STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF TIPTON SKILLED NURSING FACILITY, THE	300 FAIRGROUNDS RD TIPTON, IN 46072

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00432760 and IN00433531. Complaint IN00432760 - Federal/State deficiency related to the allegations is cited at F689. Complaint IN00433531 - No deficiencies related to the allegations were cited. Survey dates: April 26 and 29, 2024 Facility number: 000505 Provider number: 155556 AIM number: 100266350 Census bed type: SNF: 18 SNF/NF: 73 Total: 91 Census payor type: Medicare: 10 Medicaid: 52 Other: 29 Total: 91 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on May 9, 2024.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is May 29th , 2024. Facility is respectfully requesting paper compliance for all deficiencies in this POC. **/b>**	
F 0689 SS=G 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
Susan Waymire	Administrator	05/24/2024

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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	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 ensure a resident who was severely cognitively impaired and had memory problems, had assistive devices in place to prevent a fall from her moving wheelchair for 1 of 3 residents reviewed for accidents. (Resident B) This deficient practice resulted in Resident B falling forward from her wheelchair and sustaining a subarachnoid hemorrhage with facial, neck, and shoulder bruising which required hospitalization. Finding includes: A document, titled "Indiana State Department of Health Survey Report System," indicated Resident B went to the Emergency Room (ER), on 4/13/24, upon family request after a fall, while being transferred back to her room in her wheelchair. She was sent back to the facility without any injuries. Then on 4/14/24, she had a change in mental status from her baseline, was sent back to the ER, and was admitted to the hospital for an acute subarachnoid hemorrhage. The root cause of the fall was determined to be staff transporting the resident in her wheelchair without foot pedals. The fall intervention put into place by the facility to prevent another fall from her wheelchair while transporting her was to ensure the resident's wheelchair had foot pedals on it when she was being transported. The clinical record for Resident B was reviewed on 4/26/24 at 4:07 p.m. The diagnoses included, but were not limited to, vascular dementia with	F 0689	/b> Resident B's care plan reviewed, with appropriate and current interventions in place on 4/14/2024. **How will you identify other residents that have the potential to be affected by the same deficient practice and what corrective action will be taken?** All cognitively impaired residents using a wheelchair without any adaptive equipment has the potential to be affected. The DON/Designee completed an audit 5/24/2024 on all cognitively impaired residents using a wheelchair to ensure the use of adaptive equipment. Care plans and CNA assignment sheets reviewed and updated with appropriate interventions. What measures will be put in place and what systemic changes will be made to ensure that the	05/29/2024

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	psychotic disturbance, psychotic disorder with delusions and hallucinations, cognitive communication deficit, and difficulty in walking. A Significant Change Minimum Data Set (MDS) assessment, dated 4/4/24, indicated Resident B required substantial/maximal assistance for mobility. A fall risk care plan, dated 2/3/24, indicated Resident B was at risk to experience falls, had difficulty rising from a chair, had poor vision, had a history of falls, and required assistance with mobility. The plan included, but was not limited to, interventions to tilt the wheelchair seat back in addition to using anti-roll back and anti-tip equipment. On 4/26/24 at 12:20 p.m., Resident B was observed sitting at a dining room table eating her lunch in a standard wheelchair with foot pedals on it. Her standard wheelchairs did not have a back on them which could be tilted backwards. A psychiatry note, dated 4/9/24, indicated Resident B had a severe cognitive impairment and impaired memory. A facility document, titled "Basic Investigation Form," undated, indicated Resident B had a fall on 4/13/24, which resulted in an injury. The fall occurred in the hallway involving CNA 1. Mealtime had happened just prior to the event. The adaptive device being used was the resident's wheelchair. CNA 1 was transporting Resident B in her wheelchair when she fell forward out of her chair. The investigation indicated the resident was believed to have possibly put her feet down during the transport, but it was not actually seen.		deficient practice does not rec The DON/Designee in-serviced nursing staff on 5-28-2024 the policy Fall Prevention and adaptive equipment for wheelchairs and foot pedals for severely demented residents. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DNS or designee will do weekly observational audits on and resident care plan to verify fall interventions are currently in place. If the facility is with 95% compliance at the end of 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. **/b>**	

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A nursing note, dated 4/13/24 at 12:17 p.m., indicated a nurse was called to the hallway to assess Resident B. A CNA was pushing the resident in her wheelchair when the resident fell forward out of the wheelchair. She landed on the floor hitting the left side of her forehead, leaving a baseball sized hematoma. She had a skin tear to her elbow, which measured 5 cm (centimeters) by 2 cm. The resident was taken to the ER by her son to be evaluated.

The CT of the cervical spine without Intravenous contrast, dated 4/13/24 at 1:33 p.m., indicated the resident had a left frontal scalp hematoma.

A nursing note, dated 4/14/24 at 11:10 a.m., indicated the resident had bruises on her left shoulder and left knee. She was observed to be very sleepy. She was sitting up in her recliner.

A nursing note, dated 4/14/24 at 2:53 p.m., indicated Resident B was lethargic (very tired, without energy, and hard to arouse) and was unable to hold a conversation while staying awake. She had an increase in her mood. One minute she would be "ok," then the next minute she was "mean." Her son transported her to the ER for evaluation and a CT scan due to her lethargy.

The CT scan of the head without Intravenous contrast, dated 4/14/24 at 5:53 p.m., indicated the resident had a trace traumatic subarachnoid hemorrhage along the left lateral frontal cortex of the brain. She also had a left frontal scalp laceration and a contusion with hematoma.

An Interdisciplinary Team (IDT) note, dated 4/15/24 at 12:18 p.m., indicated the resident had a

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	witnessed fall on 4/13/24 at 11:38 a.m. The CNA was pushing her down the hallway in her wheelchair and she leaned forward in the wheelchair causing her to fall out. A head-to-toe assessment was completed, a hematoma was observed on her forehead, and a skin tear to her left elbow. Her son opted to take her to the ER to get her evaluated. The root cause of the fall was her wheelchair did not have foot pedals in place during the transfer. The immediate intervention was to ensure foot pedals were on her wheelchair when transporting the resident. A facility document, titled "Confidential Witness Statement," dated 4/15/24, indicated during a phone interview CNA 1 indicated she was transporting Resident B in her wheelchair when she fell forward out of the chair. The resident had been "wheeling" herself around in her wheelchair all morning. A hospital discharge summary, dated 4/17/24, indicated Resident B was admitted to the hospital on 4/14/24. The reason for her visit was encephalopathy likely worsened by concussion and urinary tract infection. Her hospital course was due to her falling out of her wheelchair at the facility. She was drowsy but arousable. The medical decision making was based off her presenting to the ER due to increasing drowsiness/lethargy. She had a trace traumatic subarachnoid hemorrhage identified on imaging. Her case was discussed with a neurosurgeon, who indicated the resident was a poor neurosurgical candidate due to her advanced age and history of severe dementia. Palliative care or hospice was offered to the family due to her significant health decline since a week or two ago. The family would consider both and let the physician know.			

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A nursing note, dated 4/18/24 at 10:25 a.m., indicated dark purple bruising was observed to the resident's face, neck, and shoulder. She had a large hematoma on the left side of her forehead. She complained of a headache of a 5 on a pain scale of 0-10 with 0 being no pain and 10 being the worst pain. The resident was medicated for her headache.

A facility document, titled "Record of Conversation," dated 4/19/24, indicated CNA 1 was involved in an accident with a resident, which resulted in a fall with an injury. The action taken was CNA 1 was educated on ensuring safe transfers with residents in wheelchairs and keeping her eyes on the resident and his/her extremities while transporting the resident in a wheelchair to ensure his/her safety.

A nursing note, dated 4/25/24 at 3:37 p.m., indicated the resident was disoriented and forgetful. She had bruising in multiple stages of healing observed on her face, head, neck, and shoulders.

A facility document, titled "Weekly Wound Evaluation," dated 4/25/24, indicated the resident had a hematoma with an abrasion to the left of her forehead which was identified on 4/19/24. The measurements of the wound were length-1.8 cm, width-2.1 cm, and depth-0.1 cm. The wound color was pink and red with some redness and warmth surrounding the wound.

A facility weekly wound evaluation document, dated 4/25/24, indicated the resident had a hematoma with an abrasion to the left of her forehead which was identified on 4/19/24. The abrasion measured 1.8 cm (centimeters) L (length)

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	by 2.1 cm W (width) by 0.1 cm D (depth) with a pink wound bed and red/warm peri wound. During an interview, on 4/26/24 at 1:24 p.m., the Executive Director (ED) indicated she would try to locate documentation to show the facility had effectively assessed the wheelchair and safety needs of Resident B prior to 4/13/24. On 4/26/24 at 12:20 p.m., Resident B was observed to have a small area of purple and yellow bruising under both her eyes, purple with yellow bruising on her left forehead, and a knot the size of a golf ball, which was purple in color and had a scab the size of a quarter above her left eye. She had purple bruising along the left side of her face by her ear and into her hairline extending onto her left side of her neck. She indicated she received the bruising and "goose egg" on her head from an accident from her wheelchair. She fell out of her wheelchair, but she did not remember how. During that time, the resident's son (POA) indicated he did observe her use her hands and arms to wheel herself, but he had not observed her to use her feet to propel herself with her wheelchair. During an interview, on 4/26/24 at 12:26 p.m., the Executive Director (ED), Director of Nursing (DON) and Assistant Director of Nursing (ADON) were in attendance. The DON indicated Resident B was just weighed in the dining room and was being taken back to her room when CNA 1 stopped at the nurse's desk to report her weight and the resident fell out of her wheelchair. Prior to her fall, on 4/13/24, she did not have foot pedals on her wheelchair because she propelled herself with her feet. She had a small subarachnoid hemorrhage of the brain and spent two days in the hospital after the fall.			

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	During an interview, on 4/26/24 at 3:37 p.m., Resident B's family indicated she did not see her mother propel her wheelchair with her feet. During an interview, on 4/29/24 at 10:22 a.m., the Rehabilitation Program Manager indicated there was an area in the facility where wheelchairs were kept. When a resident needed a wheelchair, the aides went to retrieve a wheelchair for the resident. The Rehabilitation Department did not fit residents for their wheelchairs. On 4/29/24 at 10:30 a.m., Resident B was in the therapy department working with a therapist. She was observed to propel herself in her wheelchair with her hands on both wheels. Her foot pedals were on at that time. The foot pedals were removed from the wheelchair, and she was asked to propel herself with her feet and she was unable to touch the floor with her feet. She was asked to hold her legs and feet up with her foot pedals removed from her chair and she was able to do so for 46 seconds before her feet dropped. She had been medicated for pain earlier according to her therapist. Her therapist indicated being medicated for pain would make a difference on how long she was able to hold her feet up due to pain in the hip she broke. During a phone interview, on 4/29/24 at 4:25 p.m., CNA 1 indicated, on 4/13/24, she and CNA 2 transferred Resident B from her recliner into her wheelchair, so she could take her to get her weight, then to the dining room to eat. She was pushing the resident down the hallway in her wheelchair when the resident "threw herself out of her wheelchair." She did not have foot pedals on her chair. When asked why she did not let the resident propel herself to get weighed, CNA 1 indicated she was in a hurry, it was around			

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	mealtime, and she was trying to get her weight, then to the dining room for lunch. During an interview, on 4/29/24 at 4:45 p.m., the ED indicated the facility did not have a wheelchair transfer policy. She had already provided the policy the facility had regarding wheelchairs, and there was no wheelchair assessment found for Resident B. During a confidential interview, a confidential interviewee indicated the resident had fallen in March 2024, and had broken her hip, so she had not been able to propel herself in her wheelchair with her feet because her legs had not been strong enough. She propelled herself in her wheelchair by using her hands on the wheels and moving her chair with her arms. She typically had foot pedals on her wheelchair when she was being transported out of her room. A current policy, titled "Policy and Procedure Wheelchair Usage," undated and provided by the ED on 4/26/24 at 1:24 p.m., indicated "...to provide appliances to residents that will enable them to attain and maintain their highest level of practicable functioning in relation to their medical condition including to wheelchairs...Any resident requiring a wheelchair or Geri chair will be assessed prior to application/use to determine the most effective appliance to be used. Physical Therapy will be responsible to ensure the appropriate fit and additional appliance application to the chair..." According to the facility's wheelchair usage policy, Physical Therapy (PT) was responsible to ensure the appropriate fit and additional appliance application for the wheelchairs.			

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	A current CNA curriculum, titled "Procedure #26: Transfer to Wheelchair," undated and provided by the Indiana Nurse Aide Curriculum Appendix A Procedures, indicated "...Place wheelchair on resident's unaffected side. Brace firmly against the side of bed with wheels locked and footrests out of way...Align resident's body and position footrests...." The State Operations Manuel, dated 4/16/21, indicated "...Training of staff, residents, family members and volunteers on the proper use of assistive devices/equipment is crucial to prevent accidents. It is also important to communicate clearly the approaches identified in the care plan to all staff, including temporary staff. It is important to train staff regarding resident assessment, safe transfer techniques, and the proper use of mechanical lifts including device weight limitations...Mobility devices include all types of assistive devices, such as, but not limited to, canes, standard and rolling walkers, manual or non-powered wheelchairs, and powered wheelchairs. Three primary factors that may be associated with an increased accident risk related to the use of assistive devices include: 1. Resident Condition. Lower extremity weakness, gait disturbances, decreased range of motion, and poor balance may affect some residents. These conditions combined with cognitive impairment can increase the accident risks of using mobility devices. This citation relates to Complaint IN00432760. 3.1-45(a)(2)			