| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | 155370 | A. BUILDING 00<br>B. WING | 06/23/2021 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00354116.<br><br>Complaint IN00354116 - Substantiated. Federal/state deficiencies related to the allegations are cited at F689.<br><br>Survey dates: June 22 & 23, 2021<br><br>Facility number: 000555<br>Provider number: 155370<br>AIM number: 1002677530<br><br>Census Bed Type:<br>SNF/NF: 43<br>Total: 43<br><br>Census Payor Type:<br>Medicare: 7<br>Medicaid: 30<br>Other: 6<br>Total: 43<br><br>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on June 28, 2021. | F 0000 | | |
| F 0689<br>SS=D<br>Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and | | | |

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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| | §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, record review, and interview, the facility failed to adequately supervise and implement effective interventions for 2 of 3 residents who were fall risks. Resident D had a history of falls, acquired an L1 (Lumbar) compression fracture and multiple skin tears related to a fall after interventions were not effective with his cognitive status and increased confusion and impulsivity. Resident F had a fall, received two skin tears and new interventions were not implemented to prevent future falls. (Resident D, Resident F)<br><br>Findings include:<br><br>1. During a review of the State Reportable, dated 4/27/21, provided by the Administrator on 6/22/21 at 8:30 a.m., it indicated Resident D had a fall on 4/26/21 at 5:01 a.m. Resident D denied pain at the time of the fall, but complained of pain later that day and was sent out to the hospital for evaluation. At that time he was found to have a L1 (Lumbar) compression fracture 20%. Preventative measures added: upon return from hospital the resident will be screened by therapy for level of care. He will be reminded to ask for assistance with transfers and ambulation. Signage will be placed in his room as a reminder to use the call light.<br><br>During a review of Resident D's clinical record on 6/22/21 at 9:39 a.m., it indicated Resident D was severely cognitively impaired. Resident D's diagnoses included, but were not limited to, hypertension, COPD (chronic obstructive pulmonary disease), atherosclerotic heart disease, and Alzheimer's disease. A Quarterly MDS | F 0689 | Please accept this Plan of Correction as our allegation of Compliance. Likewise, we are requesting a desk review due to low scope and severity .<br><br>Resident D is deceased.<br>Resident F Care plan has been reviewed and updated to reflect current resident status to include but not limited to:<br>Every 15 minute safety checks have been initiated.<br>Fall mat removed as it proves a tripping hazard for this resident<br>Verified by AD this resident can read and pictorial signs have been added to room as cue.<br>Hand bell to resident as extra.<br>Staff to offer eye glasses (resident often rejects)<br>Therapy screened and added a quarter tray for positioning however, resident often removes and tosses it aside.<br>Medications reviewed without changes warranted.<br>Exhibit 1-A<br><br>Residents with high risk/ history of falls, within last 6 months ,were reviewed for proper interventions and care plans updated as needed.<br>All falls will be reviewed first business day following fall by IDT | 07/21/2021 |

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| | (Minimum Data Set) assessment, dated 3/29/21, indicated Resident D required extensive staff assist of 2 with ADLs (activities of daily living) and was totally dependent with bathing. Resident D was readmitted to the facility on 4/28/21 and expired at the facility on 5/3/21.<br><br>Resident D's care plans, included, but were not limited to,<br><br>Resident exhibits self care deficit and requires assistance with activities of daily living such as bed mobility, transfers, toileting, eating, dressing/grooming, bathing and personal care needs due to current medical condition.<br>Interventions included, but were not limited to, bed mobility daily and as needed, assist with toileting and toileting management daily and as needed, assist with transfers daily and as needed.<br>Start date 3/1/21. Last revised 3/20/21.<br><br>Resident can potentially have a fall incident and may have an injury due to medications taken and unsteady gait. History of falls.<br>Interventions included, but were not limited to, assist resident with transfers, environment free of clutter, assisted daily with ADL needs, and signage in room to remind to use call light (added 5/1/21), provided non-skid footwear, therapy as ordered,<br>Start date 3/1/21. Last revised 5/1/21.<br><br>Resident D's orders included, but were not limited to,<br><br>May be up ad lib (as much and as often as desired) 2/26/21<br><br>Resident D's therapy notes indicated start date of physical therapy and occupational therapy of | | for proper interventions, root cause, assessment , injury and follow-up.<br>Exhibit 2-B<br><br>Systemic changes to include:<br>Staff education has been completed on the following topics:<br>Must be a staff member on the dementia unit at all times.<br>Staff education on the inability to "educate/re-educated those severely cognitively impaired as this is not a proper intervention.<br>Point of care tablets have been authorized for purchase by nursing assistants allowing them to remain on unit for charting needs.<br>Attempting to recruit additional staff for nursing and activities for secured unit.<br>All falls will be reviewed first business day following fall by the IDT for proper interventions, root cause, assessment, injury and follow-up.<br>Staff educated on need to not allow residents to sleep in other resident bed but, remove them and assist to own bed.<br>Exhibit 3-C<br><br>Deficient Practice will be observed for continued compliance and alleviation of deficient practice. This will be done weekly x 8 weeks, then monthly x 4 by DON/ADON/MDSC for continued compliance. Findings will be brought to Quality Assurance and | |

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| | 4/29/21 and an end date of 5/3/21, due to resident expiring. Resident refused therapy.<br><br>Resident D's progress notes indicated,<br><br>4/11/21 at 2:00 a.m.- Resident resting quietly. PRN ( as needed) pain medication administered at 12 a.m. per request for complaint of generalized discomfort. Effective. Alert with periods of confusion. Pleasant mood with staff. Mixed incontinence of urine. Wears adult briefs. Up to the bathroom with staff assist of 1, steady gait. Taking fluids well. Head of bed elevated at all times. Call light within reach.<br><br>4/26/21 at 3:00 a.m. .- Nurse heard resident yell, " Hey, could you come and help me?" Resident sitting on floor in doorway to room. Resident stated," I got up to go to the bathroom and I lost my balance coming out of the bathroom and fell to the floor. I scooted on my bottom to the doorway to get some help to get up." Call light was in place but was not used. Stated," I didn't turn it on, I am ok. I can walk with my walker." Resident reeducated to utilize call light prior to transferring out of bed and ambulating with walker. Voiced understanding. Denied hitting head when fall occurred. Neurological checks within normal limits. Grasps equal bilaterally. No change in ROM (range of motion) to extremities. Skin tear noted to left elbow 1.5 cm (centimeters) x 1 cm. Skin tear to right forearm 3 cm x 5 cm. Skin tear to right radius 1 cm x 1 cm. Skin tear to right upper forearm 1.8 cm x 1.2 cm. All areas approximated, cleansed, and steri strips applied. Non adherent dressing applied due to small amount of drainage to areas. Stated didn't know how skin tears occurred. Educated resident on proper footwear due to wearing sandals when fall occurred. Gripper socks on now. Voiced understanding. Denied pain or discomfort. | | Performance Improvement Committee for review with recommendations to continue or resolve as warranted.<br>Exhibit 4-D | |

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| | T-97.9,P-76,R-18,B/P-128/66,Pulse Ox-95% on room air.<br><br>4/26/21 at 6:00 a.m.- Resident assisted to bathroom per staff and walker. Resident stated, " My back hurts so bad." Physician notified of fall and complaint of low back pain. Family member notified.<br><br>4/26/21 at 8:07 a.m.- New order for X-ray of spine. Family notified.<br><br>4/26/21 at 12:10 p.m.- Results of X-ray received and sent to physician.<br><br>4/26/21 at 12:27 p.m.- Family contacted regarding X-ray results. No answer and no voicemail available.<br><br>4/26/21 at 1:28 p.m.- Physician evaluated X-ray impression and advised to send to emergency room. Son updated due to inability to notify spouse. Family agreeable.<br><br>4/26/21 at 1:43 p.m.- Contacted local emergency department and updated with report of fall with noted compression fracture of L1. Ambulance dispatched following report.<br><br>4/26/21 at 1:45 p.m.- Ambulance to transfer resident to emergency department for further evaluation. Stretcher transport. Alert to self.<br><br>4/26/21 at 4:49 p.m.- Resident admitted to hospital following evaluation.<br><br>A fall event, dated 4/26/21 at 4:49 a.m., indicated Resident D was in the bathroom prior to the fall and denied pain at the time of the fall. All ROM was within normal limits. Skin tears noted. | | | |

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| | Resident denied pain at the time of the fall. It further indicated no interventions were in place at the time of the fall.<br><br>Fall risk assessments were completed,<br><br>4/28/21 Fall Risk Assessment for readmission- fall risk<br>4/26/21 Post Fall Risk Assessment- fall risk<br>2/27/21 Fall Risk Assessment Admission- fall risk<br><br>The clinical record lacked effective interventions and an increase in supervision for Resident D's cognitive status related to his impulsiveness and lack of safety awareness. Resident D was unable to be educated to remember to use his call light due to his cognitive status. Resident D lacked specific interventions in place at the time of the admission due to the history of falls, interventions were lacking prior to the time of the fall on 4/26/21 to address the fall risk related to confusion and incontinence, which resulted in a L1 compression fracture.<br><br>2. During the initial tour on 6/22/21 at 8:05 a.m., the Director of Nursing (DON) indicated Resident F had a recent fall. She further indicated he was very impulsive and did not wait for staff assistance with transfers.<br><br>During an observation on 6/22/21 at 11:25 a.m., Resident F's room was noted to have the bed in the lowest position and the call light on the bed. No fall mat was observed. Resident F's walker was noted folded up and in the corner near the doorway.<br><br>During an observation on 6/22/21 at 11:30 a.m., Resident F was observed in his wheelchair in the | | | |

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| | dining room sitting at a table awaiting the noon meal. Resident F had his head tilted and was leaning to the right side.<br><br>During an observation on 6/22/21 at 12:00 p.m., Resident F was observed getting agitated and yelling at another resident in the dining room that had accidentally bumped into his wheelchair with her wheelchair. CNA 1 and CNA 2 were observed to redirect Resident F, but he continued to yell until the other resident was out of his line of vision. He did calm down after he was unable to see the other resident.<br><br>During an observation on 6/23/21 at 2:25 a.m., Resident F was observed sleeping in a chair in the activity room. Resident F's head was leaned to the right side. Resident F's wheelchair was next to the chair. LPN 1 indicated he had been "very agitated" before finally falling asleep. No staff observed on unit. LPN 1 indicated CNA 3 was covering the Alzheimer's unit and the East hall.<br><br>During an observation on 6/23/21 at 3:17 a.m., Resident F was observed lying in bed, bed in lowest position, head of bed elevated, with his wheelchair at bedside. Call light within reach. No fall mat was observed.<br><br>During an interview with the DON on 6/23/21 at 3:45 a.m., she indicated CNA 3 was able to get Resident F to go to bed. CNA 3 indicated another resident was in Resident F's bed and that was why he was sleeping in the chair in the activity room. The other resident was moved to her room and Resident F was assisted to bed.<br><br>During an observation on 6/23/21 at 4:55 a.m.- Resident F was observed lying in bed, bed in lowest position, head of bed elevated, with his | | | |

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| | wheelchair at bedside. Call light within reach.<br><br>During an observation on 6/23/21 at 7:48 a.m., Resident F was observed in his wheelchair in the dining room eating breakfast.<br><br>During a review of Resident F's clinical record on 6/22/21 at 10:05 a.m., it indicated Resident F was severely cognitively impaired. Resident F's diagnoses included, but were not limited to, cerebral palsy, hypertension, end stage renal disease, diabetes mellitus, thyroid disorder, seizure disorder, and abnormalities in gait and mobility. An Admission MDS assessment, dated 5/12/21, indicated Resident F required extensive assist of 2 for bed mobility, limited assist of 1 for transfers, limited assist of 1 for personal hygiene, and extensive assist of 2 for toileting. Resident F was total dependence for bathing. It further indicated Resident F had falls since admission.<br><br>Resident F's care plans indicated, but were not limited to,<br><br>Resident has the potential for falls and injuries related to: his current medical diagnosis (Cerebral Palsy) and history of falls with and without injury. Interventions included, but were not limited to, assist with transfers as needed, call light in reach, environment free of clutter, keep personal items within reach, therapy evaluate and treat, fall mat as needed. Start date 4/29/21. Revised 5/3/21.<br><br>On 6/23/21 at 6:41 a.m., the ADON (Assistant Director of Nursing) provided a baseline care plan, dated 4/28/21, it indicated, but was not limited to, supervision with bed mobility, assist 1-2 with transfers, assist 1-2 walking, assist 1-2 personal hygiene, assist 1-2 dressing, supervision with eating, assist 1-2 toileting, assist 1-2 bathing. | | | |

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| | Resident incontinent of bowel and bladder. Uses a wheelchair with staff assist to transfer, unsteady. Fall risk. She indicated care plans were not all entered into the electronic health record, and she was trying to enter them manually, but they were all being kept in a book right now, and this was very basic due to them switching to a new electronic health record system.<br><br>Resident F's orders included, but were not limited to,<br><br>Occupational Therapy evaluate and treat 5/1/21<br><br>Initiate Fall Prevention Program 4/30/21<br><br>Resident F's therapy notes indicated a start date for physical therapy on 5/1/21 with an end date of 6/22/21. Resident F improved independence with showering, toileting, self-feeding, and dressing with skilled therapy interventions. Occupational therapy start date of 5/3/21. Resident prognosis is good due to improved wheelchair mobility. Improvement in active participation and motivation. Increased balance is helping improve transfer activities.<br><br>Resident F's progress notes included, but were not limited to,<br><br>4/28/21 at 9:15 p.m.- Late entry on 4/29/21 at 2:13 a.m.<br>T-97.5, P-82, R-18,B/P-136/78, Pulse Oximetry-96% on room air. Transferred from local hospital. Alert to self with confusion. Pleasant mood. Lung sounds clear all fields. Abdomen soft and non distended. Bowel sounds present all 4 quadrants. Skin warm, dry and intact. Color good. Skin assessment done per facility protocol. Light red excoriation noted to peril area. No other areas of | | | |

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| | impairment noted. Bed in low position. Call light and fluids within reach.<br><br>4/29/21 at 10:08 a.m.-Resident alert and oriented to self with confusion. Speech impairment. Able to answer simple questions. Hearing impairment. Resident pleasant. Took medications whole without difficulties. Consumed 100% of his breakfast with 1 assist with feeding. Resident continued to cough and yell out throughout the morning. Clear lung sounds. Resident had no complaints at this time. 1-2 assist with transfers. Resident walked with staff to restroom. Continent of bowel and bladder with episodes of incontinence. All needs met. Call light and fluids within reach.<br><br>4/29/21 at 1:08 p.m.- Spoke with wife. Explained can not lock wheelchair if resident was not able to unlock it by himself. Discussed DNR (do not resuscitate) with her and he is DNR status. She voiced understanding of wheelchair not being locked. Explained will try to prevent falls but can not promise he will not fall. He has a history of falls. Assured her that she would be notified of all changes.<br><br>4/29/21 at 11:24 p.m.- Resident resting quietly in bed. Assisted to bathroom with staff assist of 2. Tolerated well. Bed in low position.<br><br>4/30/21 at 6:00 a.m.- Resident resting quietly in bed. Mixed incontinence of urine this p.m. Wears adult briefs. Continues to yell out occasionally. Large fluid intake. Alert and oriented to self with confusion noted. Continue to monitor. Pleasant mood. Bed in low position. Frequent staff monitoring.<br><br>4/30/21 at 1:07 p.m.- Resident currently outside | | | |

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| | with staff participating in activity, social distancing and mask in place. Mixed incontinence of urine. Wears adult briefs. Pericare per staff. Continues to yell out occasionally. Large fluid intake. Alert and oriented to self with confusion noted. Resident has tried to get out of bed himself today multiple times. Staff reeducates him to call for help when needed. Call light and fluids are within reach.<br><br>4/30/21 at 5:04 p.m.- Resident keeps getting up and down out of bed by himself without help. Resident has been educated by staff to use call light for help. Resident also wandering west hall unit and going towards front door entrance trying to get out door.<br><br>4/30/21 at 11:07 p.m.- Resident observed sitting on buttocks on floor at foot of bed holding onto foot board, two small c-shaped skin tears to right elbow 1 cm, cleansed and dressed, passive and active range of motion within normal limit, vital signs stable, no complaints of pain or discomfort, no other red, opened or bruised areas. Resident stated he wanted to go home. Resident had been agitated and restless prior to fall, offered food, drinks, toilet, assisted to bed, assisted to wheelchair, continued to pull dry brief off and made several attempts to self ambulate/transfer. All attempts to redirect unsuccessful, combative with staff, resident pulled CNA's hair. DON notified. Physician notified. Family phone number disconnected. DON notified of unable to reach family.<br><br>4/30/21 at 11:20 p.m.- Family notified of fall by cell phone, DON notified.<br><br>5/01/21 at 1:44 a.m.- Resident transferred self to wheelchair and became stuck between end of bed | | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| PREMIER HEALTHCARE OF NEW HARMONY | 251 HIGHWAY 66<br>NEW HARMONY, IN 47631 |

| (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 |
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| | and bathroom door. Assisted to toilet, voided large amount, bed turned to against wall. Resident assisted to bed.<br><br>5/01/21 at 2:18 a.m.- Resident observed standing beside bed, assisted to toilet, voided, assisted to bed.<br><br>5/01/21 at 1:20 p.m.- Resident propels self in wheelchair with abnormal posturing secondary to cerebral palsy. Resident has communication deficits with acute neurologic involvement, abrasions continue to be observed for onset of symptoms, inflammation. Resident requires repeated safety reminders due to poor safety awareness as evidenced by resident's continued attempts to transfer self and ambulate. Resident continues to be observed for complications due to current medical conditions. No visible significant changes from baseline assessment.<br><br>5/01/21 at 10:19 p.m.- Alert and oriented to self with confusion. Speech Impairment. Able to answer simple questions. Hearing impairment. Took medications whole without difficulty. 1 assist with feeding. Continues to yell out. Clear lung sounds. 1-2 assist with transfers. Continent of bowel and bladder with episodes of incontinence. Wears briefs. Call light and fluids are within reach. Resident unable to or is unwilling to use call light<br><br>5/02/21 at 8:19 a.m.- Resident continues with frequent verbal reminders for safety as resident continues to demonstrate poor safety awareness with witnessed reports of resident transferring self without signaling for assist. Resident utilizes wheelchair as primary mode of locomotion with posturing met with staff assist. Resident exhibits periods of inappropriate hollering when in room | | | |

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| | and in hallway with resident wants and needs met by staff due to physical and cognitive deficits. Resident incontinent requiring x 2 assist with completion of care as resident at times will exhibit agitation towards staff while implementing tasks.<br><br>A fall note, dated 4/30/21 at 10:22 a.m., indicated,<br><br>Prior to fall had been resting in bed. Had been agitated and restless prior to fall. Offered food, fluids, assisted to bed, assisted to wheelchair, toileted, continued to pull dry brief off. Attempted to ambulate/transfer stating he wanted to go home. Right elbow- 2 c-shaped skin tears 1 cm. Immediate interventions were analgesics, rest, and many attempts to redirect. Interventions noted to be effective. No new interventions noted.<br><br>An Admission Fall Risk Assessment, dated 4/29/21 indicated a history of falls.<br><br>The clinical record lacked effective interventions and an increase in supervision for Resident F's cognitive status related to his impulsiveness and lack of safety awareness. Resident F was unable to be educated to remember to use his call light, and redirection attempts were unsuccessful due to his cognitive status. Resident D's fall intervention of a fall mat were not implemented, and Resident F was observed on the unit without supervision.<br><br>During an interview with CNA 1 on 6/22/21 at 11:45 a.m., she indicated she did not recall Resident F having a fall mat. Indicated he is impulsive and does attempt to self transfer without asking for assistance, and is not easily redirected. He does not use his call light.<br><br>During an interview with the DON on 6/23/21 at 3:45 a.m., she indicated she had added | | | |

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| | anti-rollbacks to Resident F's wheelchair this morning. She further indicated a fall mat is no longer a current intervention, as he used to have a low bed, but was unable to get up out of it so they changed him to a regular bed. She further indicated she cannot use signage in his room to remind him to use his call light, as he does not see well enough to read. Reeducation of use of the call light does not work with him, and she indicated alarms would just agitate him. She indicated she was aware he did not have increased supervision, as staff was off the unit charting at the nurses' station on the East unit. She indicated she did not have enough staff for someone to constantly be on the Alzheimer's unit, but indicated she would look into getting a laptop and bedside table for staff to do their charting on the unit, to ensure increased supervision for fall risk.<br><br>During an observation on 6/23/21 at 4:53 a.m., a bedside table with a laptop on it, and a chair were noted upon entry to the Alzheimer's unit, in front of the dining room. CNA 3 was observed on the unit.<br><br>During an interview with the DON and LPN 1 on 6/23/21 at 3:50 a.m., they indicated Resident D's room was close enough to the nurses' station that staff could hear him in his room if he was up. They further indicated he had signage in his bathroom and in his room to remind him to use his call light. The DON indicated staff " checked on him more frequently."<br><br>During an interview with the DON on 6/23/21 at 5:45 a.m., she indicated she placed a table and a laptop on the Alzheimer's unit so staff could chart on the unit to ensure supervision of fall risks. She indicated the CNA should not have been at the | | | |

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| | computer with her back facing the unit when charting, but at the other computer where she could see part of the unit through the window.<br><br>During an interview with the ADON on 6/23/21 at 6:40 a.m., she indicated Resident F was very impulsive and other times not so much. Reeducation and redirecting does not work with him. Indicated he and Resident D were severely cognitively impaired, and increased supervision should have been implemented to prevent falls.<br><br>During a review of the current policy, " Falls and Fall Risk, Managing," undated, provided by the DON on 6/23/21 at 3:58 a.m., indicated, " Based on previous evaluations and current data, the staff will identify the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling...will identify appropriate interventions to reduce the risk of falls...The interdisciplinary team (IDT) will review the fall incident the following business day for root cause, intervention, assessment, injury, and need for and frequency for further follow up."<br><br>During a review of the current policy, " Fall Risk Assessment," undated, provided by the DON on 6/23/21 at 3:58 a.m., indicated, " The staff and Attending Physician will collaborate to identify and address modifiable risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable."<br><br>This Federal tag relates to Complaint IN00354116.<br><br>3.1-45(a) | | | |