STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDAR RIDGE OF FORT WAYNE	3320 EAST STATE BOULEVARD FORT WAYNE, IN 46805

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00400850. Complaint IN00400850 - Substantiated. Deficiencies related to the allegations are cited at R0036 and R0240. Survey date: February 17, 2023 Facility number: 012107 Residential Census: 32 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 17, 2023	R 0000		
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review, the facility failed to immediately notify the physician of a significant change in condition that required medical treatment for 1 of 3 resident's reviewed (Resident C) Findings include:	R 0036	RE: R-0036: Failure to immediately notify the physician of a significant change in conditions that required medical treatment The community will monitor healthcare follow up to ensure that physician notification is completed	03/17/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tanya Olson	Regional Nurse Specialist	03/24/2023

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	On 2/17/23 at 11:47 A.M., Resident C's record was reviewed. Diagnoses included history of hemorrhagic stroke (brain bleed), short term memory deficits, atrial fibrillation with use of blood thinners, and high blood pressure. She was prescribed Coumadin (blood thinner) 7.5 milligrams by mouth daily. A Mini Mental Exam, dated 9/13/22, indicated Resident C had mild cognitive impairment. A Fall risk assessment, dated 9/13/22, indicated the resident was at high risk for falls with a score of 6. On 12/10/22, Resident C had several falls. Communication Logs were as follows: -12/10/22 at 12:00 p.m., the resident experienced a fall inside her apartment. Vital signs were collected and were within normal limits. The resident had mobility issues and hadn't wanted to be moved from the floor. Staff assisted her back into bed and family were notified. Resident declined hospitalization but agreed to an x-ray exam of her lumbar spine. Staff were to monitor her. -At 1:45 p.m., Resident C sustained another fall. This resulted in injury to her right upper extremity. She was refused hospitalization. The resident was encouraged to apply pressure to the wound. All pertinent notifications were made and monitoring was to continue. -At 2:04 p.m., the resident fell again and had bleeding to the right arm. The family was notified. Incident Reports, provided by the Regional Clinical Specialist on 2/17/23 at 4:33 p.m., indicated		in a timely manner. 1. Education will be provided to staff to ensure that staff is aware of the notification process. Completed by 3/17/2023 2. The nurse will follow up and document all changes of condition within a timely basis. Daily 1. During the weekly Quality Excellence meeting the ED/DON will review healthcare follow up to ensure timely physician notification. Completed 12/31/2023 provided 90% compliance for three months achieved.	

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	the following: On 12/10/22 at 1:15 p.m., the resident had an unwitnessed fall in her room. She lost her balance and fell to the floor. She complained of lower back pain. There were no vital signs taken or neurological checks completed. The physician was not notified until 12/12/22 at 8:30 a.m. On 12/10/22 at 3:01 p.m., the resident had a fall in the bathroom and was bleeding on her right arm. She had pain in her lower back. Her vital signs were, blood pressure: 83/83 [sic] (normal 120/80), pulse: 115 (normal 60-100), and respirations: 95 [sic] (normal 16-20). She was not sent to the hospital and the physician wasn't notified. The report didn't indicate the family had been notified of the 2nd fall. On 2/17/23 at 12:36 P.M., Resident C's family member was interviewed. During the interview, they indicated the resident had fallen 3 times. Another family member had been called to come to the facility per the resident's request after her 3rd fall. When the family member arrived, the resident was bleeding profusely from a wound on her right arm and was confused. The family member took her to the hospital where she was found to have brain bleeds in 2 different areas of the brain, broken ribs and a subdural hematoma . The resident remained in the hospital for several days, returned to the facility, with hospice services, and died 3 days later. On 2/17/23 at 2:40 P.M., RN 2 (Registered Nurse) was interviewed. The RN indicated residents who are prescribed Coumadin or other blood thinners should be routinely monitored for any type of bleeding due to the increased risk for bleeding, even with minor injuries. They indicated if a			

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	resident was prescribed blood thinners and had a fall, they would assess for bleeding, provide immediate first aid, perform neurological checks and notify the physician. A current policy, titled "Change of Condition Policy and Procedures" provided by the facility on 2/17/23 at 3:23 P.M., stated the following: "A change of condition is identified when a resident experiences an alteration in their normal baseline evaluation. This may include altered mental status or a physical, emotional, or behavioral change, and may be short term, such as delirium, which is expected to return to their baseline, or long-term change. When a change in condition occurs, it is our policy to evaluate the resident, notify the physician and responsible parties, and intervene accordingly...Procedures: 1. When a resident exhibits a change of condition, notify the licensed nurse or DOW (Director of Wellness). 2. The licensed nurse or DOW will evaluate the resident change including vital signs and physical assessment. 3. The licensed nurse of DOW will notify the physician and note new orders...6. If a change of condition is determined, staff will be instructed on what specific interventions should be in place, based on physician's orders, to meet thee resident's needed (VS, observe for swelling, redness of skin, cough, congestion, behavior changes, etc)...." This State Residential Finding relates to Complaint IN00400850.			
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.	R 0240	RE: R-0240: Failure to monitor	03/17/2023

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	Based on interview and record review, the facility failed to monitor medication side effects for 1 of 3 residents reviewed for medication administration (Resident C). Findings include: On 2/17/23 at 11:47 A.M., Resident C's record was reviewed. Diagnoses included history of hemorrhagic stroke, short term memory deficits, atrial fibrillation with use of anti-coagulant, and high blood pressure. A Mini Mental Exam, dated 9/13/22, indicated Resident C had mild cognitive impairment. A Fall risk assessment, dated 9/13/22, indicated the resident was at high risk for falls with a score of 6. An Individualized Service Plan (ISP), dated 9/14/22, indicated she needed assistance with housekeeping/laundry and medication assistance daily. The resident required assistance with all other activities of daily living (ADL's) on an as needed basis. The ISP indicated she had been assessed for fall risk and was not [sic] at risk for falls. She used a walker for ambulation. Resident C was prescribed Coumadin (blood thinner) 7.5 milligrams (mg) by mouth daily. On 12/8/22, the resident's lab work indicated an INR of 2.6 (blood test to check how fast the blood clots-if the blood clots slowly, a person may bleed too much after an injury). The Nurse Practitioner was notified of the result and orders given to continue with the same dose of Coumadin and continue to monitor. Review of a Medication Administration Record		medication side effects 1. Education will be provided to staff to ensure staff are aware of side effects of blood thinners. Completed by 3/17/2023 2. Staff will complete a skin sheet for any unusual discoloration and notify the nurse. Completed by 3/17/2023 3. The emar will be updated to monitor for signs or symptoms of internal bleeding for all residents on blood thinners. Completed by 3/17/2023 4. During the weekly Quality Excellence meeting, the ED/DON will review charting to ensure staff is documenting that they are monitoring for side effects of anti-coagulant medication. The residents on these types of medications will stay on the ROAR report as part of our QA meeting. Completed 12/31/2023 provided 90% compliance for three months achieved.	

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	(MAR) for December 2023, hadn't indicated the resident was monitored for side effects of coumadin. On 12/10/22, Resident C had several falls. Communication Logs were as follows: -12/10/22 at 12:00 p.m., the resident experienced a fall inside her apartment. Vital signs were collected and were within normal limits. The resident had mobility issues and hadn't wanted to be moved from the floor. Staff assisted her back into bed and family were notified. Resident declined hospitalization but agreed to an x-ray exam of her lumbar spine. Staff were to monitor her. -At 1:45 p.m., Resident C sustained another fall which resulted in injury to her right upper extremity. She was prescribed coumadin but refused hospitalization. The resident was encouraged to apply pressure to the wound. All pertinent notifications were made and monitoring was to continue. -At 2:04 p.m., the resident fell again and had bleeding to the right arm. The family was notified. Incident Reports, provided by the Regional Clinical Specialist on 2/17/23 at 4:33 p.m., indicated the following: On 12/10/22 at 1:15 p.m., the resident had an unwitnessed fall in her room. There were no vital signs taken or neurological checks completed. The physician was not notified until 12/12/22 at 8:30 a.m. On 12/10/22 at 3:01 p.m., the resident had a fall in the bathroom and was bleeding on her right arm. She had pain in her lower back. Her vital signs were, blood pressure: 83/83 [sic] (normal 120/80), pulse: 115 (normal 60-100), and respirations: 95			

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	[sic] (normal 16-20). There were no neurological checks completed and no documentation of the resident's wound, bleeding, or first aide provided. She was not sent to the hospital and the physician wasn't notified. On 2/17/23 at 12:36 P.M., Resident C's family member was interviewed. During the interview, they indicated the resident had fallen 3 times. Another family member had been called to come to the facility per the resident's request after her 3rd fall. When the family member arrived, the resident was bleeding profusely from a wound on her right arm and was confused. The family member took her to the hospital where she was found to have brain bleeds in 2 different areas of the brain, broken ribs and a subdural hematoma on her head. The resident remained in the hospital for several days and returned to the facility, with hospice services, and died 3 days later. A Hospice Comprehensive Assessment and Plan of Care Update Report with an unknown date, indicated the resident had been admitted to the hospital following falls on 12/10/22. After the falls, the resident had decreased level of consciousness, was not following commands, and had garbled speech. She was taken to the hospital where a head CAT scan revealed a subarachnoid hemorrhage, subdural hematoma and a intraparenchymal hemorrhage. In addition, she sustained rib fractures to her right 11th and 12th ribs. She was eligible for hospice services with a diagnosis of traumatic brain injury. On 2/17/23 at 2:40 P.M., RN 2 (Registered Nurse) was interviewed. The RN indicated residents who are prescribed Coumadin or other blood thinners should be routinely monitored for any type of bleeding due to the increased risk for bleeding,			

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	even with minor injuries. They indicated if a resident was prescribed blood thinners and had a fall, they would assess for bleeding, provide immediate first aid, perform neurological checks and notify the physician. Adverse effects of Coumadin was retrieved from PDR.net (Prescribers Digital Reference) on 2/17/23 at 3:00 P.M. "Warfarin (Coumadin) can cause major or fatal bleeding". Side effects of Coumadin included intercranial bleeding, hypotension, syncope (passing out), and dizziness. The MAR and Communication Log notes hadn't indicated side effects from Coumadin were monitored routinely or following the resident's multiple falls. A current facility policy, titled "Medication Administration Policy and Procedures" was provided by the facility on 2/17/23 at 3:41 P.M., and stated the following: "It is the facility's policy to administer medication for those residents assessed by a licensed nurse as needing this service...If any side effects are noticed, document the observed side effects, inform the Director of Wellness and if needed, contact the physician...." This State Residential Finding relates to Complaint IN00400850.			