STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155809	A. BUILDING _____ B. WING _____	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREY STONE HEALTH & REHABILITATION CENTER	10445 DUPONT OAKS BLVD FORT WAYNE, IN 46845

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F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00403340, IN00403968, and IN00404501. Complaint IN00403340 - No deficiencies related to the allegations are cited. Complaint IN00403968 - Federal/state deficiencies related to the allegations are cited at F689. Complaint IN00404501 - No deficiencies related to the allegations are cited. Survey dates: March 24 and 27, 2023 Facility number: 012935 Provider number: 155809 AIM number: 201207690 Census Bed Type: SNF/NF: 78 SNF: 9 Total: 87 Census Payor Type: Medicare: 2 Medicaid: 67 Other: 18 Total: 87 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 29, 2023	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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

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F 689	Continued From page 1 §483.25(d) Accidents. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide adequate staff and assistive devices to prevent a fall for 1 of 3 residents reviewed for accidents. This deficient practice resulted in a fall with fracture, pain, and increased anxiety (Resident M). Findings include: A facility reported incident to the Indiana Department of Health, dated 3/13/23 at 1:22 p.m., indicated Resident M rolled out of bed while being assisted with care. She was sent to the hospital where x-rays indicated a tibia/fibula left ankle fracture. On 3/27/23 at 9:43 A.M., Resident M's record was reviewed. Diagnoses included acute fracture of left tibia and fibula from fall, anxiety disorder, major depressive disorder, and mild cognitive impairment. A quarterly MDS (Minimum Data Set) assessment, dated 12/23/22, indicated the resident had moderately impaired cognition. She had no behaviors of rejecting care. She required extensive assistance from 2 staff for bed mobility and toileting. She was always incontinent of bladder, frequently incontinent of bowel, and was	F 689	Past noncompliance: no plan of correction required.	

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non-ambulatory.

Care plans indicated the following:

-The resident had a self-care deficit related to impaired mobility, cataracts, and failure to thrive (last revised 8/4/21). The goal was for her needs to be met. Interventions included: assist with activities of daily living (ADL), dressing, grooming, toileting, feeding, and oral care; bed mobility with assist; dressing/grooming with assist; and toileting with assist. The care plan hadn't indicated the number of staff required to assist the resident to perform ADL's safely.

-The resident was at risk for falls due to history of falls, injuries, and multiple risk factors (last revised 8/4/21). The goal was for the resident to have no fall related injuries. Interventions included: bed in the lowest position; call bell within reach; provide assistance with toileting as needed; and implement preventative fall interventions/devices.

-The resident was incontinent of bladder (initiated 8/3/21). The goal was for her to receive assistance with toileting. Interventions included: provide incontinence care as needed. The care plan hadn't indicated the number of staff required to assist the resident with incontinent care while in bed or out.

On 3/27/23 at 10:05 A.M., Resident M was observed lying in her bed. The left side of the bed was against the air conditioning unit. The unit's level was below the window. There were quarter bedrails on both sides of the bed. The resident had a flat affect and complained of pain in her left ankle. She indicated she didn't remember the fall

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that had occurred from bed and wasn't sure how she had gotten back into bed after falling.

-1:47 P.M., the resident was observed lying in her bed. The bed had been moved away from the air conditioning unit with an approximate distance of 3 feet between the bed and unit. The Unit Manager (UM), indicated the bed brakes were locked. She tried to move the bottom of the bed which did not move however, when she moved the head of the bed, it was able to move despite the bed brake being on. The resident was observed to have purse lipped breathing and indicated she was having a lot of pain in her left ankle. She indicated she would be much better after the cast was removed from her ankle.

Progress notes indicate the following:

-3/13/23 at 3:12 a.m., a head to toe evaluation for an occurrence was completed. The nurse had been called to the resident's room where she'd had a witnessed fall from bed. A CNA (Certified Nurse Aide) indicated she had been changing the resident and as she rolled her to the side of the bed, the resident let go and slid out of the bed. A left ankle X-ray was ordered and the resident given Tylenol for pain. The left ankle was elevated on a pillow and ice applied. She complained of throbbing pain to her left ankle at a pain level of 4 out of 10 with 10 being the worst. The nurse indicated the resident needed side rails to hold onto during bed changes.

-7:36 a.m., a fall follow-up note indicated the resident was alert and oriented with neurological checks within normal limits. She complained of throbbing pain in her left ankle and rated her pain at a 8 out of 10 with 10 being the worst.

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-8:00 a.m., the resident had dark purple bruising to the left lateral ankle. The bruising.. measured 5 centimeters by 6 centimeters.

-11:20 a.m., an Interdisciplinary team progress note indicated on 3/13/23 at 2:38 a.m., the resident was being given incontinent care when she rolled towards the window and fell from the bed. Physical assessment had shown there was an acute injury with swelling around the left ankle. X-ray of the left ankle was ordered. The resident had increased complaints of pain and requested to go to the hospital. She was to be transferred to the hospital for evaluation and treatment of the left ankle injury.

-3:09 p.m., quarter bed rails were applied to both side of the resident's bed to assist with bed mobility and positioning.

-4:22 p.m., the resident returned from the hospital. She had increased anxiety and stated "I just don't like hospitals; they make me very anxious". She received routine anti-anxiety medication but was not due for the next dose until 8:00 p.m. The psychiatric Nurse Practitioner (NP) was notified and ordered a one time dose of Buspar 5 mg (a different anti-anxiety medication) with the hope the resident's anxiety would be reduced until it was time for her usual anti-anxiety medication at 8:00 p.m.

-8:44 p.m., an NP progress note indicated Resident M was seen for a post hospital visit. The resident had sustained a fall from bed while receiving care from staff. She had been to the hospital and returned with a soft cast in place to the left ankle. She was complaining of pain at a

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level of 9 out of 10, was anxious, and observed to be shaking from the pain. She had an order for as needed pain medication with recommendation to make this a routine order.

-3/14/23 at 4:54 a.m., the resident was given an opioid pain medication-Norco 5-325 milligrams (mg) 1 tablet by mouth every 6 hours as needed for pain level of 8 out of 10.

-11:41 a.m., fall follow-up documentation indicated the resident had pain in her left ankle which was rated at 7 out of 10. Her pain medication was ordered to be given routinely every 8 hours.

-3/15/23 at 9:51 a.m., a psychiatric NP progress note indicated the resident was seen for an increase in anxiety status post fall. Since her fall with fracture, she'd had an increase in anxiety. She was observed to move her hands constantly, was fidgety and restless. She told the NP that she was "more anxious and worried" but shared no further information. Her mental status exam indicated she was alert and oriented to self, place, and time. She had fair eye contact and was anxious, restless, and fidgety. The plan was to start her on a second anti-anxiety medication-Buspar 5 mg tablets by mouth 3 times per day due to increased, observed anxiety since fall with fracture.

-At 2:45 p.m., a fall follow up indicated the resident's pain level was 0 out of 10. The note indicated the NP had discontinued the resident's routine Norco and ordered Percocet 5-325 mg by mouth every 8 hours due to ineffectiveness of Norco for pain management. The NP's note indicated the resident had been on Norco 5-325

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mg tablets-1 tablet every 8 hours but her pain had not been controlled.

-3/17/23 at 11:07 a.m., an NP progress note indicated the resident had an episode of hypoxia (low blood oxygen) early in the morning and her oxygen level had dropped to 66% on room air (normal is >90%). She was placed on oxygen. The NP suspected the hypoxia had been due to the change in narcotics. Due to the resident's uncontrolled pain, she was being sent STAT to the orthopedic's office for evaluation. The Percocet was discontinued and the routine Norco re-started for pain management. The resident's routine Ativan (anti-anxiety medication) was to be held for 1 week while she was on narcotics.

An Orthopedic progress note, indicated the resident had been seen on 3/17/23 and a short leg cast applied to her left ankle. During the visit, the resident was observed with an elevated blood pressure of 160/100 and pulse at 104.

-3/22/23 at 7:14 a.m., a psychiatric NP progress note indicated the resident was visited for follow up of increased anxiety following a fall with fracture and not eating. The resident had not been eating, had complaints of her stomach "not being right", increase in pain, and multiple fixations on changes. During the visit, the resident indicated she was trying to eat but her stomach was in "knots". The plan was to continue her Ativan as ordered and increase her Buspar to 10 mg 3 times per day by mouth.

On 3/27/23 at 10:00 A.M., Nurse 2 was interviewed. She indicated CNA's referred to the Kardex, located on IPADs, to direct them how to care for a resident and how the CNA's were to

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document care they provided. She indicated the Kardex "should" indicate how many staff members were required to assist a resident with ADL's such as bed mobility, transfers, and incontinent care.

A Kardex report, dated 3/12/23, before the resident's fall and used by CNA's to provide care to Resident M, had interventions for activities, safety, care, skin care, activities of daily living, devices, and daily routine. The Kardex report hadn't indicated the number of staff required to provide care to the resident.

On 3/27/23 at 11:16 A.M., a witness statement was provided by the Unit Manager indicated CNA 3 worked the night shift on 3/12-3/13/23 and cared for Resident M. The CNA was changing the resident's brief and had rolled her onto her left side facing the window. As the CNA pushed the bed pad and brief under the resident, the resident let go of the bed and her body started rolling off. The CNA tried to grab her so she wouldn't fall but the resident's entire body rolled off the bed and landed on the air conditioner unit. CNA 3 moved the bed away from the air conditioner unit so she could turn the resident on her back. The resident's right leg was extended in front of her but her left leg was underneath her and she was sitting on it. CNA 3 pulled the resident beneath her arms away from being between the wall and air conditioner unit. The CNA got the resident's left leg out from underneath her and extended her left leg. The resident's left ankle was swollen "immediately". CNA 3 then went to get the night supervisor.

On 3/27/23 at 2:26 P.M., Nurse 5, was interviewed. During the interview, she indicated

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on 3/13/23 at approximately 2:40 a.m., she was summoned to Resident M's room. When she came into the room, she saw Resident M on the floor, between the bed and air conditioner unit, with her head towards the head of the bed. She and CNA 3, along with a mechanical hoyer lift, got the resident off the floor and back into bed. The resident complained of pain in her left ankle. The ankle was swollen and discolored. Nurse 5 indicated the resident's ankle and foot hit the air conditioner as she fell over the side of the bed. The resident did not have side rails or transfer rails on her bed. The nurse indicated when staff assisted the resident to turn over for incontinence care, the resident would reach over the side of the bed and hold on to the bed frame to support herself. When questioned, the nurse indicated either 1 or 2 staff members could assist the resident with bed mobility and incontinence care.

A current policy, titled "Fall Prevention and Management Policy" was provided by the unit manager on 3/27/23 at 2:13 P.M. The policy indicated: "Residents will be assessed for fall risk(s) on admission, quarterly, after any fall, and as needed. If risks are identified, preventive measures will be put in place and care planned. All falls will be reviewed and investigated...Individualized interventions will be implemented based on this assessment and care planned accordingly...Falls will be reviewed by an interdisciplinary team and any new interventions identified will be implemented and the care plan updated as necessary. Such review should include results of the new fall risk assessment, discussion with resident and/or any witnessing parties as to potential causal factors, review of the environment where the fall occurred, and discussion as to any new interventions which may

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F 689	Continued From page 9 help to prevent further falls...." The deficient practice was corrected by 3/14/2023 after the facility implemented a systemic plan that included the following actions: an audit was completed to ensure resident assistance was clear on CNA Kardex and appropriate fall prevention devices were in place for residents at high risk, the staff was reeducated regarding giving care accoring to the Kardex, and m onitoring was initiated and completed regarding observations of giving care according to the Kardex. This Federal tag relates to Complaint IN00403968. 3.1-45(a)	F 689		