| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155632 | A. BUILDING 00<br>B. WING | 05/31/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| LODGE OF THE WABASH | 723 E RAMSEY RD<br>VINCENNES, IN 47591 |

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| F 0000<br><br>Bldg. 00 | This visit was for the investigation of Complaints IN00409392 and IN00401358.<br><br>Complaint IN00409392: Federal/State deficiencies related to the allegations are cited at F689.<br><br>Complaint IN00401358: Federal/State deficiencies related to the allegations are cited at F689.<br><br>The deficient practice was corrected on 5/25/23, prior to the start of the survey, and was therefore Past Noncompliance.<br><br>Survey dates: May 30 & 31, 2023<br><br>Facility number: 001138<br>Provider number: 155632<br>AIM number: 200157070<br><br>Census Bed Type:<br>SNF/NF: 52<br>Total: 52<br><br>Census Payor Type:<br>Medicaid: 44<br>Other: 8<br>Total: 52<br><br>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on June 7, 2023. | F 0000 | Preparation and execution of this plan of correction does not constitute admission or agreement by this facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because the provisions of Federal and State law require it. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of residents nor are they of such character as to limit the facility's capacity or render adequate care. | |
| F 0689<br>SS=G<br>Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents. | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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| | The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>Based on interview and record review, the facility failed to ensure a resident was free of accidents for 1 of 3 residents reviewed for falls. Staff failed to implement the facility's fall protocol following a resident fall that resulted in a hip fracture and another fall the following morning. (Resident B)<br><br>Finding includes:<br><br>During a review of state reportable incidents on 5/30/23 at 1:00 P.M., Resident B had been transferred to a hospital on 5/24/23 for complaints of left hip pain following a fall. Resident B had suffered a left hip fracture.<br><br>During record review on 5/31/23 at 10:06 A.M., Resident B's diagnoses included, but were not limited to; dementia, anxiety disorder, chronic kidney disease, and heart failure.<br><br>Resident B's baseline care plan, with an admission date; 5/22/23, included the resident was alert with confusion at times, had a history of falls within the past year and had history of fall related injury, required assistance of two with bed mobility, transfers, walking, and toileting, and used a walker or wheelchair for mobility.<br><br>Resident B's nurse's notes included the following: 5/22/23 8:21 P.M. - Resident is impulsive standing from wheelchair without assistance. Currently, | F 0689 | Facility disagrees with the Tag cited based on information that will be provided in the IDR review.<br>All nursing staff was educated on definition of a fall, and the facility policy and procedure for Incidents and accidents on 5/24/23. A performance improvement plan was implemented by QAPI team, on 5/24/23, for Incidents/Accidents.<br>Medical records were reviewed for the prior 30 days to ensure incident reports, assessment and careplan revisions were all completed for any fall.<br>Nurse xxxxx was re-educated on facility fall policies and procedures. All nursing staff were re-educated on the definition of a fall, and the facility policy and procedure for Incidents and Accidents.<br>Medical records will be reviewed by DON or designee daily for 30 days and then 4 days weekly for an additional 60 days and then 2 times per week for an additional 3 months to ensure continued compliance with all fall policies and procedures.<br>Any negative findings will be | 06/01/2023 |

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| | resident is 1 to 1 due to fall risk.<br>5/23/23 at 10:31 A.M. - Falls Assessment - There are environmental factors that impact the resident's risk for falls due to the resident's cognitive decline and impulsiveness.<br>5/23/23 at 10:36 A.M. - Verbal Pain Assessment: The resident had not had pain or been hurting at any time in the last 5 days or had rarely experienced pain or hurting in the last 5 days. The resident rated his worst pain in the last 5 days at a 2 on a 0 to 10 scale. The resident had not received any PRN (as needed) pain medications.<br>5/23/23 at 11:44 P.M. - PRN medication Tylenol 650 mg (milligram) given for pain level of 6. Location: left ankle.<br>5/23/23 at 11:48 P.M. - Resident has been yelling out for wife, has woke up several other residents, staff remains 1 to 1, has been toileted, fluids given, complains of left ankle pain so Tylenol given.<br>5/23/23 at 11:51 P.M. - No swelling or red area noted on left ankle at this time.<br>5/24/23 at 5:46 A.M. - Resident has been restless all night, continues to yell out wife's name.<br>5/24/23 at 10:04 A.M. - Continued with impulsive issues of trying to self-transfer. Assist of 2 for transfers. Resident was placed in the living room in a recliner to be observed by staff.<br>5/24/23 at 2:35 P.M. - Resident transferred at 2:30 P.M. to emergency room/acute care hospital.<br>5/24/23 at 3:03 P.M. - resident complaining of moderate pain intermittently thorough the shift, with pain intensifying to this afternoon. Location of pain: Left upper extremity, Quality of Pain: sharp.<br>5/24/23 at 3:18 P.M. - Resident had a witnessed fall. Resident slid from wheelchair on 5/24/23 at 9:30 A.M. in his room while transferring. No apparent injury. Resident denied pain. Staff involved: CNA and Physical Therapy. | | reported to the facility Quality Assurance Performance Improvement Committee.<br>Date of compliance: 6/1/23 | |

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| | 5/24/23 at 3:43 P.M. - PRN medication Tylenol 1000 mg given for pain level of 7. Location: Left leg.<br>5/24/23 at 9:30 P.M. (late entry - entered 5/25/23 at 9:08 A.M.) - (Regarding fall on 5/23/23) Following family visit, resident transferred to bed. The nurse passed by resident's room shortly after to go out to other hallway, family was gone, resident was restless but still in bed, bed on lowest setting to floor. Two CNA's on unit. One of the CNA's came reported that the resident sat down in front of his closet in his room. Resident did complain of some left ankle pain. The nurse completed full assessment and resident stated no discomfort of pain during and after assessment. Left leg and ankle had full ROM (range of motion) with no complaints of pain or discomfort. Resident back to bed, stated wanted to get some rest. Resident given call light, bed on lowest setting to the floor, covered up and this nurse left resident to rest.<br>5/25/23 8:19 A.M. - Resident is unable to ambulate on his own without supervision of staff but has impulsiveness and a lack of safety awareness due to Dementia. Wife voiced that he gets up on his own and had a fall at home. He had a fall at the facility resulting in fracture of left hip and is currently re-admitted to hospital on 5/24/23 for same. He was receiving PT/OT(physical therapy and occupational therapy) upon admission and doing well.<br><br>A hospital radiology diagnostic imaging result report for Resident B, dated 5/24/23. A final result included an X-ray of the left hip, due to fall with pain, "patient fell last night", left hip pain. Findings: There is an acute commuted left intertrochanteric hip fracture, with fracture lines through the intertrochanteric femur, with shearing fracture of the lesser and greater trochanter. There is coxa varus angulation. No other fracture of the | | | |

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| | pelvis seen.<br><br>No nurse's notes in Resident B's record indicated the resident had a fall the night of 5/23/23 or during the night shift's early morning hours of 5/24/23. No fall assessments, incident reports, or notifications to family or physician were documented within 24 hours regarding a fall during night shift on 5/23/23.<br><br>During an interview on 5/31/23 at 10:45 A.M., CNA 5 indicated having assisted Resident B to get up and dressed the morning of 5/24/23. CNA 5 indicated Resident B had fallen during night shift (5/23/23) and then again on day shift during the morning of 5/24/23. CNA 5 did not witness either fall.<br><br>During an interview on 5/31/23 at 11:15 A.M., LPN 6 indicated having been Resident B's nurse on dayshift, 5/24/23, and had transferred the resident to the hospital that afternoon following a concern from the resident's spouse about his complaints of pain. Resident B had fallen the morning of 5/24/23 when he slid from his wheelchair. That fall was witnessed by a CNA and staff were able to assist him to the floor. LPN 6 assessed the resident and completed a fall incident report with no apparent injuries from that fall. LPN 6 indicated that Resident B had fallen the night before (5/23/23), as well, but that the fall had not been communicated during shift report that morning and that LPN 6 was unaware of the fall on 5/23/23 until it was mentioned later by the oncoming nurse that afternoon, following the resident's transfer to the hospital. LPN 6 indicated that Resident B had complained of pain the morning of 5/24/23 and that the night shift nurse did mention that a PRN Tylenol was given to the resident the night prior due to complaints of pain. | | | |

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| | During an interview on 5/31/23 at 11:45 A.M., the DON (Director of Nursing) indicated that Resident B was observed by a CNA crawling on the floor in his room during the night shift of 5/23/24. The CNA alerted the nurse on duty that Resident B was on the floor crawling, and that the nurse on duty misunderstood and was under the impression that Resident B was witnessed to sit himself on the floor. Staff assisted the resident back to bed and the nurse on duty did not complete any fall assessments, incident reports, document the fall, or notify the family and physician. The DON indicated that Resident B was not actually witnessed to sit on the floor on 5/23/23, and that it was unknown how the resident came to be on the floor. Any time a resident is found to be on the floor, it should be considered a fall, and the facility's fall protocol should be enacted and followed, and an immediate intervention should be put into place to prevent further falls.<br><br>On 5/31/23 at 12:10 P.M., the DON provided a facility policy titled, Incidents and Accidents, dated 8/2021, along with a copy the facility's "Fall Checklist." The policy included, "All incidents and accidents occurring on the facility premises must be investigated and reported to the Administrator. ...The licensed nurse will: i. physically assess and make injured person safe and comfortable ...b. If the incident is a resident fall, follow the Fall Checklist through to completion." The Fall Checklist included, "1. Ensure that the resident needs are met and the resident is safe... Assess the scene and begin the Fall Scene Investigation form... 2. In the electric medical record, complete a thorough Incident Report... The new intervention that was immediately implemented should be included as | | | |

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| | part of the Incident Report, it should relate to the fall and the information provided in the report... 5. In the electronic medical record, complete a new Fall Assessment... 8. Notify all on-shift staff of any change/addition of intervention(s) and assign responsibility to the appropriate staff member to implement any new resident safety interventions..."<br><br>The deficient practice was corrected by 5/25/23 after the facility implemented a systemic plan that included the following actions: licensed nurses educated regarding the definition of a fall, and the facility's policies and procedures for incidents and accidents, medical record review for all residents for the prior 30 days to ensure no other residents were affected, ongoing monitoring and auditing of residents' medical records to ensure all falls were handled appropriately, and referral to the QAPI program for continued follow-up and monitoring.<br><br>This Federal tag relates to complaint allegations IN00409392 and IN00401358.<br><br>3.1-45(a)(2) | | | |