a fall after being restless and redirected several times by staff. The resident attempted to stand and the wheelchair rolled back, which caused the resident to land on her bottom.<br><br>-On 9/21/21 at 4:00 p.m., the resident fell while self ambulating in her bedroom. The resident was reminded multiple times throughout the shift and staff tried redirection. The resident sustained a head injury and verbally complained of pain.<br><br>-On 11/21/21 at 11:25 p.m., the resident was found on her bottom after a fall.<br><br>-On 12/19/21 at 1:00 a.m., the resident was found in her room after a fall. The resident sustained a head injury with laceration to the forehead and bridge of the nose. Steri strips were applied to the laceration. | | | |

-On 2/2/22 at 3:30 a.m., the resident was found in her bathroom after a fall. The resident complained of left hip pain during patient care. The resident sustained a left hip fracture which could not be treated.

-On 2/6/22 at 6:06 a.m., the resident was found on their floor after a fall.

The resident sustained 30 falls between 4/23/21 and 2/6/22.

Resident B's radiology report, dated 2/3/22, indicated the resident had a fractured left hip.

Resident B's service plan, dated 2/8/22 , indicated the resident had a poor mental health status, couple propel self at times in wheelchair, staff propelled resident to and from places, was ambulatory, and had a few falls; one resulted in sutures and another which caused a fracture to the left arm. Fall interventions included staff to intervene as necessary to assist the resident to remain safe while they ambulated and during transfers.

On 4/27/22 at 11:30 a.m., the Director of Nursing (DON) indicated Resident B had frequent falls. No fall follow-up reviews were completed, no RCA (root cause analysis) were completed, nor any IDT (interdisciplinary team) notes completed after the falls in an

attempt to find a probable cause of the falls. The DON indicated they did not know if falls were required to be reviewed for an assisted living facility.

2. On 4/26/22 at 11:00 a.m., the Director of Nursing (DON) indicated Resident C had a fall with a hip fracture.

On 4/26/22 at 12:52 p.m., Resident C's closed clinical record was reviewed. The diagnoses included, but were not limited to dementia, compression fracture, and left hip fracture.

The Pre-Admission Evaluation, dated 7/26/21, indicated Resident C had cognitive impairment; Alzheimer's/dementia; used a walker; had no falls in the past 30 days; had no falls in the past 60 days; walked on a regular basis; used walker for fall prevention; incontinent of bladder; required hands on assistance with toileting; required reminders/cueing with transfers; and required reminders/cueing for walking.

The Service Plan, dated 7/26/21, indicated Resident C had a diagnosis of dementia and required staff to provide appropriate interventions to assist resident's dementia diagnosis. The service plan lacked documentation of what

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| | appropriate interventions were required.<br><br>The Incident Report Log indicated the following:<br><br>-On 11/24/21 at 7:07 a.m., Resident C was found on the floor near her chair and walker.<br><br>-On 11/30/21 at 6:26 p.m., Resident C fell on her way to bed. She had no injuries.<br><br>The Initial Evaluation, dated 12/7/21, indicated Resident C had cognitive impairment; Alzheimer's/dementia; used a walker; had no falls in the past 30 days; had no falls in the past 60 days; walked on a regular basis; used walker for fall prevention; required no additional fall prevention measures; incontinent of bladder; required hands on assistance with toileting; required reminders/cueing with transfers; and required reminders/cueing for walking. The Initial Evaluation lacked documentation of Resident C's falls on 11/24/21 and 11/30/21. | | | |

The Service Plan, dated 12/7/21, indicated Resident C had diagnosis of dementia and required staff to provide appropriate interventions to assist resident's dementia diagnosis. The service plan lacked documentation of what appropriate interventions were required.

The Semi-Annual Evaluation, dated 12/17/21, indicated Resident C had cognitive impairment; Alzheimer's/dementia; used a walker; had no falls in the past 30 days; had no falls in the past 60 days; walked on a regular basis; used walker for fall prevention; required no additional fall prevention measures; incontinent of bladder; required hands on assistance with toileting; required reminders/cueing with transfers; and required reminders/cueing for walking. The Initial Evaluation lacked documentation of Resident C's falls on 11/24/21 and 11/30/21.

The Service Plan, dated 12/17/21, lacked documentation of interventions for falls.

The Incident Report Log indicated the following:

-On 12/28/21 at 6:00 p.m., Resident C was found on the floor in the common living area near her door.

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| | -On 3/25/22 at 1:58 p.m., around 5:00 a.m., Resident C was found laying on the floor on her left side. Her walker was knocked over next to her. Resident C complained of left hip pain and lower back pain. She was unable to move her left lower leg due to pain. She was assisted back to bed with 2 staff members.<br><br>The observation note, dated 3/25/22 at 10:14 a.m. indicated when staff went to assist Resident C with care in the morning, had "quite a bit of pain" in her lower back and left hip area. She was unable to ambulate and was extremely uncomfortable while sitting in her chair. She was assisted back to bed. She was unable to lift her left leg without assistance. Her family took Resident C to hospital for further evaluation. Family was notified.<br><br>The observation note, dated 3/25/22 at 12:45 p.m., indicated Resident C had a left hip fracture, lumbar vertebra compression fracture, and a bruise on her scalp. | | | |

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| | The Hospital After Visit Summary, dated 3/25/22, indicated Resident C had a sacrum fracture (lower back fracture); left pubic ramus fracture (pelvic fracture); and lumbar vertebra compression fracture (lumbar spine fracture).<br><br>The clinical record lacked documentation of evaluations to identify the possible causes of falls and lacked documentation of potential fall interventions after the falls.<br><br>During an interview on 4/27/22 at 11:30 a.m., the Director of Nursing indicated there were no documentation of evaluations to identify the possible causes of falls and no documentation potential fall interventions after the falls.<br><br>During an interview on 4/28/22 at 10:40 a.m., the Director of Nursing indicated when a resident falls during the night, the staff member will call her. If the resident had injuries, they would be sent to the emergency room for evaluation. When Resident C fell, she had complaints of pain and could not move her left leg. She was not sent to the emergency room until later in the morning.<br><br>On 4/27/22 at 2:45 p.m., the Executive Director provided the facility policy, "Resident Agreement," revised 2/20/18, | | | |

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| | and indicated it was the policy currently being used. A review of the policy indicated, "... Health Needs Which Grand Brook Memory Care Cannot Meet: Should the Resident need health services which cannot be provided ... Grand Brook Memory Care will immediately notify the Responsible Part to assist in transitioning the Resident to an appropriate care setting..." The policy further indicated, "...5. ASSUMPTION OF THE RISK/SHARED RISK ... there are some risks that are unavoidable in any community care setting, including but not limited to: wandering inside or outside of the Community (elopement); resident to resident altercation; loss of skin integrity; loss of personal, sentimental or monetary property; change in human intimacy behavior; dehydration; falls; later stage weight loss; disease progression..."<br><br>On 4/28/22 at 2:00 p.m., the Administrator provided the facility's policy, "Falls Prevention Protocol," undated, and indicated this was the policy currently being used by the facility. A review of the policy indicated, "....A resident who has had a serious fall, or who has fallen more than once in a four week period of time, should be evaluated in an attempt to identify the possible cause of the fall(s) and potential | | | |

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| | interventions that should be implemented....Use the information collected from the assessments to develop an intervention plan for the resident and make sure these interventions are listed on the resident's care plan..."<br><br>This Residential tag relates to the Complaint IN00372660. | | | |
| R 0117 | Personnel - Deficiency<br><br>410 IAC 16.2-5-1.4(b)<br><br>(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be | R 0117 | We have worked with staff and all shifts currently have a staff member that has a CPR/First Aide certificate. We are continuing to work with a the few staff members have that the CPR certificate, but are missing the First Aide certificate.<br><br>Current community residents were at risk on those shifts that did not have a staff member with their First Aide Certificate.<br><br>All new hires will be required to provide valid certificates at time of hire.<br><br>The Administrator or designee will conduct an audit of the certificate book weekly X 4 weeks, then monthly X 5 months. Results of audit will be brought to QA Committee meeting for review/recommendations. | 05/28/2022 |

assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.

Based on interview and record review, the facility failed to ensure working staff were first aid certified for 4 of 21 shifts.

Findings include:

On 4/28/22 at 11:00 a.m., a review of the schedule, dated 4/18/22 to 4/24/22, indicated the following:

-On 4/18/22, the third shift did not have a certified first aid staff member working.

-On 4/21/22, the third shift did not have a certified first aid staff member working.

-On 4/23/22, the first shift did not have a certified first aid staff member working.

-On 4/24/22, the first shift did not have a certified first aid staff member working.

On 4/28/22 at 2:00 p.m., the Executive Director indicated all shifts should have a certified first aid staff member working and they did not know the staff did not have the first aid certification.

Based on interview and record review, the facility failed to ensure working staff were first

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| | aid certified for 4 of 21 shifts.<br><br>Findings include:<br><br>On 4/28/22 at 11:00 a.m., a review of the schedule, dated 4/18/22 to 4/24/22, indicated the following:<br><br>-On 4/18/22, the third shift did not have a certified first aid staff member working.<br><br>-On 4/21/22, the third shift did not have a certified first aid staff member working.<br><br>-On 4/23/22, the first shift did not have a certified first aid staff member working.<br><br>-On 4/24/22, the first shift did not have a certified first aid staff member working.<br><br>On 4/28/22 at 2:00 p.m., the Executive Director indicated all shifts should have a certified first aid staff member working and they did not know the staff did not have the first aid certification. | | | |
| R 0216 | Evaluation - Noncompliance<br><br>410 IAC 16.2-5-2(c)(1-4)(d)<br><br>(c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: | R 0216 | The weight record for Resident #2 has been reviewed with no concerns of significant weight loss or gain identified.<br><br>An audit of residents admitted has been completed to identify any significant weight loss or gain with no concerns identified. | 05/28/2022 |

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| | (1) The resident ' s physical, cognitive, and mental status.<br><br>(2) The resident ' s independence in the activities of daily living.<br><br>(3) The resident ' s weight taken on admission and semiannually thereafter.<br><br>(4) If applicable, the resident ' s ability to self-administer medications.<br><br>(d) The evaluation shall be documented in writing and kept in the facility.<br><br>Based on record review and interview, the facility failed to ensure a resident's weight was taken or documented upon admission to the facility for 1 of 7 residents reviewed for admission weights. (Resident 2)<br><br>Findings include:<br><br>On 4/27/22 at 11:20 A.M., Resident 2's clinical record was reviewed. The diagnosis was cognitive impairment. The resident's admission date was 3/10/22. The first documented weight was dated 4/1/22.<br><br>During an interview on 4/28/22 at 2:15 P.M., the Director of Nursing indicated the resident's first documented weight was on 4/1/22.<br><br>Based on record review and interview, the facility failed to ensure a resident's weight was | | Care staff will be re-educated on obtaining resident weight upon admission.<br><br>The Administrator or designee will conduct an audit of new admission weekly X 4 weeks, then monthly X 5 months. Results of audit will brought to QA Committee meeting for review/recommendations. | |

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| | taken or documented upon admission to the facility for 1 of 7 residents reviewed for admission weights. (Resident 2)<br><br>Findings include:<br><br>On 4/27/22 at 11:20 A.M., Resident 2's clinical record was reviewed. The diagnosis was cognitive impairment. The resident's admission date was 3/10/22. The first documented weight was dated 4/1/22.<br><br>During an interview on 4/28/22 at 2:15 P.M., the Director of Nursing indicated the resident's first documented weight was on 4/1/22. | | | |
| R 0217 | Evaluation - Deficiency<br><br>410 IAC 16.2-5-2(e)(1-5)<br><br>(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:<br><br>(1) The services offered to the individual resident shall be appropriate to the:<br><br>(A) scope;<br><br>(B) frequency;<br><br>(C) need; and<br><br>(D) preference;<br><br>of the resident. | R 0217 | Service Plans have been scheduled from May through August to cover all residents semi annual plans.<br><br>All residents have been identified as potentially being affected.<br><br>The ED and DON have been in-serviced that the agreed upon service plan shall be signed and dated by the resident’s POA.<br><br>The Administrator or designee will conduct an audit of care plan signatures weekly X 4 weeks, then monthly X 5 months. Results of audit will be brought to QA Committee meeting for | 05/28/2022 |

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| | (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.<br><br>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.<br><br>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.<br><br>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.<br><br>Based on record review and interview, the facility failed to ensure service plans were signed and dated by the resident or resident's representative for 7 of 7 residents reviewed for service plan signatures. (Resident 1, Resident 2, Resident 3, Resident C, Resident B, Resident 6, and Resident 7)<br><br>Findings include:<br><br>1. On 4/26/22 at 10:45 A.M., Resident 1's clinical record was | | review/recommendations. | |

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| | reviewed. The diagnosis was dementia.<br><br>The resident's Individual Service Plan, dated 12/14/21, was not signed or dated by the resident or resident's representative.<br><br>2. On 4/27/22 at 11:20 A.M., Resident 2's clinical record was reviewed. The diagnosis was cognitive impairment.<br><br>The resident's Individual Service Plan, dated 3/10/22, was not signed or dated by the resident or resident's representative.<br><br>3. On 4/26/22 at 11:10 A.M., Resident 3's clinical record was reviewed. The diagnosis was Alzheimer's disease.<br><br>The resident's Individual Service Plan, dated 2/3/22, was not signed or dated by the resident or resident's representative.<br><br>4. On 4/27/22 at 10:05 A.M., Resident C's clinical record was reviewed. The diagnosis was dementia.<br><br>The resident's Individual Service Plan, dated 3/25/22, was not signed or dated by the resident or resident's representative. | | | |

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| | 5. On 4/26/22 at 10:50 A.M., Resident B's clinical record was reviewed. The diagnoses included but were not limited to, hypertension and senile degeneration.<br><br>The resident's Individual Service Plan, dated 2/8/22, was not signed or dated by the resident or resident's representative.<br><br>6. On 4/28/22 at 10:00 A.M., Resident 6's clinical record was reviewed. The diagnosis was dementia.<br><br>The resident's Individual Service Plan, dated 1/21/22, was not signed or dated by the resident or resident's representative.<br><br>7. On 4/27/22 at 11:00 A.M., Resident 7's clinical record was reviewed. The diagnoses included, but were not limited to, anxiety and dementia.<br><br>The resident's Individual Service Plan, dated 3/9/22, was not signed or dated by the resident or resident's representative.<br><br>During an interview on 4/27/22 at 11:00 A.M., the Executive Director indicated the resident service plans were emailed to the residents' representatives, and they were not signed by the resident or residents' representatives.<br><br>Based on record review and interview, the facility failed to | | | |

ensure service plans were signed and dated by the resident or resident's representative for 7 of 7 residents reviewed for service plan signatures. (Resident 1, Resident 2, Resident 3, Resident C, Resident B, Resident 6, and Resident 7)

Findings include:

1. On 4/26/22 at 10:45 A.M., Resident 1's clinical record was reviewed. The diagnosis was dementia.

The resident's Individual Service Plan, dated 12/14/21, was not signed or dated by the resident or resident's representative.

2. On 4/27/22 at 11:20 A.M., Resident 2's clinical record was reviewed. The diagnosis was cognitive impairment.

The resident's Individual Service Plan, dated 3/10/22, was not signed or dated by the resident or resident's representative.

3. On 4/26/22 at 11:10 A.M., Resident 3's clinical record was reviewed. The diagnosis was Alzheimer's disease.

The resident's Individual Service Plan, dated 2/3/22, was not signed or dated by the resident or resident's representative.

4. On 4/27/22 at 10:05 A.M., Resident C's clinical record was

reviewed. The diagnosis was dementia.

The resident's Individual Service Plan, dated 3/25/22, was not signed or dated by the resident or resident's representative.

5. On 4/26/22 at 10:50 A.M., Resident B's clinical record was reviewed. The diagnoses included but were not limited to, hypertension and senile degeneration.

The resident's Individual Service Plan, dated 2/8/22, was not signed or dated by the resident or resident's representative.

6. On 4/28/22 at 10:00 A.M., Resident 6's clinical record was reviewed. The diagnosis was dementia.

The resident's Individual Service Plan, dated 1/21/22, was not signed or dated by the resident or resident's representative.

7. On 4/27/22 at 11:00 A.M., Resident 7's clinical record was reviewed. The diagnoses included, but were not limited to, anxiety and dementia.

The resident's Individual Service Plan, dated 3/9/22, was not signed or dated by the resident or resident's representative.

During an interview on 4/27/22 at 11:00 A.M., the Executive Director indicated the resident

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| | service plans were emailed to the residents' representatives, and they were not signed by the resident or residents' representatives. | | | |
| R 0275 | Food and Nutritional Services - Deficiency<br><br>410 IAC 16.2-5-5.1(h)<br><br>(h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires.<br><br>Based on interview and record review, the facility failed to ensure the physician reviewed and/or revised the diet for a resident with significant weight loss for 1 of 7 residents reviewed for weight loss. (Resident 1)<br><br>Findings include:<br><br>Resident 1's clinical record was reviewed on 4/26/2022 at 11:45 a.m. The diagnoses included, but were not limited to dementia without behaviors and chronic kidney disease.<br><br>A review of Resident 1's weights indicated the following:<br><br>-220 pounds (lbs) on 6/1/2021<br><br>-239.5 lbs on 7/13/2021<br><br>-208.6 lbs on 8/4/2021 | R 0275 | The weight record for Resident #1 has been reviewed with no concerns of significant weight loss or gain identified. Resident was on hospice at the time of weight loss and hospice requested weights monthly and no concerns were voiced by the hospice doctor.<br><br>An audit of residents admitted has been completed to identify any significant weight loss or gain with no concerns identified.<br><br>Care staff will be re-educated on obtaining an accurate weight.<br><br>The Administrator or designee will conduct an audit of new admission weekly X 4 weeks, then monthly X 5 months. Results of audit will brought to QA Committee meeting for review/recommendations. | 05/28/2022 |

-207.8 lbs on 9/16/2021

-209.4 lbs on 10/1/2021

-205.8 lbs on 11/3/2021

-195.6 lbs on 12/1/2021

-195.2 lbs on 2/2/2022

-186 lbs on 3/2/2022

-184.2 lbs on 4/1/2022

This was an assessed 11.09% severe weight loss in six months from 6/1/2021 through 12/1/2021.

The Pre-Admission Evaluation, dated 5/27/2021, for Resident 1 indicated the diet as regular and "No" to experienced any recent weight changes.

The Semi-Annual Evaluation, dated 12/14/2021, for Resident 1 indicated the diet as regular, the current weight as 220 lbs and "No" to experienced any recent weight changes.

Physician orders, dated 6/1/2021 through 4/28/2022, lacked documentation of Resident 1 having been prescribed a supplement for severe weight loss and did not indicate the resident was on Hospice services.

The Individual Service Plan, dated 12/14/2021, for Resident 1 indicated, "... Diet: Regular ...

Nutritional Patterns ... NEED: Regular diet ... GOAL: Resident to maintain proper nutrition ... INTERVENTION: Resident has a regular diet; no staff intervention or special diet needed ..."

The clinical record lacked documentation of a physician having reviewed and/or revised Resident 1's diet since the weight loss began on 7/13/2021.

During an interview on 4/27/2022 at 10:15 a.m., the Director of Nursing (DON) indicated the resident had lost weight due to his disease process. He had been on Hospice previously and had not been on any supplements. They just hired a dietician and would be looking at the resident's weight loss.

During an interview on 4/27/2022 at 12:15 p.m., Qualified Medication Aide (QMA) 1 indicated the resident had not been on any supplements. The family had been concerned about his weight loss last year and would bring him in extra food from outside restaurants. There would not be any notes in the resident's chart related to weight loss due to him telling them in the past he wanted to lose weight.

The Hospice notes for Resident 1 were requested and were not received by the survey exit date of 4/28/2022.

On 4/28/2022 at 11:50 a.m., the Executive Director indicated the facility did not have a policy related to nutrition.

Based on interview and record review, the facility failed to ensure the physician reviewed and/or revised the diet for a resident with significant weight loss for 1 of 7 residents reviewed for weight loss. (Resident 1)

Findings include:

Resident 1's clinical record was reviewed on 4/26/2022 at 11:45 a.m. The diagnoses included, but were not limited to dementia without behaviors and chronic kidney disease.

A review of Resident 1's weights indicated the following:

-220 pounds (lbs) on 6/1/2021

-239.5 lbs on 7/13/2021

-208.6 lbs on 8/4/2021

-207.8 lbs on 9/16/2021

-209.4 lbs on 10/1/2021

-205.8 lbs on 11/3/2021

-195.6 lbs on 12/1/2021

-195.2 lbs on 2/2/2022

-186 lbs on 3/2/2022

-184.2 lbs on 4/1/2022

This was an assessed 11.09% severe weight loss in six months from 6/1/2021 through 12/1/2021.

The Pre-Admission Evaluation, dated 5/27/2021, for Resident 1 indicated the diet as regular and "No" to experienced any recent weight changes.

The Semi-Annual Evaluation, dated 12/14/2021, for Resident 1 indicated the diet as regular, the current weight as 220 lbs and "No" to experienced any recent weight changes.

Physician orders, dated 6/1/2021 through 4/28/2022, lacked documentation of Resident 1 having been prescribed a supplement for severe weight loss and did not indicate the resident was on Hospice services.

The Individual Service Plan, dated 12/14/2021, for Resident 1 indicated, "... Diet: Regular ... Nutritional Patterns ... NEED: Regular diet ... GOAL: Resident to maintain proper nutrition ... INTERVENTION: Resident has a regular diet; no staff intervention or special diet needed ..."

The clinical record lacked documentation of a physician having reviewed and/or revised Resident 1's diet since the weight loss began on 7/13/2021.

During an interview on 4/27/2022 at 10:15 a.m., the Director of Nursing (DON) indicated the resident had lost weight due to his disease process. He had been on Hospice previously and had not been on any supplements. They just hired a dietician and would be looking at the resident's weight loss.

During an interview on 4/27/2022 at 12:15 p.m., Qualified Medication Aide (QMA) 1 indicated the resident had not been on any supplements. The family had been concerned about his weight loss last year and would bring him in extra food from outside restaurants. There would not be any notes in the resident's chart related to weight loss due to him telling them in the past he wanted to lose weight.

The Hospice notes for Resident 1 were requested and were not received by the survey exit date of 4/28/2022.

On 4/28/2022 at 11:50 a.m., the Executive Director indicated the facility did not have a policy

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| | related to nutrition. | | | |

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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