

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/04/2024
NAME OF PROVIDER OR SUPPLIER CHARTER SENIOR LIVING OF GATEWAY PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 6338 WEST QUIET ROAD, GREENFIELD, , 46140			
(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 Complaints IN00445580 and IN00446649. Complaint IN00445580 - State deficiencies related to the allegations are cited at R240. Complaint IN00446649 - State deficiencies related to the allegations are cited at R240. Survey date: November 4, 2024 Facility number: 015521 Residential Census: 38 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 6, 2024.	R 0000			
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance	R 0240	Complaint # 00446649	11/22/2024	

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with activities of daily living, shall be provided based upon individual needs and preferences.

Based on interview and record review, the facility failed to ensure a resident's needs with transfers and conduct laboratory (lab) testing timely for 1 of 3 residents reviewed for falls and 1 of 3 residents reviewed for weight loss. (Resident B and Resident E)

Findings include:

1. The clinical record for Resident E was reviewed on 11/4/24 at 3:30 p.m. The diagnoses listed on a foot clinic note included, but were not limited to, muscle weakness, unsteadiness on feet, osteoarthritis, acquired deformities of right foot, and ataxic gait (failure of muscle coordination and is characterized by an irregular foot placement, wide base, and instability).

A foot clinic note, dated 11/20/23, indicated Resident E had a shuffling gait, drop foot gait, and Resident E utilized a cane.

A Mini-Mental State Examination (MMSE), dated 6/18/24, indicated no cognitive impairment.

A Custom Level of Care Tool,

What will be done to prevent missed labs for residents:

Reached out to our provider - Gateway Labs @ Hancock Health to set up that RR at Gateway Park will be faxed any lab results directly from the lab once complete.

How will be track this - Lab draws are completed weekly & nursing will follow up and document in resident file when labs were drawn and then when results are received.

How to track progress to ensure our solution is sustained:

DON will complete weekly audits x 6 weeks then monthly.

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revised 6/18/24, indicated Resident E was listed as needing stand-by supervision for transfers on a regular basis. Resident E was previously listed as independent for transfer ability on 4/3/24.

A progress note, dated 6/29/24, indicated the following,
"...Resident was unable to help [symbol for with] his care all night, he could not stand to help [symbol for with] toileting or get to bed...had to change him in his bed all night he can roll for you but would not bare [sic] any wt [weight] on his legs. Completely dependent on nursing staff...."

The next consecutive progress note, dated 7/12/24 at 10:00 a.m., indicated the following,
"Resident still very weak, but was able to get his shower...."

The next consecutive progress note, dated 8/7/24 at 11:00 p.m., indicated the following,
"Resident assisted to bathroom to maintain continence needs. Res [resident] preference is to urinate standing over toilet from side of bowl, holding both grab bars and top of head resting against wall...."

A progress note, dated 8/11/24 at 8:30 p.m., indicated the following, "Resident had a witness [sic] fall @ [at] 8:30 pm. We was transferring to the

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wheelchair to go to bathroom I had to slide him down onto the floor [symbol for and] in the process his Lt [left] hand hit his w/c [wheelchair] and resident has a skin tear on back of his hand...."

A progress note, dated 8/22/24 at 8:00 p.m., indicated Resident E was no longer being provided therapy services due to plateau and "doesn't do any better".

A progress note, dated 10/4/24, indicated the following, "...In the process of trying to transfer Resident from chair to w/c [wheelchair] to go to the restroom resident almost fell to the floor but [symbol for with] my support he was easily lowered back onto his chair and nurse fell to the floor instead [sic]...."

A progress note, dated 11/3/24 at 4:40 p.m., indicated a large skin tear was noted to Resident E's left lower extremity and he was transferred to the local hospital.

An incident report, dated 11/3/24, indicated Resident E was being transferred by facility staff from his recliner to his wheelchair. The left lower extremity was caught in the footrest and caused a large skin tear.

A progress note, dated 11/3/24 at 10:00 p.m., indicated Resident E returned to the

facility with family. Resident E had 12 sutures placed to the left lower extremity while at the local hospital.

A hospital document, dated 11/3/24, indicated Resident E had a laceration to the left leg with sutures placed and sutures should be removed in ten days.

A Custom Level of Care tool had not been updated to reflect Resident E's current level of care since 6/18/24.

During an interview conducted with Family Member 3 on 11/4/24 at 1:29 p.m., she indicated Resident E had a seizure, in June 2024, and ever since then he hasn't been able to transfer himself or ambulate. He was dependent on facility staff for assistance with transfers. The facility staff were to request help from the memory care unit when needing assistance to transfer Resident E. On 11/3/24, Home Health Aide (HHA) 2 got in between Resident E's feet with their feet, his leg got pinned in her leg and caused his leg to press into his wheelchair. Resident E's leg "tore" and it took 12 stitches to close up the laceration.

During an interview conducted with the Executive Director (ED) on 11/4/24 at 1:35 p.m., she indicated HHA 2 was transferring Resident E and his

leg got "pinned" against HHA 2 and the resident obtained a laceration to his leg that required 12 stitches. Resident E was dependent on staff for activities of daily living, especially transferring.

During an interview conducted with HHA 2 on 11/4/24 at 1:48 p.m., she indicated she was in the process of transferring Resident E from his recliner to his wheelchair. She had transferred him during the day without any problems. HHA 2 was a newer employee at the facility and, 11/3/24, was the first day she had worked with Resident E by herself. Resident E usually didn't like for HHA 2 to conduct transfers because he referred to HHA 2 as "too small". HHA 2 indicated she could not find facility staff to assist her with transferring Resident E. HHA 2 usually had a nurse or some other facility staff member standing by with Resident E's transfers since he was scared about falling, again. While in the process of transferring Resident E, his legs got "twisted" and he stated, "my leg". It looked like his leg got caught on a part of his wheelchair and it tore the skin. When HHA 2 looked down she saw blood. Resident E preferred to look downward during transfers and that limited the view of HHA 2's ability to see Resident E's feet and legs.

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Resident E had no gait belt or other assistive devices in the apartment besides his wheelchair. Resident E wasn't able to stand on his own and the staff must "physically transfer him".

An observation and interview were conducted with Resident E, Family Member 4, and Family Member 3 on 11/4/24 at 3:05 p.m. Family Member 4 indicated when he transfers Resident E, he gives him a "bear hug", then Resident E stands, and then pivots to transfer. Resident E shuffles with his gait during transfers and was not able to walk. Resident E needed someone to hold onto to help him balance and assist with the transfer. Family Member 3 indicated Resident E's balance was off and he shuffled his feet rather than walking. While Resident E was in therapy, they would utilize a gait belt. There was no gait belt in Resident E's room and Family Member 3 indicated there hadn't been a gait belt for the staff to utilize in Resident E's apartment.

During an interview conducted with the ED on 11/4/24 at 3:23 p.m., she indicated there was no facility policy regarding transfers. The memory care unit was usually staffed with a qualified medication aide (QMA) and one to two Certified Nurse Aides (CNAs). So, staff from

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Assisted Living can receive help from memory care if needed. The ED indicated the Director of Nursing was conducting education regarding transfers and utilization of foot pedals. The ED was unsure why the current Level of Care Tool didn't reflect Resident E's level of assistance from staff members for transferring.

A document titled "Assistive Devices", undated, was provided by the ED on 11/4/24 at 3:47 p.m. The document indicated the following, "...Each resident uses the most appropriate assistive devices properly and safely, when he or she needs it...A physician or physical therapist determines a resident's need for an assistive device...Canes, walkers, and crutches help residents walk. Check to see that... The device is available and used properly...Wheelchairs help residents move about when they cannot walk. Check to see that...The resident is positioned properly in the chair...The wheelchair is working properly...The foot rests are at the appropriate height...."

The Indiana State Department of Health Nurse Aide Curriculum, revised November 19, 2015, indicated the following, "...PROCEDURE #24: USING A GAIT BELT TO ASSIST WITH

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AMBULATION...3. Place belt around resident's waist with the buckle in front and adjust to a snug fit ensuring that you can get your hands under the belt...4. Assist the resident to stand on count of three...6. Stand to side and slightly behind resident while continuing to hold onto belt...PROCEDURE #26: TRANSFER TO WHEELCHAIR...2. Place wheelchair on resident's unaffected side...4. Stand in front of resident and apply gait belt around the resident's abdomen...."

2. The clinical record for Resident B was reviewed on 11/4/24 at 11:30 a.m. The diagnoses included, but were not limited to, malnutrition and hypothyroidism.

A nurse practitioner (NP) note, dated 9/30/24, indicated Resident B appeared "too thin" and ordered laboratory (lab) testing to be conducted.

There was no lab results for Resident B located in the clinical record.

An interview conducted with the ED, on 11/4/24 at 3:23 p.m., indicated the physician should send the request for lab work directly to the lab conducting the testing. She was unsure what the holdup was. The family reached out to the ED and the

laboratory was called. Resident B was on the schedule for lab work, but it was "weeks later". There was no facility policy regarding lab work. A lab result was provided by the ED and indicated the lab work was conducted on 10/23/24, for the lab work that was ordered on 9/30/24.

This citation relates to Complaints IN00445580 and IN00446649.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR
PROVIDER/SUPPLIER REPRESENTATIVE'S
SIGNATURE

TITLE

(X6) DATE