STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENCES AT COFFEE CREEK	2300 VILLAGE POINT, CHESTERTON, , 46304

(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 IN00373895. Complaint IN00373895 - Substantiated. State deficiencies related to the allegations are cited at R0036, R0297, and R0349. Survey date: March 7, 2022 Facility number: 014469 Residential Census: 68 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/11/22.	R 0000	Residences at Coffee Creek (the “Provider”) submits this Plan of Correction (“POC”) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider herby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether	

			such remedies are imposed by the state of Indiana or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. We are requesting paper compliance for the deficiencies cited.	
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.	R 0036	Staff attempted to inform Resident C's physician about her change in condition relating to a fall with swollen ribs and a possible yeast infection, but staff were unable to get ahold of her via telephone or fax. Staff suggested to Resident C's POA to switch doctors due to having a hard time getting ahold of the primary physician. POA declined due to this physician being a family friend. Resident C did not experience	04/06/2022

	Based on record review and interview, the facility failed to promptly notify the resident's physician of a significant change in condition related to a fall with swollen ribs and a possible yeast infection for 1 of 3 residents reviewed for physician notification. (Resident C) Finding includes: The record for Resident C was reviewed on 3/7/22 at 1:35 p.m. Diagnoses included, but were not limited to, dementia without behaviors and glaucoma. Nurses' Notes, dated 1/11/22 at 10:10 p.m., indicated at 9:00 p.m., the resident was observed on the bathroom floor. The staff assisted the resident up and noted the resident had bowel movement in her brief. The resident was placed in bed and a head to toe assessment was completed. The resident screamed in pain when her right upper rib area was touched. The area was swollen. The son was notified and the writer suggested she be sent to ER, but the son denied the evaluation and informed writer to just monitor resident. A fax was sent to the doctor, due to not being able to reach by phone. There was a fax to the Physician, dated 1/11/21, which indicated "fall." There was no		any negative outcomes associated with this finding. Immediately after the survey, Resident C's physician was notified of the change in condition relating to a fall with swollen ribs and a possible yeast infection. No other residents experienced any negative outcomes associated with this finding. Nurses have been re-in serviced on notifying a resident's physician of a significant change of condition. Any future nurse will be in-serviced on notifying a resident's physician of a significant change of condition during their job specific orientation. A routine audit will be completed by the Director of Resident Services or designee by reviewing nursing notes to ensure that any resident's physician was timely notified of a resident's change in condition. Routine audits will be completed daily during the week and completed on Monday for over the weekend for 60 days by the	

	other information regarding the swollen area to the right rib area. A Nurses' Note, dated 1/12/22 at 2:11 p.m., indicated the resident refused to allow the writer to perform neuro checks. She was wandering up and down hallways at the time and denied pain. The next documented Nurses' Note was dated 1/23/22 (12 days after the fall) at 6:54 a.m., which indicated the resident had complaints of right rib pain and fell 12 days ago on her right side, with no reports of injury at that time. The nurse left a note that the resident's primary care physician needed to be contacted in order to obtain an order for an x-ray. There was no documentation the resident's Physician had been notified for a need of an x-ray of her rib cage. The next documented entry in Nurses' Notes, was on 1/29/22 at 4:18 p.m., which indicated the day staff member stated the resident was observed at 8:30 a.m. in her room lying on the floor. There was no incident report completed. There was a large hematoma on the back of her skull upon exam. The son was contacted and denied the resident be sent out to the ER. The son was informed of		Resident Services Director or designee or until 100% compliance is achieved. These audits will be reviewed routinely at the QA committee. These systematic changes will be put into place by April 6, 2022.	

	suggesting to switch doctors due to not being able to contact the doctor for weeks and the fax number was being rejected. The writer also informed him the resident needed treatment for a current yeast infection and had attempted to contact the physician with no success. There was no documentation the resident's Physician was promptly notified of her significant changes. Interview with the Director of Nursing on 3/7/22 at 2:50 p.m., indicated there was no documentation the resident's doctor was notified in a timely manner of the swollen rib and a possible yeast infection. This State Residential finding relates to Complaint IN00373895. Based on record review and interview, the facility failed to promptly notify the resident's physician of a significant change in condition related to a fall with swollen ribs and a possible yeast infection for 1 of 3 residents reviewed for physician notification. (Resident C) Finding includes:			

	The record for Resident C was reviewed on 3/7/22 at 1:35 p.m. Diagnoses included, but were not limited to, dementia without behaviors and glaucoma. Nurses' Notes, dated 1/11/22 at 10:10 p.m., indicated at 9:00 p.m., the resident was observed on the bathroom floor. The staff assisted the resident up and noted the resident had bowel movement in her brief. The resident was placed in bed and a head to toe assessment was completed. The resident screamed in pain when her right upper rib area was touched. The area was swollen. The son was notified and the writer suggested she be sent to ER, but the son denied the evaluation and informed writer to just monitor resident. A fax was sent to the doctor, due to not being able to reach by phone. There was a fax to the Physician, dated 1/11/21, which indicated "fall." There was no other information regarding the swollen area to the right rib area. A Nurses' Note, dated 1/12/22 at 2:11 p.m., indicated the resident refused to allow the writer to perform neuro checks. She was wandering up and down hallways at the time and denied pain.			

	The next documented Nurses' Note was dated 1/23/22 (12 days after the fall) at 6:54 a.m., which indicated the resident had complaints of right rib pain and fell 12 days ago on her right side, with no reports of injury at that time. The nurse left a note that the resident's primary care physician needed to be contacted in order to obtain an order for an x-ray. There was no documentation the resident's Physician had been notified for a need of an x-ray of her rib cage. The next documented entry in Nurses' Notes, was on 1/29/22 at 4:18 p.m., which indicated the day staff member stated the resident was observed at 8:30 a.m. in her room lying on the floor. There was no incident report completed. There was a large hematoma on the back of her skull upon exam. The son was contacted and denied the resident be sent out to the ER. The son was informed of suggesting to switch doctors due to not being able to contact the doctor for weeks and the fax number was being rejected. The writer also informed him the resident needed treatment for a current yeast infection and had attempted to contact the physician with no success. There was no documentation the resident's Physician was			

	promptly notified of her significant changes. Interview with the Director of Nursing on 3/7/22 at 2:50 p.m., indicated there was no documentation the resident's doctor was notified in a timely manner of the swollen rib and a possible yeast infection. This State Residential finding relates to Complaint IN00373895.			
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on record review, and interview, the facility failed to ensure medications were available from the pharmacy when a resident was readmitted with new medications from the hospital for 1 of 3 residents reviewed for a significant change. (Resident B)	R 0297	Resident B did not experience any negative outcomes associated with this finding. Nurses have been re-in serviced on following any resident’s discharge instructions and on obtaining a resident’s medications in a timely manner. Any future nurse will be in-serviced on following any resident’s discharge instructions and on obtaining a resident’s medications in a timely manner during their job specific orientation. Also, nurses have been in-serviced on using the facility’s pyxis system and using it when medications are not available right away.	04/06/2022

	Finding includes: The record for Resident B was reviewed on 3/7/22 at 9:45 a.m. Diagnoses included, but were not limited to, high blood pressure, seizures, history of falling, traumatic brain injury, and difficulty walking. The resident was sent to the hospital on 11/5/21 and returned on 11/23/21. Nurses' Notes, dated 11/5/21 at 4:22 a.m., indicated the resident had used the pendant and was on floor in his room lying between the bed and closet. No pain or injuries noted. Nurses' Notes, dated 11/5/21 10:55 p.m., indicated the resident had complaints of increasing pain to his right side due to previous fall. Unable to sit up in bed per self, needed assistance. Notified the POA and she wants him sent to the ER. The resident returned to facility on 11/23/22. The discharge plan of care, dated 11/23/22, indicated the resident was to start taking new medications. They were as follows: Lisinopril 40 milligrams (mg) daily Duloxetine 30 mg daily Midodrine 5 mg twice a day with		A routine audit will be completed by the Director of Resident Services or designee by reviewing nursing notes to ensure that any resident that returns to the facility and has new orders will be followed up on immediately. Routine audits will be completed daily during the week and completed on Monday for over the weekend for 60 days by the Resident Services Director or designee or until 100% compliance is achieved. These audits will be reviewed routinely at the QA committee. These systematic changes will be put into place by April 6, 2022.	

meals

Lidocaine 4% patch to the right rib

Xarelto 15 mg daily

Pantoprazole 40 mg in the morning before breakfast

Nurses' Notes, dated 11/26/22 at 9:22 a.m., indicated spoke with daughter in law about medication ordering, she would like medications to go through the facility's pharmacy.

Physician's Orders, dated 11/26/21, indicated Lisinopril 40 milligrams (mg) daily, Duloxetine 30 mg daily, Xarelto 15 mg daily, and Lidocaine 4% patch to the right rib.

Physician's Orders, dated 11/27/22, indicated Pantoprazole 40 mg in the morning before breakfast.

Physician's Orders, dated 11/29/22, indicated Midodrine 5 mg twice a day with meals.

The medications were not administered until 11/26, 11/27, and 11/29/21, several days after the resident had returned from the hospital.

Interview with the Director of Nursing on 3/7/22 at 12:40 p.m., indicated nursing staff were to follow the discharge instructions and obtain the resident's

	medications in a timely manner. This State Residential finding relates to Complaint IN00373895. Based on record review, and interview, the facility failed to ensure medications were available from the pharmacy when a resident was readmitted with new medications from the hospital for 1 of 3 residents reviewed for a significant change. (Resident B) Finding includes: The record for Resident B was reviewed on 3/7/22 at 9:45 a.m. Diagnoses included, but were not limited to, high blood pressure, seizures, history of falling, traumatic brain injury, and difficulty walking. The resident was sent to the hospital on 11/5/21 and returned on 11/23/21. Nurses' Notes, dated 11/5/21 at 4:22 a.m., indicated the resident had used the pendant and was on floor in his room lying between the bed and closet. No pain or injuries noted. Nurses' Notes, dated 11/5/21 10:55 p.m., indicated the resident had complaints of increasing pain to his right side due to previous fall. Unable to sit up in bed per self, needed assistance. Notified the POA			

	and she wants him sent to the ER. The resident returned to facility on 11/23/22. The discharge plan of care, dated 11/23/22, indicated the resident was to start taking new medications. They were as follows: Lisinopril 40 milligrams (mg) daily Duloxetine 30 mg daily Midodrine 5 mg twice a day with meals Lidocaine 4% patch to the right rib Xarelto 15 mg daily Pantoprazole 40 mg in the morning before breakfast Nurses' Notes, dated 11/26/22 at 9:22 a.m., indicated spoke with daughter in law about medication ordering, she would like medications to go through the facility's pharmacy. Physician's Orders, dated 11/26/21, indicated Lisinopril 40 milligrams (mg) daily, Duloxetine 30 mg daily, Xarelto 15 mg daily, and Lidocaine 4% patch to the right rib.			

	Physician's Orders, dated 11/27/22, indicated Pantoprazole 40 mg in the morning before breakfast. Physician's Orders, dated 11/29/22, indicated Midodrine 5 mg twice a day with meals. The medications were not administered until 11/26, 11/27, and 11/29/21, several days after the resident had returned from the hospital. Interview with the Director of Nursing on 3/7/22 at 12:40 p.m., indicated nursing staff were to follow the discharge instructions and obtain the resident's medications in a timely manner. This State Residential finding relates to Complaint IN00373895.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible.	R 0349	Resident B, C, and D did not experience any negative outcomes associated with this finding. Nurses have been re-in serviced on ensuring the clinical record is complete and accurate regarding, but not limited, follow up assessment and documentation after a fall with injury, a hospital return, the initiation of antibiotic therapy for cellulitis, the delay in	04/06/2022

	(4) Systematically organized. Based on record review and interview, the facility failed to ensure the clinical record was complete and accurate related to follow up assessment and documentation after a fall with injury, a hospital return, the initiation of antibiotic therapy for cellulitis, the delay in Physician's Orders, and blood pressures not obtained before the administration of antihypotensive medication for 3 of 3 residents reviewed falls and a significant change in status. (Residents B, C, and, D) Findings include: 1. The record 3/7/22 at 9:45 a.m. Diagnoses included, but were not limited to, high blood pressure, seizures, history of falling, traumatic brain injury, and difficulty walking. The resident was sent to the hospital on 11/5/21 and returned on 11/23/21 Nurses' Notes, dated 11/5/21 at 4:22 a.m., indicated the resident had used the pendant and was on floor in his room lying between the bed and closet. No pain or injuries noted. Nurses' Notes, dated 11/5/21 10:55 p.m., indicated the resident had complaints of increasing pain to his right side		Physician’s Orders, and blood pressures not being obtained before administration of antihypotensive medication, falls, and a significant change in status. Any future nurse will be in-serviced on ensuring the clinical record is complete and accurate regarding, but not limited, follow up assessment and documentation after a fall with injury, a hospital return, the initiation of antibiotic therapy for cellulitis, the delay in Physician’s Orders, and blood pressures not being obtained before administration of antihypotensive medication, falls, and a significant change in status during their job specific orientation A routine audit will be completed by the Director of Resident Services or designee by reviewing nursing notes to ensure that the clinical record is complete and accurate regarding, but not limited, to follow up assessment and documentation after a fall with injury, a hospital return, the initiation of antibiotic therapy for cellulitis, the delay in Physician’s Orders, and blood pressures not being obtained before	

	due to previous fall. Unable to sit up in bed per self and needed assistance. Notified the POA and she wants him sent to ER. The resident returned to facility on 11/23/22, however, there was no documentation or an assessment of the resident at the time of return on 11/23/22. The first documented entry in Nurses' Notes, was on 11/26/22. Nurses' Notes, dated 1/12/22 at 10:00 p.m., indicated the resident's pendant was on. He was found on the floor. He indicated he tried to stand and his legs gave out. An assessment was completed with increased swelling noted to the right calf with shooting pain when touched. The was a protruding area noted on the right calf. 911 was called. Nurses' Notes, dated 1/13/22 at 4:10 a.m., indicated blood work and ultrasound was completed with no abnormal findings. The resident returned per son. There was a dark bruise noted on the right calf. The next entry in Nurses' Notes was on 1/13/22 at 7:18 p.m., and there was no assessment of the resident or his injury to the right leg/calf. Nurses' Notes, dated 1/16/22 at 8:30 p.m., indicated a fax was		administration of antihypotensive medication, falls, and a significant change in status. Routine audits will be completed daily during the week and completed on Monday for over the weekend for 60 days by the Resident Services Director or designee or until 100% compliance is achieved. These audits will be reviewed routinely at the QA committee. These systematic changes will be put into place by April 6, 2022.	

sent to MD/NP to come visit resident due to leg edema and some pain at their earliest convenience.

The next documented entry was on 1/17/22 at 9:08 p.m., which indicated notified NP of resident's weeping and swollen leg, purple bruising to anterior and posterior lower calf. The resident had complained of pain. A new order was received and noted to start Doxycycline (an antibiotic) 100 milligrams (mg) 1 twice a day times 10 days. Also make an appointment with physician to assess vascular status.

Nurses' Notes, dated 1/19/22 at 8:20 a.m., indicated the resident was found on the floor and sustained a skin tear to the right hand. The skin tear was cleaned and a bandage was applied.

There was no follow up assessment or documentation regarding the skin tear.

Nurses' Notes, dated 1/20/22 at 5:15 p.m., indicated the resident returned from doctor with new orders for tubigrips and Doxycycline 100 mg twice a day times 14 days.

There was no assessment of the resident's legs after he returned from the doctor's appointment.

Nurses' Notes, dated 1/24/22 at

12:23 p.m., indicated the vascular and vein center called and stated the resident was to have an angiogram on Thursday 1/27/22 at 9:00 a.m.

There was no documentation in Nurses' Notes on 1/27/22 when the resident left or when he returned. There was no assessment of the resident after his procedure. The first entry after 1/27/22 was on 1/30/22.

Nurses' Notes, dated 1/30/22 at 9:56 a.m., indicated the family was notified for the need for tubigrips for the resident. They indicated they will be shipped via Amazon.

Physician's Orders, dated 1/30/22, indicated tubigrips to both legs. The order was not obtained for 10 days after it was prescribed by the Physician.

The resident had fallen again on 1/30/22 and was sent to the hospital for a fractured femur.

Nurses' Notes, dated 1/30/22 at 7:52 p.m., indicated a telephone call from the hospital, requesting information and orders status post the vascular evaluation/angiogram. Right groin site clear and right lower leg cellulitis with scabbed skin tear/abrasion present with edema and warmth (when seen last night per this nurse)

There was no assessment of

the right groin or the scabbed areas, edema and infection to the right lower leg documented in the clinical record.

Physician's Orders, dated 12/29/21, indicated Midodrine 5 mg every 8 hours as needed for systolic blood pressure under 100.

The Medication Administration Record (MAR), dated 1/2022, indicated the Midodrine 5 mg was signed out as being administered on 1/1 at 8:49 a.m., 1/8 at 5:00 p.m., 1/9 at 9:15 a.m., 1/12 at 12:34 p.m., 1/15 at 7:28 a.m. and 2:00 p.m., 1/16 at 9:00 a.m., 1/21 at 10:45 a.m., 1/22 at 2:00 p.m., 1/24 at 8:00 p.m., and 1/29/22 at 5:00 p.m.

There was no documentation of any blood pressures prior to the administration of the Midodrine.

Interview with the Director of Nursing on 3/7/22 at 12:40 p.m., indicated the Midodrine was administered, however, there was no documentation of any blood pressures obtained. There was no follow up documentation or an assessment after the resident's falls with injuries. There was no documentation of when the resident went out for the angiogram procedure and no documentation or an assessment when he returned or what the site looked like.

There was no documentation of the resident's swelling, edema and leg while taking the Doxycycline.

2. The record for Resident C was reviewed on 3/7/22 at 1:35 p.m. Diagnoses included, but were not limited to, dementia without behaviors and glaucoma.

Nurses' Notes, dated 1/11/22 at 10:10 p.m., indicated at 9:00 p.m., the resident was observed on the bathroom floor. The staff assisted the resident up and noted the resident had bowel movement in her brief. The resident was placed in bed and a head to toe assessment was completed. The resident screamed in pain when her right upper rib area was touched. The area was swollen. The son was notified and the writer suggested she be sent to ER, but the son denied the evaluation and informed writer to just monitor resident. A fax was sent to the doctor, due to not being able to reach by phone.

A Nurses' Note, dated 1/12/22 at 2:11 p.m., indicated the resident refused to allow the writer to perform neuro checks. She was wandering up and down hallways at the time and denied pain.

There was no follow up

assessment or documentation of resident's swollen rib area.

The next documented Nurses' Note was dated 1/23/22 (12 days after the fall) at 6:54 a.m., which indicated the resident had complaints of right rib pain and fell 12 days ago on her right side, with no reports of injury at that time. The nurse left a note that the resident's primary care physician needed to be contacted in order to obtain an order for an x-ray.

The next documented entry in Nurses' Notes, was on 1/29/22 at 4:18 p.m., which indicated the day staff member stated the resident was observed at 8:30 a.m. in her room lying on the floor. There was no incident report completed. There was a large hematoma on the back of her skull upon exam. The son was contacted and denied the resident be sent out to the ER. The son was informed of suggesting to switch doctors due to not being able to contact the doctor for weeks and the fax number was being rejected. The writer also informed him the resident needed treatment for a current yeast infection and had attempted to contact the physician with no success.

The next documented entry was 2/9/22 and there was no follow up assessment or documentation of large

hematoma or the possible yeast infection.

Nurses' Notes, dated 3/6/22 at 3:55 p.m., indicated at 3:00 p.m. heard a crash in the living room in front of the nursing station. The resident was noted on the floor and profusely bleeding from her forehead. The resident had a gash on her forehead and compression applied. 911 called for needing sutures.

There was no follow up assessment of the resident when she returned from the hospital or of the sutures to her forehead.

Interview with the Director of Nursing on 3/7/22 at 2:50 p.m., indicated the resident had returned yesterday with sutures to her forehead and there was no follow up assessment or documentation after the falls with injury.

3. The record for Resident D was reviewed on 3/7/22 at 1:45 p.m. Diagnoses included, but were not limited to, heart failure, high blood pressure, weakness, dementia without behaviors, and arthritis.

Nurses' Notes, dated 2/5/22 at 11:23 a.m., indicated the nurse and aide heard the resident screaming for help. The resident was on the floor next to her bed. The resident sustained a small abrasion on her right lower

back.

Nurses' Notes, dated 2/6/22 at 11:41 a.m., indicated the resident was found on the floor and she said she hit her head. No injuries were noted. There was no follow up documentation or assessment regarding the abrasion to the right lower back.

Nurses' Notes, dated 2/8/22 at 8:27 a.m., indicated at 6:15 a.m., the resident was observed on the floor calling for help. She was found next to the bed with her head resting on the night stand. A bump to the left side of the her head was observed.

There was no other documentation or assessment of bump to the left side of her head.

Nurses' Notes, dated 2/8/22 at 11:22 p.m., indicated at approximately 9:45 p.m., the staff walked into the room to assist the resident to bed. The resident was laying on the floor next to the bed. The CNA assisted the resident up in wheelchair and noted she was slurring her words and slumped over the arm of the wheelchair. The resident was placed in bed and the doctor was contacted. New orders to send out to the hospital. The ambulance was called and arrived to facility at 10:50 p.m. and she was transported to the ER for

evaluation.

There was no documentation or an assessment of the resident when she returned to the facility.

Nurses' Notes, dated 2/9/22 at 8:55 p.m., indicated at 5:15 p.m., indicated the resident was observed laying on the floor flat on her stomach and face. Her right arm was twisted behind her body. The resident had a gold size hematoma on the right side of the forehead and was screaming from shoulder pain. 911 was called.

Interview with the Director of Nursing on 3/7/22 at 2:50 p.m., indicated there was no follow up documentation or assessment after the falls and the resident's injuries.

This State Residential finding relates to Complaint IN00373895.

Based on record review and interview, the facility failed to ensure the clinical record was complete and accurate related to follow up assessment and documentation after a fall with injury, a hospital return, the initiation of antibiotic therapy for cellulitis, the delay in Physician's Orders, and blood pressures not obtained before the administration of antihypotensive medication for 3 of 3 residents reviewed falls and a significant change in status.

(Residents B, C, and, D)

Findings include:

1. The record 3/7/22 at 9:45 a.m. Diagnoses included, but were not limited to, high blood pressure, seizures, history of falling, traumatic brain injury, and difficulty walking.

The resident was sent to the hospital on 11/5/21 and returned on 11/23/21

Nurses' Notes, dated 11/5/21 at 4:22 a.m., indicated the resident had used the pendant and was on floor in his room lying between the bed and closet. No pain or injuries noted.

Nurses' Notes, dated 11/5/21 10:55 p.m., indicated the resident had complaints of increasing pain to his right side due to previous fall. Unable to sit up in bed per self and needed assistance. Notified the POA and she wants him sent to ER.

The resident returned to facility on 11/23/22, however, there was no documentation or an assessment of the resident at the time of return on 11/23/22. The first documented entry in Nurses' Notes, was on 11/26/22.

Nurses' Notes, dated 1/12/22 at 10:00 p.m., indicated the resident's pendant was on. He

was found on the floor. He indicated he tried to stand and his legs gave out. An assessment was completed with increased swelling noted to the right calf with shooting pain when touched. The was a protruding area noted on the right calf. 911 was called.

Nurses' Notes, dated 1/13/22 at 4:10 a.m., indicated blood work and ultrasound was completed with no abnormal findings. The resident returned per son. There was a dark bruise noted on the right calf.

The next entry in Nurses' Notes was on 1/13/22 at 7:18 p.m., and there was no assessment of the resident or his injury to the right leg/calf.

Nurses' Notes, dated 1/16/22 at 8:30 p.m., indicated a fax was sent to MD/NP to come visit resident due to leg edema and some pain at their earliest convenience.

The next documented entry was on 1/17/22 at 9:08 p.m., which indicated notified NP of resident's weeping and swollen leg, purple bruising to anterior and posterior lower calf. The resident had complained of pain. A new order was received and noted to start Doxycycline (an antibiotic) 100 milligrams (mg) 1 twice a day times 10 days. Also make an

appointment with physician to assess vascular status.

Nurses' Notes, dated 1/19/22 at 8:20 a.m., indicated the resident was found on the floor and sustained a skin tear to the right hand. The skin tear was cleaned and a bandage was applied.

There was no follow up assessment or documentation regarding the skin tear.

Nurses' Notes, dated 1/20/22 at 5:15 p.m., indicated the resident returned from doctor with new orders for tubigrips and Doxycycline 100 mg twice a day times 14 days.

There was no assessment of the resident's legs after he returned from the doctor's appointment.

Nurses' Notes, dated 1/24/22 at 12:23 p.m., indicated the vascular and vein center called and stated the resident was to have an angiogram on Thursday 1/27/22 at 9:00 a.m.

There was no documentation in Nurses' Notes on 1/27/22 when the resident left or when he returned. There was no assessment of the resident after his procedure. The first entry after 1/27/22 was on 1/30/22.

Nurses' Notes, dated 1/30/22 at 9:56 a.m., indicated the family was notified for the need for

tubigrips for the resident. They indicated they will be shipped via Amazon.

Physician's Orders, dated 1/30/22, indicated tubigrips to both legs. The order was not obtained for 10 days after it was prescribed by the Physician.

The resident had fallen again on 1/30/22 and was sent to the hospital for a fractured femur.

Nurses' Notes, dated 1/30/22 at 7:52 p.m., indicated a telephone call from the hospital, requesting information and orders status post the vascular evaluation/angiogram. Right groin site clear and right lower leg cellulitis with scabbed skin tear/abrasion present with edema and warmth (when seen last night per this nurse)

There was no assessment of the right groin or the scabbed areas, edema and infection to the right lower leg documented in the clinical record.

Physician's Orders, dated 12/29/21, indicated Midodrine 5 mg every 8 hours as needed for systolic blood pressure under 100.

The Medication Administration Record (MAR), dated 1/2022, indicated the Midodrine 5 mg was signed out as being administered on 1/1 at 8:49 a.m., 1/8 at 5:00 p.m., 1/9 at

9:15 a.m., 1/12 at 12:34 p.m., 1/15 at 7:28 a.m. and 2:00 p.m., 1/16 at 9:00 a.m., 1/21 at 10:45 a.m., 1/22 at 2:00 p.m., 1/24 at 8:00 p.m., and 1/29/22 at 5:00 p.m.

There was no documentation of any blood pressures prior to the administration of the Midodrine.

Interview with the Director of Nursing on 3/7/22 at 12:40 p.m., indicated the Midodrine was administered, however, there was no documentation of any blood pressures obtained. There was no follow up documentation or an assessment after the resident's falls with injuries. There was no documentation of when the resident went out for the angiogram procedure and no documentation or an assessment when he returned or what the site looked like. There was no documentation of the resident's swelling, edema and leg while taking the Doxycycline.

2. The record for Resident C was reviewed on 3/7/22 at 1:35 p.m. Diagnoses included, but were not limited to, dementia without behaviors and glaucoma.

Nurses' Notes, dated 1/11/22 at 10:10 p.m., indicated at 9:00 p.m., the resident was observed on the bathroom floor. The staff assisted the resident up and

noted the resident had bowel movement in her brief. The resident was placed in bed and a head to toe assessment was completed. The resident screamed in pain when her right upper rib area was touched. The area was swollen. The son was notified and the writer suggested she be sent to ER, but the son denied the evaluation and informed writer to just monitor resident. A fax was sent to the doctor, due to not being able to reach by phone.

A Nurses' Note, dated 1/12/22 at 2:11 p.m., indicated the resident refused to allow the writer to perform neuro checks. She was wandering up and down hallways at the time and denied pain.

There was no follow up assessment or documentation of resident's swollen rib area.

The next documented Nurses' Note was dated 1/23/22 (12 days after the fall) at 6:54 a.m., which indicated the resident had complaints of right rib pain and fell 12 days ago on her right side, with no reports of injury at that time. The nurse left a note that the resident's primary care physician needed to be contacted in order to obtain an order for an x-ray.

The next documented entry in

Nurses' Notes, was on 1/29/22 at 4:18 p.m., which indicated the day staff member stated the resident was observed at 8:30 a.m. in her room lying on the floor. There was no incident report completed. There was a large hematoma on the back of her skull upon exam. The son was contacted and denied the resident be sent out to the ER. The son was informed of suggesting to switch doctors due to not being able to contact the doctor for weeks and the fax number was being rejected. The writer also informed him the resident needed treatment for a current yeast infection and had attempted to contact the physician with no success.

The next documented entry was 2/9/22 and there was no follow up assessment or documentation of large hematoma or the possible yeast infection.

Nurses' Notes, dated 3/6/22 at 3:55 p.m., indicated at 3:00 p.m. heard a crash in the living room in front of the nursing station. The resident was noted on the floor and profusely bleeding from her forehead. The resident had a gash on her forehead and compression applied. 911 called for needing sutures.

There was no follow up assessment of the resident when she returned from the

hospital or of the sutures to her forehead.

Interview with the Director of Nursing on 3/7/22 at 2:50 p.m., indicated the resident had returned yesterday with sutures to her forehead and there was no follow up assessment or documentation after the falls with injury.

3. The record for Resident D was reviewed on 3/7/22 at 1:45 p.m. Diagnoses included, but were not limited to, heart failure, high blood pressure, weakness, dementia without behaviors, and arthritis.

Nurses' Notes, dated 2/5/22 at 11:23 a.m., indicated the nurse and aide heard the resident screaming for help. The resident was on the floor next to her bed. The resident sustained a small abrasion on her right lower back.

Nurses' Notes, dated 2/6/22 at 11:41 a.m., indicated the resident was found on the floor and she said she hit her head. No injuries were noted. There was no follow up documentation or assessment regarding the abrasion to the right lower back.

Nurses' Notes, dated 2/8/22 at 8:27 a.m., indicated at 6:15 a.m., the resident was observed on the floor calling for help. She was found next to the bed with her head resting on the night

stand. A bump to the left side of the her head was observed.

There was no other documentation or assessment of bump to the left side of her head.

Nurses' Notes, dated 2/8/22 at 11:22 p.m., indicated at approximately 9:45 p.m., the staff walked into the room to assist the resident to bed. The resident was laying on the floor next to the bed. The CNA assisted the resident up in wheelchair and noted she was slurring her words and slumped over the arm of the wheelchair. The resident was placed in bed and the doctor was contacted. New orders to send out to the hospital. The ambulance was called and arrived to facility at 10:50 p.m. and she was transported to the ER for evaluation.

There was no documentation or an assessment of the resident when she returned to the facility.

Nurses' Notes, dated 2/9/22 at 8:55 p.m., indicated at 5:15 p.m., indicated the resident was observed laying on the floor flat on her stomach and face. Her right arm was twisted behind her body. The resident had a gold size hematoma on the right side of the forehead and was screaming from shoulder pain. 911 was called.

	Interview with the Director of Nursing on 3/7/22 at 2:50 p.m., indicated there was no follow up documentation or assessment after the falls and the resident's injuries. This State Residential finding relates to Complaint IN00373895.			

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