STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155291	A. BUILDING 00 B. WING	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAGLE VALLEY MEADOWS	3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00394438, IN00393410, and IN00390027. Complaint IN00394438 - Substantiated. Federal/State deficiencies related to the allegations are cited at F657 and F684. Complaint IN00393410 - Substantiated. Federal/State deficiencies related to the allegations are cited at F657 and F684. Complaint IN00390027 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: December 28, 2022. Facility number: 000188 Provider number: 155291 AIM number: 100266310 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 4 Medicaid: 47 Other: 13 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 6, 2023.	F 0000		
F 0657 SS=D	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Holder	Executive Director	01/27/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Bldg. 00	§483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, interview and record review, the facility failed to update a care plan and put measures in place to prevent falls for a resident who had multiple times during her stay at the facility (Resident B). Findings include: During an anonymous interview, Resident B's family member indicated she had fallen multiple	F 0657	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of	02/03/2023

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	times. She had spoken with the Director of Nursing (DON) and Executive Director (ED) many times. She was told the staff would be educated and care plans would be put into place. She just wanted the resident to have received the care she deserved. On 12/28/22 at 10:00 a.m., the medical record for Resident B was reviewed. The record indicated Resident B was admitted on 8/10/22 and discharged home with family and home hospice services on 12/12/22. The diagnoses included, but were not limited to, dementia and senile degeneration of the brain. The resident was impulsive and lacked safety awareness due to her dementia. A care plan, initiated 8/11/22, indicated Resident B was at risk for falls due to dementia, impaired mobility, weakness and occasional incontinence. The resident attempted to ambulate frequently. The short term goal, target date 1/18/23, indicated the resident's fall risk factors would be reduced in an attempt to avoid significant fall related injuries. The interventions added after falls were as follows: 12/6/22 "scoop mattress"; 11/28/22 "arrange for early get up time per reference [sic] of resident and fall mat." The only edit dates on the care plan were 11/28/22 and 12/6/22. The care plan did not indicate the resident had actually fallen and no additional post fall care plan was initiated. An interdisciplinary team (IDT) note, created 9/2/22 at 11:34 p.m., indicated on 9/1/22 at 12:47 p.m., Resident B was attempting to sit in a regular chair, in the TV (television) room, while the lights were dimmed. She missed the chair and slid down to the floor, per staff interview, lights were dimmed to help calm residents after lunch. The care plan interventions to address the root cause		this plan of correction in lieu of post survey revisit. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident no longer resides at the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Any resident that had a fall had the potential to be affected. Audits for residents that have had falls for the last 30 days have been reviewed to ensure care plans are up to date and interventions are in place. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** IDT has been in-serviced on updating care plans by the Director of Clinical Training on 1/27/23 with special focus on Fall Care Plans including interventions. DNS/Designee will round daily to ensure fall interventions are in place per care plan. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**	

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	were to make sure there was adequate lighting in the TV room at all times during the day and refer resident to optometry for decreased peripheral vision. On 9/16/22 an IDT note indicated Resident B fell at 4:59 p.m. Resident B was walking into the dining room area, another resident was getting up from a chair, in the dining area, and pushed the chair out from the table obstructing the walkway. Resident B was walking passed the chair that was pushed out from the table, tripped over the chair, and fell to her buttocks. Immediate/short term interventions in place at time of the fall included free environment of clutter, un-obstruct walkway by pushing chair back up to the table and obtain labs to rule out any infection. An IDT note, dated 9/20/22 at 9:03 a.m. and recorded as Late Entry on 9/21/22 at 12:08 p.m., indicated Resident B had a fall on 9/19/22 at 7:06 p.m. Staff witnessed the resident ambulating out of room doorway into the hallway. Staff observed resident having an unsteady gait, so staff rushed to resident to attempt to prevent a fall, however per interview resident was falling to the floor. Staff was able to catch resident and lowered resident to the floor. On 9/25/22 an IDT note indicated at 5:00 p.m., Resident B had a fall. The resident was ambulating without assistance became unsteady and fell to the floor, in the common area. Interventions were to include therapy to evaluate and treat, and resident was given a wheelchair. On 9/25/22 at 5:50 p.m., a nurse progress note indicated Resident B had a witnessed fall on 9/25/22. Resident was ambulating on the unit, became unsteady, and fell to floor before staff		Ø Care Plan Updating QAPI tool will be completed weekly x 4 then monthly x 6 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director Ø If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	were able to assist resident back to the wheelchair. Resident B was fully dressed with non-skid footwear in place as ordered. The resident expressed pain to the right leg. A nurse progress note, dated 9/26/22 at 6:30 a.m., indicated Resident B's daughter was on site to shower the resident and then taking resident to the emergency room for evaluation of recent falls. While bathing, daughter found 2 areas of bruising on the resident. One on the right shoulder and one on the right hip. Daughter stated they would be checked in the emergency room (ER). On 10/9/22 at 8:24 p.m., a nurse progress note indicated Resident B had an unwitnessed fall at 5:20 p.m. Resident B's family came in after being called and was upset that this was the 6th fall in 2 months. The family was informed the concern would be discussed with therapy in the morning. On 10/27/22 an IDT fall note indicated Resident B had a fall on 10/26/2022 at 6:00 a.m. and interventions would be determined. On 10/28/22 at 10:28 a.m., an IDT note indicated Resident B attempted to ambulate from wheelchair without asking for assistance, stood up attempt to ambulate and tripped over foot pedals. Immediate/short term interventions put in place at time of the fall were to be, "Add foot pedal cushion to wheelchair to prevent resident from tripping over foot pedals." The root cause of fall was determined to be Resident B had attempted to ambulate without assistance, stood up from wheelchair and tripped over foot pedal. Intervention to be put in place to address the root cause of fall were add wheelchair cushion/padding to foot pedals, verify and check orders were updated with new interventions, Care			

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	plan was updated, and the resident's profile / care sheets were updated. On 11/16/22 at 12:35 a.m., an IDT note indicated Resident B attempted to transfer self out of bed without asking for assistance became weak and fell. Immediate/short term intervention put in place at time of the fall was a body pillow placed for tactile boundaries. On 11/24/22 at 2:00 p.m., Resident B slid from the wheelchair to the floor and was lying front of vending machine. Immediate/short term interventions put in place at time of the fall included: pathways free of clutter, non-skid footwear, toilet upon rising before and after meals and at bedtime, fall mat, body pillow, 1/2 lap tray to wheelchair, hipsters if resident allows, labs/clinical, therapy to evaluate, therapy to downgrade, and ensure adequate lighting. On 12/6/22 at 4:00 a.m., a nurses note indicated Resident B was found by night shift on the floor with the mattress near her bed. She was lying on her left side asleep and her head on the pillow. The Certified Nurse Assistant (CNA) helped to place her back on the bed, did not complaint of (c/o) pain during movement. A thorough physical and neurological assessment was completed and there were no noted injuries to her extremities with vital signs within normal limits. The as needed (PRN) Lorazepam (anti-anxiety medication) was given and was somewhat effective. On 12/8/22 at 9:44 a.m., an IDT Fall Review Note, recorded as Late Entry on 12/9/22 at 12:50 p.m., indicated Resident B fell on 12/7/22 at 5:15 p.m. Resident B was noted on buttocks with legs straight sitting at dining room entrance. Interventions put in place at time of the fall			

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	included: scoop mattress, high-back wheelchair, arrange for early get up per resident's preference, fall mat, body pillow, 1/2 lap tray to wheel chair, toilet upon rising between meals and at bedtime, non-skid footwear, anti-rolls backs to wheel chair, hipsters in place as resident allows. On 11/28/22 an Event note indicated Resident B had a fall on 11/28/22 at 6:04 a.m. The intervention indicated add to the night shift get up list. On 12/28/22 at 2:15 p.m., during an interview, the DON indicated she did not know if Resident B needed a care plan which stated she had actually fell. The care plan "Potential for Falls" was the only one she had. She would have to check the policy. The care plan should have been updated after each fall. A policy titled, "Fall Management Policy, was provided by the ED on 12/22/22 at 2:00 p.m. It indicated, " ...A fall event will be initiated as soon as the resident has been assessed and cared for. All falls will be discussed by the interdisciplinary team (IDT) at the first IDT meeting after the fall to determine the root cause and other possible interventions to prevent future falls. The fall event will be reviewed by the team, the IDT note will be written, the care plan will be reviewed and updated, as necessary and "hot" charting will be initiated post fall ...." This Federal tag relates to Complaints IN00394438 and IN00393410. 3.1-35(c)(1)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that			

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	applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to complete and document follow-up neurological check assessments after falls for 2 of 3 residents reviewed for post fall assessments (Residents B and C). Findings include: 1. During an anonymous interview, Resident B's family member indicated she had fallen multiple times. She had spoken with the Director of Nursing (DON) and Executive Director (ED) many times. She was told the staff would be educated. She just wanted the resident to have received the care she deserved. On 12/28/22 at 10:00 a.m., the medical record for Resident B was reviewed. The record indicated Resident B was admitted on 8/10/22 and discharged home with family and home hospice services on 12/12/22. The diagnoses included, but were not limited to, dementia and senile degeneration of the brain. The resident was impulsive and lacked safety awareness due to her dementia. On 11/29/22 at 12:08 p.m.., a Post Fall Follow-up note indicated Neuro checks were being completed. Resident B's record lacked neurological documentation sheets for the 11/29/22 fall.	F 0684	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B no longer resides at the facility. Resident C neurological assessment has been completed, MD and family aware of all falls. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Any resident that had a fall had the potential to be affected.	02/03/2023

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	On 12/6/22 at 4:00 a.m., a nurses note indicated Resident B was found by night shift on the floor with the mattress near her bed. She was lying on her left side asleep and her head on the pillow. The Certified Nurse Assistant (CNA) helped to place her back on the bed, did not complaint of (c/o) pain during movement. A thorough physical and neurological assessment was completed and there were no noted injuries to her extremities with vital signs within normal limits. The as needed (PRN) Lorazepam (anti-anxiety medication) was given and was somewhat effective. Resident B's record lacked neurological documentation sheets for the 12/6/22 fall or post fall monitoring. On 12/8/22 at 9:44 a.m., an interdisciplinary team (IDT) note, "Fall Review Note," recorded as Late Entry on 12/9/22 at 12:50 p.m., indicated Resident B fell on 12/7/22 at 5:15 p.m. Resident B was noted on her buttocks with her legs straight sitting at dining room entrance. The resident did not have injuries and neuro checks were within normal limits. Resident B's record lacked neurological documentation sheets for the 12/7/22 fall or post fall monitoring. On 12/28/22 all neuro check documentation for all of Resident B's falls were requested. The Director of Nursing (DON) provided Neurological (Neuro) Check Sheets for the falls of 9/25/22, 10/9/22, 11/15/22, and 11/24/22. She indicated those were the only neuro assessments she was able to find. The documents indicated the post fall assessments were to be completed every 8 hours for 72 hours after falls. The assessment sheet for the fall of 9/25/22 had missing documentation for 9/26/22: 2 p.m. to 10 p.m., 10 p.m. to 6 a.m., 9/27 6 a.m. to 2 p.m., 2 p.m. to 10 p.m., and 9/28: 2 p.m. to 10 p.m. and 10 p.m. to 6 a.m.		Audit was completed for falls in the last 4 weeks to ensure neurological assessment was completed and MD and family notification present. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Inservice all nurses on Fall Management Program to be completed by DNS/Designee. DNS/Designee will be contacted after each fall to ensure neuro checks are completed and documented in the medical record. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ø Fall Management QAPI will be utilized weekly x 4 weeks then monthly x 6 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director Ø If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	The post fall documentation from the fall on 10/9/22, lacked documentation assessments were completed for the 10 p.m. to 6 a.m. shift on 10/11/22, the 2 p.m. to 10 p.m. shift on 10/12/22 or the 10 p.m. to 6 a.m. shift on 10/12/22. The post fall documentation from the fall on 11/15/22, lacked documentation assessments were completed on 11/16/22 on the 1 hour check for 11/16/22 6:00 p.m. check. The post fall assessments for the fall on 11/24/22 lacked documentation on 11/27/22 for the 2 p.m. to 10 p.m. shift. Resident B's record lacked documentation of neuro checks for unwitnessed falls on 10/26/22, 11/28/22, 12/6/22 or 12/7/22. 2. On 12/28/22 at 11:00 a.m., a comprehensive record review was completed for Resident C. She had the following diagnoses, but not limited to frontotemporal neurocognitive disorder (the result of damage to the neurons to the frontal and temporal lobes of the brain), encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition (such as viral infection or toxins in the blood)), hypertension, major depressive disorder, hyperlipidemia (an abnormally high concentration of fats or lipids in the blood), dementia, vitamin D deficiency, and unspecified mood disorder. Resident C had a fall on 10/17/22 at 1:34 a.m. She was found on the floor in her room. The fall was unwitnessed. No injury was observed with the fall. An intervention was added to her care plan to place a pad next to her bed. Resident C had a fall on 12/11/22 at 2:10 p.m. She			

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	was found on the floor in her room. The fall was unwitnessed. No injury was observed with the fall. An intervention was added to her care plan for her to wear hipsters (shorts with pads to protect the hips from injuries with falls). During an interview with the DNS on 12/22/22 at 1:29 p.m., she indicated that neurological assessments should have been completed with both of Resident C's falls since they were unwitnessed. She was unable to provide documentation to indicate that neurological assessments were completed after these falls. A policy titled, "Fall Management Policy, was provided by the ED on 12/22/22 at 2:00 p.m. It indicated, "Any resident experiencing a fall will be assessed immediately by the charge nurse for possible injuries and necessary treatment will be provided. A neurological assessment will be initiated on all unwitnessed falls ...." This Federal tag relates to Complaints IN00394438 and IN00393410. 3.1-37(a)			