STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	01/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00397558 and IN00397604. Complaint IN00397558 - Substantiated. Federal/state deficiencies related to the allegations are cited at F689. Complaint IN00397604 - Substantiated. Federal/state deficiencies related to the allegations are cited at F689. Survey date: January 3, 2023 Facility number: 000131 Provider number: 155226 AIM number: 100274910 Census Bed Type: SNF/NF: 70 Total: 70 Census Payor Type: Medicare: 4 Medicaid: 58 Other: 8 Total: 70 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 5, 2023	F 0000		
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Roland Mann	Administrator	01/16/2023

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 - §483.25(d)(1) The resident environment 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 interview and record review, the facility failed to ensure a dependent resident did not experience a fall from their bed that later resulted in a hospitalization with a nasal fracture, lip hematoma (solid swelling of clotted blood within the tissues), and a clavicle contusion (bruise) for 1 of 1 resident reviewed for accidents. (Resident B) Findings include: The clinical record for Resident B was reviewed on 1/3/23 at 11:46 a.m. The diagnoses included, but were not limited to, chronic respiratory failure with hypoxia, Alzheimer's disease with late onset, attention to tracheostomy, hemiplegia and hemiparesis, muscle weakness, contracture to left and right ankle, and malnutrition. A quarterly minimum data set (MDS) assessment, dated 10/5/22, indicated the inability to perform a mental status assessment, the need for total assistance of 2 staff person for bed mobility, transfers, toileting, and bathing. Also, the need for total assistance of one staff for dressing and personal hygiene. A fall event, dated 12/3/22 at 2:03 p.m., indicated a witnessed fall occurred. The document indicated Resident B had a witnessed fall to where they hit their head. There was a laceration and swelling along with pain. Resident B was nonverbal and	F 0689	It is the policy of this facility to ensure each resident receives adequate supervision and assistance to prevent accidents. **What corrective action(s) will be accomplished for those residents found to have been affected by deficient practice:** · Resident B has discharged from facility **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken:** · All dependent residents have the potential to be affected by this alleged deficiency · An audit was completed on all residents that are total assist with care per MDS. Care plans were reviewed for each resident and appropriate as needed per resident preferences and abilities. Audit completed January 12, 2023. · All nursing staff will be in-serviced on providing care to residents requiring total assistance by Director of Nursing or Designee by January 16, 2023	01/16/2023

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	unable to voice their needs and wants. Prior to the fall Resident B was lying in bed and after the fall the resident was positioned on the floor lying on their stomach. The summary on how the fall occurred indicated the following, "she was providing incontinence care and had resident on her right side. when residents upper body began to slide out. She attempted to grab her, but she was too slippery [sic]." A progress note, dated 12/3/22 at 1:30 p.m., indicated the following, "...Writer was notified by staff that the resident had fallen out of bed during check and change. The resident was visualized lying prone on the ground between the bed and window. She was dressed in only a gown and was disconnected from her vent. Writer rolled the resident over and unhooked her from the Gtube [gastrostomy tube] feeding. RT [Respiratory Therapist] stepped in and began to Ambu resident. Upon assessment, the resident sustained a laceration to her lip and hematoma to her forehead. At baseline resident is non verbal, unable to articulate orientation or follow commands...." An interview conducted with Certified Nursing Assistant (CNA) 2, on 1/3/23 at 12:18 p.m., indicated Resident B just "slid off" the mattress when she was providing care. Resident B had 2 "padded things" on both sides of her bed. She conducted care with the padded items on the bed because the resident doesn't have side rails. Resident B slid off towards the head of the bed. She was laying on her right side. She required total assistance with care and was not able to move. When she turned, the machine she was on had her coughing and it "jerked her". When she jerked her whole body moved while she was on her side. She went headfirst when she fell. The		**What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur:** · All nursing staff will be in-serviced on providing care to residents requiring total assistance by Director of Nursing or Designee by January 16, 2023 · Unit manager/Designee will conduct rounds on every shifts, utilizing Total Assistance Rounding Tool, to ensure residents are receiving assistance per plan of care. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place:** ·Total Assistance QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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	bed was positioned flat. Resident B proceeded to be on her right side, coughed, and then slid while on her side. Resident B was on a special mattress for her skin, but her daughter put lotions and "oils her up" with Vaseline and stuff. The daughter does that often. Resident B's whole body was covered. CNA 2 wasn't sure if the daughter came in on 12/3/22. An interview conducted with Corporate Nurse 3 on 1/3/23 at 3:50 p.m. indicated Resident B was on a specialty mattress that had bolsters, but the bolsters were a part of the mattress and did not disconnect from the mattress. The mattress was described as having individual pockets that fill up with air and that didn't require the need to have any specialty instructions for any type of linen to place on the mattress. With the mattress the nursing staff would be able to place a fitted sheet to have linen underneath the resident. An interview conducted with Family Member (FM) 5, on 1/4/23 at 9:46 a.m., indicated she did not receive a phone call from the nursing facility in regards to Resident B falling from her bed. She received a phone call from the emergency room physician around 6:20 p.m. and was asked questions about Resident B. This was when she was made aware of Resident B being in the hospital. Resident B had been in the hospital at 4 hours at that point. FM 5 indicated Resident B flipped over the bolsters and hit the nightstand with the side of her face. The bed bolsters were not there to secure her while changing her. She was a 2-person assist with transfers and care. There was only 1 person caring for her. She was 183 pounds. The CNA rested Resident B's body against the bolsters and when the CNA pushed Resident B over, she landed over them and onto the floor. There was another CNA on the			

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	Ventilator unit that should have been in the room but they were not. Resident B had been at the facility since March of 2013. She ended up having a fractured nose, hematoma to her face, bilateral black eyes, and was unstable in the intensive care unit for days. Resident B was on a standard mattress while at the facility. The bed bolsters were just added protection. There were separate from the mattress and they attached to the bed frame. The bolsters were not meant for support. Resident B couldn't lift her legs nor her body. Her right side was contracted. Resident B had Aquafor but she was out of Aquafor. The last time she was there visiting Resident B was the day prior to the incident on 12/3/22. FM 5 doesn't recall what condition her skin was like at the hospital besides the swelling and bruising to her face. A hospital document, dated 12/3/22, indicated the following, "...History and Physical...What was described to me is that while repositioning and turning her in the bed, the top half of her body got over the rail and she ultimately fell to the floor face first. After the event her vital signs were similar...Assessment/Plan...1. Trauma...has nasal fracture...lip hematoma, right periclavicular contusion...." A Skills Validation document titled "OCCUPIED BED", dated 02/2010, was provided by the Executive Director on 1/3/23 at 2:27 p.m. The document indicated the following, "...8. Lower head of bed...9. Drape resident...10. Turn resident on side, away from staff...11. Loosen bottom sheet and roll sheet toward resident tucking it snugly against the resident's back...12. Unfold clean bottom sheet on center of bed and fit corners over mattress...14. Slowly turn resident onto back then to other side over roll of linen...27. Document and			

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	report any unexpected findings...." This Federal tag relates to Complaints IN00397558 and IN00397604. 3.1-45(a)(1) 3.1-45(a)(2)			