STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155472	A. BUILDING 00 B. WING	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOOSIER VILLAGE	9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268

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F 0000 Bldg. 00	This visit was for the Investigation of Non-Certified Comprehensive (NCC) Complaints IN00437440, IN00437580, and IN00439205. Complaint IN00437440 - No deficiencies related to the allegations are cited. Complaint IN00439205 - No deficiencies related to the allegations are cited. Complaint IN00437580 - State deficiencies related to the allegations are cited at F9999. Survey dates: July 23 and 24, 2024 Facility number: 000548 Provider number: 155472 Census Bed Type: SNF: 11 NCC: 52 Total: 63 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 1, 2024.	F 0000		
F 9999 Bldg. 00	3.1- 37 QUALITY OF CARE (a) Each resident must receive and the facility	F 9999	Resident F passed away on 7/4/24. To ensure no other residents were potentially affected, residents with falls within the last 30 days have been audited to	08/22/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mindy Kantz	RN, Executive Director	08/14/2024

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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	must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and care plan. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure post fall assessments were completed for 1 of 3 Non-Certified Comprehensive (NCC) residents reviewed for accidents (Resident F). Findings include: Resident F's record was reviewed on 7/24/24 at 2:30 p.m. Diagnosis included, but was not limited to, Dementia (the loss of cognitive functioning, including thinking, remembering, and reasoning, to such an extent that it interfered with a person's daily life and activities). An Occurrence Journal Report, dated 5/2/24 at 7:50 a.m., indicated day shift Certified Nursing Assistant (CNA) went in to get Resident F up for breakfast and the resident had slid out of the bed onto the floor, was twisted up in a comforter and sitting on her buttocks. She did not hit her head nor have any injuries. Range of motion (ROM) was within normal limits (WNL). No complaints of pain. The Director of Nursing (DON) and the Power of Attorney (POA) were made aware of the fall. Staff will monitor the resident. Resident F's blood pressure, respirations, pulse, oxygen saturation, temperature, and cognition of oriented x 1 (person) were documented in the report. A nursing progress note, dated 5/2/24 at 5:06 p.m., indicated day shift CNA went in to get Resident F up for breakfast and the resident had slid out of		ensure thorough completion of post-fall assessments. No other resident were found to be affected. As a means to ensure ongoing compliance, the DON and Administrator have reviewed the facility fall policy and procedure and updated them with current practices. The DON and ADON have reviewed the updated fall policy and procedure with nursing staff and provided education to staff to ensure thorough assessments are completed after each fall, including completion and recording of vital signs and neurological checks. An updated fall procedure has been placed at each nurse's station for nursing staff reference. Review of all falls are a part of the daily interdisciplinary teams morning meetings as well as the IDT weekly risk meeting. The fall audit tool will be completed after each fall and will be reviewed weekly x 4 weeks, monthly x 2 months, and then quarterly during QAPI meetings, or until such time as QAPI committee determines substantial compliance has been achieved.	

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	bed onto the floor, was twisted up in a comforter and sitting on her buttocks. She had not hit her head nor had any injuries. The resident's medical record lacked documentation of additional post falls assessments completed for Resident F including 15 minute checks, neurological checks, nor vitals. An Occurrence Journal Report, dated 5/10/24 at 8:00 a.m., indicated Resident F fell this morning in her room. She had no complaints of pain and no injuries. She denied hitting her head. The DON and POA were made aware of the fall. Resident F's blood pressure, respirations, pulse, oxygen saturation, temperature, and cognition of oriented x 3 (person, place and time) were documented in the report. A nursing progress note, dated 5/10/24 at 12:07 p.m., indicated Resident F fell this morning in her room. She had no complaints of pain and no injuries. She denied hitting her head. The DON and POA were made aware of the fall. Resident F's blood pressure, respirations, pulse, oxygen saturation, and temperature were documented in the progress note. The resident's medical record lacked documentation of additional post falls assessments completed for Resident F including 15 minute checks, neurological checks, nor vitals. An Occurrence Journal Report, dated 5/14/24 at 8:20 a.m., indicated the nurse was summoned to Resident F's room at approximately 8:20 a.m. Resident F was discovered on the floor lying face down at the foot of her bed. The nurse assessed the resident with eyes pupils were equal, round and reactive to light and accommodation			

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	(PERRLA). No bumps or bruises were observed on the resident's head. No bruises or skin tears noticed at the time of the assessment. ROM on bilateral lower extremities (BLE) and bilateral upper extremities (BUE) were WNL for the resident with no complaints of pain. The DON and POA were made aware of the fall. Resident F's blood pressure, respirations, pulse, oxygen saturation, and temperature were documented in the report. A nursing progress note, dated 5/14/24 at 12:09 p.m., indicated the nurse was summoned to Resident F's room at approximately 8:20 a.m. The resident was discovered on the floor lying face down at the foot of her bed. The nurse assessed the resident with eyes pupils were equal, round and reactive to light and accommodation (PERRLA). No bumps or bruises were observed on the resident's head. No bruises or skin tears noticed at the time of the assessment. ROM on bilateral lower extremities (BLE) and bilateral upper extremities (BUE) were WNL for the resident with no complaints of pain. The DON and POA were made aware of the fall. Resident F's blood pressure, respirations, pulse, oxygen saturation, and temperature were documented in the progress note. The resident's medical record lacked documentation of additional post falls assessments completed for Resident F including 15 minute checks, neurological checks, nor vitals. An Occurrence Journal Report, dated 5/27/24 at 6:00 a.m., indicated the nurse was in the hallway at the medication cart and heard Resident F softly calling for help. Upon entering the room, the resident was observed on the floor rolled up in a blanket. Resident F noted rolling onto back then onto right side. The resident was unable to tell the			

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	nurse what happened and there was no witness to the incident. The CNA reported Resident F was toileted 30 minutes prior to the fall. A nursing progress incident note, dated 5/27/24 at 6:18 a.m., indicated the nurse heard resident softly saying "please help me" while in the hallway at the medication cart. Upon entering the resident's room, the resident was observed on the floor rolled up in a blanket laying on her right side. The resident was noted rolling onto her back then back onto her right side. Resident F was able to move all extremities without expressing pain or discomfort. The resident's vital signs were stable. Staff will continue to monitor. The nurse notified the on-call doctor, and the DON. Resident F had no acute distress noted. The resident's medical record lacked documentation of additional post falls assessments completed for Resident F including 15 minute checks, neurological checks, nor vitals. During an interview, on 7/24/23 at 11:53 a.m., the DON indicated the facility did not have a policy and procedure for nursing follow up assessments when a resident had an unwitnessed fall, but the nurse should complete neurological checks and nursing assessments immediately, then four times every 15 minutes, then every 30 minutes four times, then every 4 hours for 2 days or 48 hours and the nurse should document the assessments in the resident's electronic health record (EHR). The facility needed to add the nursing assessments post fall neurological checks and nursing assessments information documentation into the EHR medical system to ensure the post fall assessments were completed timely. This citation relates to the NCC Complaint			

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