STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00424946 and IN00425285. Complaint IN00424946 - Federal/State deficiencies related to the allegations are cited at F0580. Complaint IN00425285 - Federal/State deficiencies related to the allegations are cited at F0580. Survey dates: January 10 and 11, 2024 Facility number: 000136 Provider number: 155231 AIM number: 100275450 Census Bed Type: SNF/NF: 56 Total: 56 Census Payor Type: Medicare: 10 Medicaid: 38 Other: 8 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 22, 2024.	F 0000	This Plan of Correction is being prepared and executed because it is required by the provisions of state regulation, and not because Randolph Nursing and Rehabilitation agrees with the allegations and citations listed on the statement of deficiencies. Randolph Nursing and Rehabilitation maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Randolph Nursing and Rehabilitation's written credible allegations of compliance. This plan of correction Is not meant to establish any standard of care contract, obligation or position, and Randolph Nursing and Rehabilitation reserves all possible contentions and defenses in any civil or criminal actions or proceeding.	
F 0580 SS=G Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keona Parkison	Health Facility Administrator	02/02/2024

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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	when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) 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); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical			

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	configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to immediately notify the physician and resident representative for a resident's change in condition and failed to notify the physician prior to administration of an antiplatelet medication after a resident fell with a head injury for 1 of 3 residents reviewed for accidents. (Resident B) This deficiency resulted in Resident B experiencing a delay in treatment for a large right subdural hematoma with midline shift (brain bleed with significant swelling). Findings include: Resident B's clinical record was reviewed on 1/10/24 at 3:49 p.m. Diagnoses included severe vascular dementia with psychotic disturbances, unspecified abnormalities of gait and mobility, long term use of antiplatelets, generalized muscle weakness, and history of falling. A nursing admission assessment, dated 12/21/23, indicated the resident was a high risk for falls. The resident had one or more falls within the previous six months. She had urgency, frequency, and incontinence with bowel and urine elimination. The resident required assistance or supervision for mobility, transfer, or ambulation. She lacked understanding of physical and cognitive limitations. A physician's order, dated 12/22/23, included clopidogrel (blood thinner) 75 milligrams (mg) by mouth daily for occlusion and stenosis of unspecified carotid artery.	F 0580	Randolph-F 580 G- Notify of Changes *What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* Resident B's physician was notified of the condition change and was transferred to the hospital. *How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action(s) will be taken?* Any resident who experiences a fall with head trauma may be affected by the alleged deficient practice. Residents reviewed no other residents identified to be affected by the alleged deficient practice. *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* Licensed nurses were provided re-education with emphasis on	02/09/2024

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	A Fall Event Report, dated 12/25/23, indicated the resident had Fall #1 on this date, which was an unwitnessed fall in the resident's room that resulted in a large hematoma to the right eye measuring four centimeters in diameter. The physician was notified on 12/25/23 at 9:25 p.m. A Fall Event Report, dated 12/27/23 at 5:22 p.m., indicated the resident had Fall #2 at this time. It was a witnessed fall, in the dining room, without injury. A discharge Minimum Data Set assessment, dated 12/27/23, indicated the resident had an unplanned discharge to an acute hospital with return not anticipated. The resident's cognitive status was severely impaired. The resident had one fall without injury, one fall with injury except major, and no falls with major injury. A care plan, dated 12/21/23, indicated the resident was at risk for falls related to a history of falls, impaired mobility, generalized weakness, dizziness, and dementia. Interventions included, assist and supervise the resident with transfers and ambulation as the resident needs (12/21/23), and place bed against the wall with the bedside table next to it (12/26/23). A care plan, dated 12/21/23, indicated the resident was at risk for abnormal bleeding or excessive bruising related to the use of anti-platelet medication. Interventions included the following: observe and report increased bruising and administer or hold medications as ordered (12/21/23). The care plan was not updated on 12/25/23 aft the resident developed a right eye hematoma.		notification of antiplatelet medication order(s) and/or changes in condition to the physician or physician designee after a fall event has occurred. Licensed nurses will notify physicians or physicians designee of antiplatelet medication order after a fall event has occurred. Licensed nurses will document physician or physician designee notification of antiplatelet medication order in the resident's medical record. Licensed nurses will notify physicians or physicians designee of changes in condition after a fall event has occurred. Licensed employees will document physician or physician designee notification of a change in condition in the resident's medical record. *How will the corrective action(s) be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?* The DON or designee will complete an audit of falls with injury, to ensure antiplatelet medication(s) order and changes of condition are notified to the physician or physician designee. The audit will be completed daily for 4 weeks, then 3 days a week x 4 weeks, then weekly x 4 weeks, then once a month for 4 months to ensure substantial compliance.	

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	A care plan, dated 12/25/23, indicated the resident had a right eye hematoma from a fall. Interventions included, report abnormal findings to the wound nurse and Medical Doctor (MD (12/26/23). A Nurse's Note, dated 12/25/23 at 9:45 p.m., indicated the physician was sent a picture of the resident's hematoma. Orders were received to ice the eye, monitor with neurological checks per protocol, and hold aspirin (anticoagulant) for five days. The physician notification was 20 minutes after the resident's fall on this date. The telephone order lacked any communication regarding clarification for clopidogrel. Review of a 2024 patient education document titled "Clopidogrel (Plavix), retrieved from https://my.clevelandclinic.org/health/drugs/20743-clopidogrel-tablets indicated the following: " ...it's good to remember that the medicines that protect you also make you bleed more easily. You may want to switch to an electric razor and find safer food prep methods to prevent cuts. Avoid direct blows to the head, as you might be at increased risk for intracranial bleeding with head trauma. Be sure to follow your healthcare provider's instructions for taking clopidogrel ...." Review of the Medication Administration Record (MAR) indicated clopidogrel was administered to the resident daily from 12/22/23 through 12/27/23. The MAR lacked any information regarding a hold or clarification with the physician prior to administration. Review of the neurological assessment on 12/27/23 at 10:30 a.m., indicated the resident had normal respirations at 18 breaths per minute and the right pupil response was positive (reactive).		Failure of licensed nurses to follow the policy and procedure will result in re-education and disciplinary action up to and including termination. The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated. *By what date will the systemic changes for each alleged deficiency be completed?* 2/9/2024	

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	Review of the neurological assessment, dated 12/27/23 at 6:30 p.m., indicated the resident had a change to shallow respirations at 22 breaths per minute and the right pupil response was negative (non-reactive). This document lacked any information to show the physician was immediately notified. The clinical record lacked information regarding physician notification with the resident's change in neurological assessment between 6:30 p.m. and 10:15 p.m. A Nurse's Note, dated 12/27/23 at 10:15 p.m., indicated the resident was unresponsive to stimuli. The physician was notified of the resident's condition and informed the right pupil was not reactive to light. A Nurse's Note, dated 12/27/23 at 10:30 p.m., indicated a cold cloth was placed on the resident's anterior chest without any arousal. The physician and resident representative was updated at this time. Review of a Hospital progress note, dated 12/27/23 at 11:53 p.m., indicated the resident presented from the nursing home after a fall. Emergency Medical Services states the nursing home witnessed the fall and then they stated she went to sleep. Her pupils were 4 millimeters (mm), sluggishly reactive, and she had bilateral bruising of the eyes. Imaging of the head included a large right subdural hematoma with midline shift. The resident was admitted for comfort care. During an interview on 1/10/24 at 2:17 p.m., LPN 3 indicated Resident B had a witnessed fall without injury in the dining room on 12/27/23 close to 5:30			

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	p.m. The resident continued to have a large amount of bruising surrounding the right eye and some bruising to the left eye as a result of the first fall on 12/25/23. The resident representative and the physician were notified immediately of the fall with no new orders. The resident remained on neurological checks as a result of the fall on 12/25/23. During shift change, LPN 3 reported to LPN 2 the neurological checks had been normal the duration of the shift. During an interview on 1/10/24 at 3:00 p.m., LPN 2 indicated she was unaware when the neurological checks were due on 12/27/23 during her shift. Resident B's neurological checks were completed once during her shift, between 8:00 p.m. to 10:00 p.m., during bedtime medication administration pass. The resident did not arouse when her vitals were obtained. Since the resident was sleeping, LPN 2 decided to give the resident a few more minutes before she obtained the neurological check and brought her night medications. When she returned to the resident's room a few minutes later, the resident was unresponsive and the resident's right pupil did not react to light during the neurological check. She called both the physician and resident representative immediately. The resident's representative came to the facility immediately after the notification and consented to send the resident out to the hospital for evaluation and treatment. Review of the resident's Neurological Assessment form indicated the resident's neurological assessment was due and completed on 12/27/23 at 6:30 p.m. and indicated neurological changes. During an interview on 1/10/23 at 4:22 p.m., the resident representative indicated the resident admitted to the facility from home where she had frequent falls and multiple fractures. He was			

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	notified promptly of the resident's first fall at the facility that resulted in a large amount of bruising to the resident's face. He received notification of the second fall on 12/27/23 a few minutes after 5:00 p.m. and was informed the resident did not have any new injuries. He denied any further notification of a change in the resident's condition until 12/27/23 at 10:36 p.m. when they called and informed him the resident could not be roused. He lived very close to the facility and drove there right away. The resident was sent to the hospital. During an interview on 1/11/24 at 8:45 a.m., the DON reviewed the neurological checks for resident B from the fall dated 12/25/23. She indicated the neurological checks were not ideal, but she did not have any further information to provide on them. During an interview on 1/11/24 at 10:04 a.m., LPN 4 indicated she provided care for the resident on 12/26/23 from 6:00 a.m. to 6:30 p.m. She received shift report that morning and was notified the resident had a large hematoma to the right eye, orders for ice to the hematoma, and required on going neurological checks. LPN 4 indicated the resident's right eye was rather swollen and she had not been able to assess the right pupil during the neuro checks on her shift. Neurological checks were to have both pupils assessed and documented on the Neurological Assessment Log. The assessment of pupils should have included the size of the pupils and a minus sign for non-reactive pupils or a plus sign for reactive pupils. The physician should have been notified immediately with any changes in the resident's neurological checks. During an interview on 1/11/24 at 12:39 p.m., MD 9 indicated on 12/27/23 around 5:30 p.m., LPN 3			

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	notified her of the resident's second fall. She had not received any more communication from the facility on 12/27/23 until LPN 2 notified her the resident was unresponsive on 12/27/23 at 10:30 p.m. and again at 10:48 p.m. It was the expectation of the facility to notify the physician promptly with any changes in the neurological checks, especially after a resident had two falls and a hematoma to the right eye. If she had been notified of any changes in the resident's neurological assessment on 12/27/23 at 6:30 p.m., she would have spoken with the resident representative to let him know it was a possible sign of a brain bleed so the representative could have decided whether to send the resident to the hospital at that time. This would have allowed earlier intervention for the resident. Any fall with a hematoma would typically have anti-platelet and anticoagulant medications held for three to five days. MD 9 indicated the resident was prescribed clopidogrel. She could not recall any communication with staff about holding the resident's clopidogrel after the resident's fall resulting in a hematoma on 12/25/23. It would have been safe to hold the residents clopidogrel and it was not held. During an interview on 1/11/24 at 2:17 p.m., the DON indicated any changes on the neurological assessments for Resident B should have been reported immediately to the physician and the resident's representative. Nursing staff were required to notify the MD prior to administration of any anti-platelets or anticoagulants when a resident had a fall with a hematoma or large bruising. A current facility policy, dated October 2010, titled "Change in a Resident's Condition or Status," provided by the DON on 1/11/24 at 2:17 p.m.,			

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	indicated the following: "...Our facility shall promptly notify the resident, his or her Attending Physician, and representative [sponsor] of changes in the resident's medical/mental condition and /or status... Policy Interpretation and Implementation 1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: ...d. A significant change in the resident's physical/emotional/mental condition; e. A need to alter the resident's medical treatment significantly; f. A need to transfer the resident to a hospital/treatment center ... 2. A "significant change" of condition is a decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions ... b. Impacts more than once area of the resident's health status; and c. Requires interdisciplinary review and/or revision to the care plan. d. The final decision regarding what constitutes a significant change in status is based on the judgement of the clinical staff and the guidelines outlined in the Resident Assessment Instrument and 42 CFR 483.20(b)(ii) ... 6. The Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status ...." A current facility policy, dated 7/2020, titled "Neuro Check Assessment," provided by the DON on 1/11/24 at 2:17 p.m., indicated the following: "Purpose: Neuro checks are used to assess an individual's neurological functions and level of consciousness in order [sic] determine whether or not individual is functioning properly and reacting appropriately to the test being performing [sic]. The purpose of a neurological assessment is to make sure an individual's			

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	neurological functions aren't impaired or nonresponsive after an injury or surgery... These checks/assessments are often performed on individuals dealing with head injuries ... and may be performed every 15 minutes, 30 minutes, 1 hour, 4 hours, 8 hours or in other timed increments as needed... Procedure ... Perform a pupil check (PERRLA: pupils equal, round, react to light and accommodation) ... Prior to and while performing these tests it is important to assess the patients' level of conciseness [sic] and compare it against their baseline, and previous test results. Any abnormality or decline in condition needs to be reported to MD for further evaluation. Report changes in neuro assessment additionally to responsible party...." This citation relates to Complaints IN00424946 and IN00425285. 3.1-5(a)(2) 3.1-5(a)(3)			