STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155674	A. BUILDING 00 B. WING	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ST CHARLES HEALTH CAMPUS	3150 ST CHARLES ST JASPER, IN 47546

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00447969 and Complaint IN00447994. Complaint IN00447969 - Federal/state deficiencies related to the allegations are cited at F689 Complaint IN00447994 - Federal/state deficiencies related to the allegations are cited at F689 Survey dates: December 11, 12, 2024 Facility number: 002628 Provider number: 155674 AIM number: 100299110 Census Bed Type: SNF/NF: 17 NF: 40 Residential: 34 Total: 91 Census Payor Type: Medicare: 22 Medicaid: 29 Other: 6 Total: 57 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 20, 2024.	F 0000		
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on interview and record review, the facility failed to ensure each resident received adequate	F 0689	The submission of this plan of correction does not indicate an	01/02/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jon Howard	Executive Director	12/30/2024

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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	supervision and assistance to prevent accidents for 1 of 3 residents reviewed for falls. New interventions were not placed following falls to prevent further falls for a cognitively impaired resident. (Resident G) Finding includes: On 12/11/24 at 1:57 P.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, left tibia shaft fracture, osteoporosis, and Alzheimer's disease. Resident G was admitted to the facility on 8/12/24 and discharged 11/4/24. The most recent Admission MDS (Minimum Data Set) Assessment, dated 8/15/24, indicated a severe cognitive impairment and no behaviors. Resident G was dependent on staff for toileting, bed mobility, transfers, and from sitting to standing. Resident G had experienced a fall with fracture that required surgical repair prior to admission. Physician orders included, but were not limited to: Activity: Two staff assist - Strict NWB (non-weight bearing) to left leg, dated 9/3/24. Sounding alarms to bed and chair at all times, and to check the function each shift three times a day, dated 9/9/24. Nurse to verify that bed and chair alarms functioning properly each shift, three times a day, dated 10/21/24. A falls care plan, dated 8/29/24, included the following interventions: Nurse to verify that alarm is functioning, dated 10/21/24.		admission by St. Charles Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of St. Charles Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. **Corrections to be completed by 1/2/25** F689: Accidents and Hazards 1 Resident G was not affected by the alleged deficient practice. Resident no longer resides at the facility. 2 All residents that have had a fall have the potential to be affected. Existing resident falls have been reviewed for appropriate root cause analysis and	

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	Not to be left in room in wheelchair unattended, dated 9/30/24. Sounding alarm to bed and chair, dated 9/10/24. Mat beside bed, dated 9/10/24. Toileting schedule, dated 9/9/24. Encourage resident to assume standing position slowly, dated 8/29/24. Ensure the floor is free of liquids and foreign objects, dated 8/29/24. Keep call light in reach, dated 8/29/24. Keep personal and frequently used items within reach, dated 8/29/24. Provided non-skid footwear, dated 8/29/24. Staff to assist resident with transfers as needed, dated 8/29/24. Therapy evaluate and treat as needed, dated 8/29/24. An ADL (activities of daily living) care plan, dated 8/29/24, indicated Resident G required staff assistance to complete mobility functional tasks completely and safely. A hospital post-operative note, dated 8/9/24, indicated Resident G was admitted for surgical repair of a closed displaced comminuted fracture of shaft of left tibia From 9/8/24 through 10/19/24, Resident G		implementation of appropriate fall interventions. Nurses educated on implementation of appropriate interventions at the time of the fall. Interdisciplinary team educated on root cause analysis and determination of appropriate long-term intervention placement that is related to the root cause of the fall. 3 The Director of Health Services (DHS) or designee, will audit 5 falls, if available, to ensure root cause analysis has been completed and appropriate intervention is implemented. Audit will occur weekly x 4 weeks, every other week x 2 months, and monthly x 3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	experienced the following falls: Fall 1 A progress note, dated 9/8/24 at 4:30 P.M. indicated Resident G fell in her room at 4:00 P.M. after restlessly wheeling around hallway. The resident was observed on the floor in the entryway of the bathroom after attempting to transfer self to toilet. The note indicated the new intervention was to routinely toilet the resident. The falls care plan was updated on 9/9/24 to include an intervention of toileting schedule. The clinical record lacked documentation that the toileting schedule had been followed or implemented. On 12/12/24 at 10:53 A.M., the Director of Nursing (DON) indicated Resident G's toileting schedule had been started on 9/9/24, and the Certified Nurse Aides (CNA) would have followed their assignment sheet at that time for the toileting schedule, but would not necessarily document it. On 9/8/24, an x-ray was ordered for the left leg. A progress note dated 9/8/24 at 9:36 P.M. indicated a left fibular neck fracture. Results were communicated with the physician, who indicated he would like for the resident to be monitored overnight and for the orthopedic to be notified the following morning on how to proceed. Resident G's clinical record lacked documentation of the communication with the orthopedic physician on 9/9/24. On 12/12/24 at 10:53 A.M., DON indicated she was unable to find any documentation of the communication with the orthopedic physician. She indicated there were no new orders related to the x-ray findings, because it had shown an existing fracture that the			

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	resident was admitted with. At that time, she was unaware that the x-ray result had indicated a new fracture of the fibula. A progress note dated 9/11/24 indicated Resident G's fall on 9/8/24 was reviewed. Resident was non-weight bearing to the left lower extremity and transferred self from the wheelchair and fell to the floor. The note indicated an x-ray was completed with no new fractures. Per daughter's request, Resident G was to have sounding alarms to the wheelchair and bed at all times. An order for sounding alarms was initiated 9/9/24. A progress note, documented by Registered Nurse (RN) 3 on 9/13/24, indicated Resident G had been making several attempts to wheel herself to her room. RN 3 informed the resident that she could not stay in her room by herself because she would attempt to get up by herself and was strict non-weight bearing to the left lower extremity. Fall 2 A progress note dated 9/28/24 at 8:18 P.M. indicated the nurse was notified by the CNA of the resident attempting to self transfer to the toilet. The fall was not witnessed and the resident was found on the bathroom floor. An Interdisciplinary Team (IDT) note, dated 9/30/24, indicated the resident was toileted and assisted to bed after being found on the bathroom floor on 9/28/24. The note indicated a new intervention to not be left in the room in wheelchair unattended. The falls care plan was updated on 9/30/24 to include not to be left in room in wheelchair unattended.			

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	On 12/12/24 at 10:30 A.M., RN 3 indicated is was "known" by all staff that Resident G was not to get up by herself due to being non-weight bearing on her left leg, and would try to constantly. She indicated the resident had the behaviors of trying to get up on her own from the time she was admitted to the facility. She indicated all staff were actively supervising Resident G and trying to prevent her from getting up on her own well before an intervention was placed to do so. Fall 3 A progress note on 10/19/24 at 4:45 P.M. indicated Resident G was found by the door in her room. Fall was unwitnessed. The resident indicated she "crawled" to the door. At the time of the fall, the alarm did not sound. An IDT note dated 10/21/24 indicated following the fall on 10/19/24, the new intervention would be for the nurse to verify that alarm was functioning properly each shift. The falls care plan was updated on 10/21/24 to include an intervention for the nurse to verify that the alarm is functioning properly each shift. The order for alarms dated 9/9/24 indicated to check for functionality each shift. On 12/12/24 at 10:39 A.M., CNA 25 indicated all residents that were at risk of falling were toileting frequently. She indicated CNA assignment sheets were updated daily with mobility assistance indicated for each resident. On 12/12/24 at 10:57 A.M., Qualified Medication Aide (QMA) 21 indicated Resident G required a lot of supervision due to her wanting to get up			

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	and "go home". She indicated the resident needed pretty much a 1:1 supervision, and at times staff would call her daughter to sit with her because they could not supervise her as she required. She indicated Resident G was very confused and believed she could get up on her own, and staff was aware from the time she was admitted that she needed constant supervision. On 12/12/24 at 10:30 A.M., RN 3 indicated Resident G was confused and attempted to get up on her own from day one. She indicated staff would try and keep her in the common area or by the nurses station as she had strict NWB orders to the left leg. On 12/12/24 at 11:34 A.M., the DON indicated she was unsure why the alarm was not sounding when Resident G fell on 10/19/24. She indicated the facility did not typically use sounding alarms, but the resident's daughter was insistent on using them, so the facility complied. She indicated care plans should be revised and updated following each fall, and depending on the circumstances, a new intervention put into place. On 12/12/24 at 1:08 P.M., a current Fall Management policy, dated 12/31/23, was provided and indicated "Any orders received from the physician should be noted and carried out ... The resident care plan should be updated to reflect any new or change in interventions" This citation relates to Complaint IN00447969 and Complaint IN00447994. 3.1-45(a)			