STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155199	A. BUILDING _____ B. WING _____	C 09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE PARK VILLAGE	776 N UNION ST WESTFIELD, IN 46074

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F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00417153 and IN00415768. Complaint IN00417153 - Substantiated. Federal/state deficiencies related to the allegations are cited at F689. Complaint IN00415768 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: September 19 and 20, 2023 Facility number: 000106 Provider number: 155199 AIM number: 100266390 Census Bed Type: SNF/NF: 74 SNF: 4 Total: 78 Census Payor Type: Medicare: 7 Medicaid: 41 Other: 30 Total: 78 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on September 28, 2023.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	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)(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 interview and record review, the facility failed to protect a resident from injury when the resident was left unattended in a bed which was not in the lowest position, and without a fall mat on the floor. The resident fell out of bed, sustained a laceration to the left side of the forehead and an acute left femoral neck fracture (a type of hip fracture of the thigh bone, just below the ball of the ball-and-socket hip joint). (Resident B) The facility also failed to ensure staff providing care were using/following the care sheet or electronic record which provides information on safety precautions put in place, resulting in Resident C had to be lowered to the floor, for 2 of 3 residents reviewed for accidents. (Resident B and C) The deficient practice was corrected on 9/12/23, prior to the start of the survey, and was therefore past noncompliance. Findings include: 1. During a phone interview, on 9/19/23 at 10:04 a.m., the Power of Attorney (POA) for Resident B indicated Resident B was dressed and prepped for a full body mechanical lift, which should have had two people to perform. After the resident was dressed, the other staff member should have remained in the room with Resident B. The POA indicated she felt the facility was not following protocol and the resident sustained injury during the lift and indicated "she was dropped during a	F 689	Past noncompliance: no plan of correction required.	

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Hoyer [mechanical lift] transfer." She did not "see her [the resident] having the strength to roll out of bed."

During an interview, on 9/19/23 at 1:02 p.m., Resident 7 (Roommate for Resident B) indicated she was awake when Resident B fell. The CNA came in, got her ready, and put the Hoyer pad under her then left the room to get the lift. She did not know why she did not bring it with her, they usually did, but she heard a thud "like a basketball hitting the floor." Another aide who was working on the hall, must have seen her on the floor. She was the one who responded.

The record for Resident B was reviewed on 9/19/23 at 11:13 a.m. Diagnoses included, but were not limited to, dementia, unspecified fracture of unspecified femur, and fracture of unspecified part of neck of right femur subsequent encounter for closed fracture with routine healing status after a partial hip replacement procedure.

A care plan, with a problem start date of 6/11/17, indicated Resident B was at risk for falls related to, but not limited to, dementia, impulsive and polyneuropathy (simultaneous malfunction of many peripheral nerves throughout the body). The interventions included the bed was to be in the lowest position when the resident was in the bed.

A physician's order, with a start date of 4/20/22, and end date of 9/15/23, indicated "...Mattress on floor next to bed when in bed...every shift...." The Medication and Treatment Record was signed off by the nurse, on the day of the fall, to indicate the mattress/mat was present on the floor at the

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bedside, when the nurse checked Resident B.

A Care Sheet (resident care profile), provided by LPN 2 on 9/19/23, at 1:31 p.m., indicated "...Bed in lowest position when resident is in the bed...."

A nursing note, dated 9/8/2023 at 7:36 a.m., indicated "...CNA called writer et [and] said resident is on the floor. Writer went in et saw resident lying on her left side bleeding from her L [left] forehead. Had 3x.5 cm [centimeter] cut; Pressure applied to stop bleeding. As per aide, resident rolled out of bed as she reached out to get Hoyer lift [full body mechanical lift] to transfer resident...."

A radiology report, dated 9/8/23, indicated Resident B had an acute left femoral neck fracture.

An Incident Report to the Indiana State Department of Health, dated 9/8/23, indicated the resident was found on the floor next to the bed. The resident had a laceration to the forehead and was complaining of hip pain.

A statement provided by the Executive Director, on 9/20/23 at 11:40 a.m., indicated "...I [CNA 1 name] was getting Resident B dressed for the day. After dressing the resident, the lift pad was placed under her, and she was left laying on her back...I believe she tried to get up from the bed when I went to get a spotter/the nurse to help me with the Hoyer lift. When I stepped out and return, she was laying on the floor...." The statement was unsigned and undated.

A statement provided by the Executive Director, on 9/20/23 at 11:40 a.m., indicated Resident B

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had been witnessed moving in the bed unassisted. The statement was signed by LPN 4 on 9/8/23.

A statement provided by the Executive Director, on 9/20/23 at 11:40 a.m., indicated Resident B was witnessed moving by herself in bed and there were times where she had witnessed Resident B sitting up in bed and the resident would attempt to get out of bed herself. She would have her legs out of bed sitting upright as if she was going to stand and try to get up. The statement was signed by Staff 5 on 9/11/23.

A statement provided by the Executive Director, on 9/20/23 at 11:40 a.m., indicated Resident B was observed independently moving her body and repositioning herself. The statement was signed by LPN 6 on 9/15/23.

During an interview, on 9/19/23 at 1:29 p.m., the Director of Nursing indicated the CNAs could find safety information on their care sheets. They could also pull up the information electronically.

During an interview, on 9/19/23 at 2:10 p.m., the Director of Nursing indicated staff were supposed to follow the care plan and the CNA was supposed to follow the care sheet.

During a telephone interview, on 9/19/23 at 2:20 p.m., CNA 1 indicated she was getting Resident B up and dressed. She put the full body mechanical lift sling under Resident B after she dressed her. She left the room to get a "spotter" (second person to assist with the lift transfer) and when she returned Resident B was on the floor. She indicated "the bed was not high at all, maybe medium," she left Resident B lying on her back in

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the bed. She believed the resident tried to get up. She did not have the CNA care/assignment sheet, she did not know they (the facility) had them and she did not know where to find them. It was her first time working the night shift and the front hall. The resident did not have a mat on the floor beside her bed when she entered the room.

During an interview, on 9/19/23 at 2:46 p.m., LPN 3 indicated when she responded to the fall for Resident B, the bed was at hip height (her hip height) and indicated the bed was to be in a low position when the resident was in bed. She also indicated the mat was on the floor at the bedside during the shift; she did check it during her shift.

A document, titled "Employee Communication Form," provided by the Executive Director on 9/20/23 at 11:40 a.m., indicated "...Res [resident] was left unattended without fall precautions being put back in place, that resulted with res falling out of bed...." The document was signed by CNA 1 and the Assistant Director of Nursing on 9/12/23.

2. The record for Resident C was reviewed on 9/19/23 at 12:50 p.m. Diagnoses included, but were not limited to, unspecified dementia with other behavioral disturbance, essential hypertension, and generalized muscle weakness.

A care plan, initiated on 12/30/21, indicated the resident required assistance with activities of daily living (ADLs) including transfers. An intervention, initiated on 7/7/22, indicated the resident was to be an assist x 2 with transfers (two people were needed to transfer the resident).

A nurses' note, dated 7/5/23 at 10:26 a.m., indicated "...Resident being assisted from toilet to

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wheelchair and started to sit down before in contact with wheelchair. Staff lowered her to floor to prevent injury. Resident assisted off floor and into wheelchair and then bed. No injuries noted. ROM [range of motion] WNL [within normal limits]. Denies pain. Did not hit head...."

On 9/19/23 at 1:29 p.m., a care plan policy and safety intervention policy were requested of the Director of Nursing.

During an interview, on 9/19/23 at 2:10 p.m., the Director of Nursing indicated the facility did not have a policy on safety interventions and she provided the care plan policy.

During a telephone interview, on 9/19/23 at 2:50 p.m., CNA 7 indicated it was her first day. She was working the other side and she did not have Resident C on her assignment. She heard Resident C yelling for help and thought it was an emergency, so she responded. She was not aware of how the resident transferred and thought she was a limited transfer. She transferred the resident with a gait belt to toilet, she changed the resident on the toilet, and put on socks with the gripper (nonskid). When she went to transfer the resident back to the chair, the resident said she was going to fall. CNA 7 called for another CNA, in the hall, and together they gently lowered the resident to floor and then got the nurse. She indicated she did not have a resident care sheet, it was electronic.

During an interview, on 9/20/23 at 8:54 a.m., the Executive Director (ED) indicated the resident care profile were to be carried on the CNA along with a gait belt. CNA care profiles are in a three (3) ring binder at each nursing station. The CNAs

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knew where to find them, even clinical resource group (corporate as needed pool of employees) are educated in training on where they can be found for all facilities. He and management complete rounds in the morning and check to be sure gait belts and care sheets are with the CNAs.

A current policy, titled "IDT Comprehensive Care Plan Policy," dated as last reviewed on 8/2023 and received from the Director of Nursing on 9/19/23 at 2:10 p.m., indicated "...It is the policy of this facility that each resident will have an interdisciplinary comprehensive person-centered care plan developed and implemented...The care plan must include...resident specific interventions based on the residents needs and preferences to promote the psychosocial well-being. Physician's orders are considered part of the comprehensive plan of care...."

The deficient practice was corrected by 9/12/23 after the facility implemented a systemic plan that included the following actions: The facility investigated the incident involving Resident B, disciplined CNA 1, educated the staff on fall prevention, began audits on safety precautions in place for all residents with fall risks, and ensured Resident B received medical care as well as follow up care and monitoring.

This Federal Tag relates to Complaint IN00417153.

3.1-45(a)(2)