STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155796	A. BUILDING 00 B. WING	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARS THE	14409 SUNRISE CT LEO, IN 46765

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00387360 and IN00390573. Complaint IN00387360 - Unsubstantiated due to lack of evidence. Complaint IN00390573 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Survey dates: September 20 and 21, 2022 Facility number: 001215 Provider number: 155796 AIM number: 100450890 Census Bed Type: SNF/NF: 34 Total: 34 Census Payor Type: Medicare: 1 Medicaid: 20 Other: 13 Total: 34 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 26, 2022.	F 0000		
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment			

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

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	remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to implement fall interventions to prevent accidents, identify the root cause of falls, and update the care plan to prevent further falls for 3 of 3 residents reviewed for accidents (Residents O, R, and S). Findings include: 1. On 9/20/22 at 2:32 P.M., Resident O's record was reviewed. The diagnosis included, but was not limited to, Alzheimer's dementia. A significant change MDS (Minimum Data Set) assessment, dated 6/7/22, indicated the resident had severely impaired cognition. She required extensive assistance from 2 staff members for bed mobility and transfers. A Fall CAA (Care Area Assessment) indicated the resident had a remote fall history; required a broda chair for mobility; assistance of 2 for transfers and was at high risk for falls. She would have a care plan with interventions to prevent falls. A care plan, dated 8/12/21 and revised on 6/7/22, indicated the resident was at risk for falls related to confusion, gait/balance problems, incontinence, poor communication, unaware of safety needs, and hyperactivity while in a recliner chair. The goal was to be free of falls. The interventions included, but were not limited to, 2 assist with all transfers (start date 8/23/21) and Dycem to high back wheelchair (start date 8/16/22).	F 0689	The Cedars will implement an in-service for resident transfers including where to find the plan of care on the Kardex and education on safely transferring residents according to the plan of care. Monitoring of transfers will occur with observations of 10 transfers per week for 3 months then 5 transfers a week for 3 months. This will be monitored in a QAPI PIP. An in-service will also be completed with the nurses to include The Cedars fall protocol and the requirements in it. A QAPI PIP will also be created to monitor transfers, initial fall evaluations by the Nurse on duty, follow up assessments by Nurses, Care Plan updates for falls, and fall review with root cause analysis. All falls will be reviewed for 3 months. If 95% is achieved 5 falls will be reviewed for an additional 3 months. Score of 95% compliance will is required to close the PIP. These corrections will be completed and/or implemented by October 18, 2022.	10/18/2022

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A physician's order, dated 8/24/21, was to transfer the resident with 2 staff members and a gait belt.

A Social Services note, dated 9/6/22 at 4:31 p.m., indicated the family had reported a large bruise and swelling to the resident's left side of her face.

A State reportable form, dated 9/6/22 at 4:35 p.m., indicated Resident O had a bruise of unknown origin to the left side of her face, a reddened left ear, and scratches to her right leg with bruising. An investigation was initiated. A follow up report, completed on 9/12/22, indicated the facility was unable to determine the cause of the bruise and scratches.

The investigation summary was provided on 9/20/22 at 11:30 A.M., by the Administrator and indicated Resident O had yelled out when being transferred to bed in the afternoon on 9/6/22. The resident was transferred with assistance of 1 staff member (CNA 3 [Certified Nurse Assistant]). CNA 3's statement indicated when the resident had yelled out, she had checked the resident but hadn't seen the reason for her yelling.

On 9/20/22 at 4:00 P.M. and 9/21/22 at 2:00 P.M., Resident O was observed seated in her broda chair in the common room. She had a large area of yellow discoloration across the left side of her forehead which extended down her left temple and cheek. She appeared calm, in no distress, and smiled and mumbled at others passing by her.

On 9/21/22 at 10:20 A.M., CNA 5 was interviewed. She indicated she had gotten Resident O up from bed for supper at around 4:00 p.m. on 9/6/22. The room had been dark with the blinds closed and she hadn't noticed a bruise or bump to the

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	residents head. She changed the resident and transferred her into the broda chair and took her out to the common room. She was told about the bruise when a family member came in shortly after and saw a large bump and purple bruising to the residents left side of her face and asked what had happened. The resident had not fallen nor had she complained of pain when transferred to her chair. She transferred the resident by herself that day and did so on the resident's "good days". On 9/21/22 at 10:47 A.M., the Director of Nursing (DON) was interviewed. She indicated each resident had a Kardex report in addition to a CNA sheet which told staff how to care for and transfer residents. The DON provided a copy of Resident O's Kardex which was highlighted to show that 2 persons were to be used for transfers. She provided a copy of the CNA sheet for the resident which had no information regarding the resident's transfer ability and need for assistance. The DON indicated she could not determine the cause of the bruising nor could she determine if a fall had occurred but determined that CNA 3 and CNA 5 had not followed the plan of care to prevent falls/injury and had transferred the resident without assistance of 2 staff members on 9/6/22. 2. On 9/21/22 at 3:15 P.M., Resident R's record was reviewed. The diagnoses included, but were not limited to, dementia, Parkinson's disease, diabetes, anxiety, and atrial fibrillation with long standing use of anticoagulant (Coumadin). An annual MDS assessment, dated 8/25/22, indicated the resident had severely impaired cognition. She was non-ambulatory and required assistance of 1 staff member for transfers. A care plan, dated 9/3/21 and revised 8/17/22,			

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	indicated the resident was at high risk for falls due to history of falls, gait and balance problems, medication side effects, poor safety awareness, and Parkinson's. The goal was to be free from falls. The interventions were to anticipate and meet resident needs, keep call light close, ensure wearing proper footwear, therapy to evaluate and treat as needed, provide a safe environment, and review information on past falls and attempt to determine cause of falls. Record possible root causes and remove potential causes if possible. An Incident Note, dated 9/17/22 at 7:38 p.m., indicated the resident had been found on the floor outside the shower room. Resident R had been observed lying on her right side with her head resting on a shower blanket and her unlocked wheelchair sitting beside the shower door. She denied pain and no new skin issues were identified. 9/21/22 at 4:55 P.M., Resident R was observed seated in her wheelchair in the dining room. She had numerous large dark purple/red bruises on her right forearm and upper arm. The resident denied pain when asked. Resident R's record had no further documentation completed regarding her fall on 9/17/22. There was no root cause analysis completed, no updates to the care plan, and no follow up monitoring or documentation for injuries completed. 3. On 9/21/22 at 4:59 P.M., Resident S's record was reviewed. The diagnoses included, but were not limited to, dentia, major depressive disorder, anxiety disorder, and overactive bladder. A quarterly MDS assessment, dated 8/5/22, indicated the resident had severely impaired			

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	cognition. She was independent in most activities of daily living. A care plan, dated 11/12/20 and revised on 11/4/21, indicated the resident had actual falls with the last one occurring on 11/1/21. The care plan hadn't indicated the resident's fall risk nor actual falls and interventions for falls that occurred on 9/14/22 and 9/18/22. An Incident Note, dated 9/14/22 at 11:09 a.m., indicated Resident S had been found on the floor by the CNA. The CNA reported he heard a "thud" and found the resident on the floor beside her bed. She was observed laying on her back and she didn't know why she was on the floor. She had a skin tear to her right elbow and to both her knees which were cleansed and covered with a dressing. Neurological checks were initiated and continued through 9/16/22 at 8:28 p.m. An Incident Note, dated 9/18/22 at 2:04 a.m., indicated the resident had been found on the floor laying on her back beside her bed. She complained of back pain and was unable to be helped up. EMS was called and she was transported to the hospital for further evaluation. The resident returned shortly thereafter with no injuries found and no new orders. Resident S's record had no further documentation completed regarding her fall on 9/14/22 or on 9/18/22. There was no root cause analysis completed, no updates to the care plan, and no follow up monitoring or documentation for injuries completed. On 9/21/22 at 5:15 P.M., the DON was interviewed. She provided a Fall Protocol Checklist which served as the current facility policy for fall			

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	prevention. She indicated the Fall Protocol Checklist had not been followed. There had been no root cause analysis completed for Resident R or Resident S following their falls, care plans had not been updated, and there were no follow up assessments and documentation completed per their policy. The Fall Protocol Checklist indicated the following: "Assess the resident for injury; Obtain full set of vital signs including blood glucose level if diabetic; Begin neuros if resident hits head or was unwitnessed; Assist resident to bed or chair if no suspicion of fracture or dislocation; If resident is on anti-coagulation therapy and hits their head, staff must notify MD/NP to see if the resident needs to go to the ER for CT scan; Check on resident frequently for remainder of shift; Complete Morse Fall Assessment; Implement the new interventions which must be documented on incident report, the care plan and communicated to staff; Complete documentation which must include...the circumstances surrounding the fall, physical condition of resident, description or fall and precipitating events, new interventions that were initiated post fall...Follow up assessment for witnessed fall is every shift for 24 hours. Unwitnessed fall is every shift for 72 hours. These MUST include VS and neuros if applicable...." This Federal tag relates to IN00390573. 3.1-45(a)(2)			