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	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PRIMROSE RETIREMENT COMMUNITY OF KOKOMO	329 W RAINBOW DR KOKOMO, IN 46901

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00381855. Complaint IN00381855 - Substantiated. State deficiencies related to the allegations are cited at R52. Survey dates: July 26 and 27, 2022 Facility number: 011555 Residential: 71 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-5. Quality review was completed on August 3, 2022.	R 0000	Please accept this as the Plan of Correction for Primrose Retirement Community of Kokomo.	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to ensure a resident was free from neglect, related to a resident with a diagnosis of vascular dementia and who was identified as a high risk for falls and was left unattended on the toilet by CNA 1, then fell and fractured her nose for 1 of 1 residents reviewed for neglect. (Resident B) Finding includes:	R 0052	**R 052 Resident Rights Offense** 1. What Corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Nursing staff have been re-educated on the needs of Resident B.	08/31/2022

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

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	A document, titled "Incident Details for Resident Name," dated 7/27/22, indicated Resident B had an unwitnessed fall in her bathroom on 3/3/22 at 3:20 p.m. The DNS indicated in the incident report upon her entering the resident's apartment, she was found lying face down and bleeding. The resident's head was rolled to the side and a laceration to the bridge of the nose was visible, which was examined. 911 was called, then the resident was assisted to roll onto her back and blood was noted to her face and nasal area. She was transported to the hospital. The incident facts indicated Resident B was left alone in the bathroom and attempted to get up unassisted while CNA 1 went to get new clothes for her and the resident fell. The record review for Resident B was completed on 7/27/22 at 2:30 p.m. Diagnoses included, but were not limited to, vascular dementia, Parkinson's disease and depression. A document, titled "Resident Service Plan Without Schedule," signed on 2/2/22 by the resident and DNS, indicated Resident B had a Mini Mental Status Exam (assessed the residents overall brain function) of 18. A score of 10-20 indicated moderate cognitive impairment. The dressing and grooming category indicated she required two persons to assist with dressing. The note section indicated the resident now required the assistance of at least two persons for transfers. The general mobility section indicated the resident required the physical assist of two persons for transfers. The safety and wellness section indicated the resident had an increased potential for falls and she had more than one fall within the last year.		2. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice? All residents have the potential to be affected by the alleged deficient practice. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the alleged deficient practice does not recur? Nurse staff will be re-educated on orientation documentation and procedures by August 31st. The Director of Nursing or her designee will routinely review documentation of new nurse staff to ensure documentation is appropriate. If the review does not reach a 95% threshold further education would be completed for the appropriate staff members by the Director of Nursing or her designee. 4. How the corrective action will be monitored to ensure the alleged deficient practice with not recur, i.e. what quality assurance program will be put into place? The Director of Nursing or her designee will report to the Quality Assurance committee monthly of their review results. A percentage of 95% would be the acceptable threshold. The Quality Assurance committee will review the findings	

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	A document, titled "Mobility Assessment," dated 1/27/22, and signed by the DNS on 2/2/22, indicated the resident had a diagnosis of Parkinson's disease, vascular dementia as well as incontinence and an unsteady gait. She exhibited confusion or dementia. She had risks for falling such as; she was unable to get her shoes on properly occasionally and she had an unsteady gait. The fall investigation for Resident B was requested. The fall investigation was provided by the Executive Director (ED) on 7/26/22 at 2:26 p.m. An "Indiana State Department of Health survey Report System" document, undated, indicated on 3/3/22 at approximately 3:20 p.m., CNA 1 was assisting Resident B in the bathroom when she stepped away to retrieve clean clothing for the resident. She asked the resident not to move and told her she would be right back. The resident attempted to stand unassisted and fell. The resident was transported to the hospital by 911 and returned to the facility later the same day. She had a fractured nose. The preventative measures taken by the facility, to prevent further falls was the resident was being attended by two staff members and she was re-educated to wait for staff assistance before standing up. A document, titled "Post Fall Investigation," indicated Resident B's fall was on 3/3/22 at 3:20 p.m. The resident was identified as a "High Risk" prior to her fall and had history of falls. She had to stand without assistance. The physical status of the resident at the time of the fall was she had weakness and fatigue. She was sitting on the toilet, while the CNA was getting her a new pair of pants due to she had soiled the pair of pants she had on and she attempted to stand without assistance.		monthly and take appropriate actions if needed. 5. By what date the systemic changes will be completed? August 31, 2022	

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	A document, titled "Resident Service Delivery Daily Record," was dated 3/1/22. The directions indicated the staff was to use the form to create a resident specific service delivery record. The staff were to enter the time of day the scheduled items was to be performed. The staff member was to initial each service delivered/observed, in the time and date and space provided. The staff members were to verify their initials on the reverse side of the paper. Under the Service category, there was a section, which indicated Resident B required an assist of two with dressing and she was a fall risk. There was initials marked in both box for the 3/3/22, dayshift indicating 2 staff members had assisted her with dressing for the shift and the staff members who provided care for her knew she was a fall risk. An untitled document, dated 3/4/22, indicated "Please sign below indicating you have reviewed the residents plan of care" signed by CNA 1 and dated 3/14/22. An untitled document, dated 3/6/22, indicated "Reviewed with New CNA that this resident (referring to Resident B) is a 2 person assist" signed by the Director of Nursing Services (DNS) and CNA 1. A document, titled "CT [Computerized Tomography] head without IV [Intravenous] contrast," dated 3/3/22, indicated Resident B fell forward hitting her face and head in the bathroom causing a laceration to the bridge of her nose. She had a right frontal scalp hematoma (a collection of blood outside the blood vessels, which causes pain and swelling. Results from injury to larger blood vessels)/contusion (an area of injured tissue of skin in which the blood capillaries have			

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	been ruptured. This is the medical term for bruise.) A document, titled "CT Maxillofacial without Contrast," dated 3/3/22, indicated Resident B fell forward hitting her head in the bathroom causing a laceration to the bridge of her nose and pain to her nose with swelling. 1. The resident had a mild comminuted (the bone was broken into two or more pieces and usually caused by high-impact injuries) buckle fracture (one side of the bone bent, but did not actually break through the bone) of the distal (farthest from the tip of the nose) right nasal bone and nasal tip with adjacent soft tissue contusion. 2. The resident had a soft tissue contusion to the right paramedian frontal calvarium (the top part of the skull) without an adjacent calvaria fracture. During an interview, on 7/27/22 at 1:45 p.m., the DNS indicated CNA 1 was the CNA who cared for Resident B on 3/3/22, when she fell. She was a new CNA to the facility and she did not read the resident's plan of care prior to taking care of her, so she did not know the resident was a two person assist for transfers or dressing. CNA 1 left her alone in the bathroom on the toilet while she went to get her a clean pair of pants and the resident stood up by herself and fell. The DNS wrote her up for leaving the resident in the bathroom by herself. She should have had another staff member with her. During an interview, on 7/27/22 at 2:26 p.m., Resident B was observed sitting in a recliner in her apartment watching television. Her wheelchair was observed sitting in the doorway of her bedroom approximately 75 feet away from her chair. She indicated she fell a lot because her legs did not hold her anymore when she tried to get up by herself. She turned her call light on for help,			

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	but the staff did not always get to her soon enough, so she tried to get up by herself and that was when she fell. During an interview, on 7/27/22 at 2:44 p.m., the DNS indicated the CNAs were not assigned residents to care for. Whenever a light went off, whichever CNA was closest to the resident with the light on went to answer the call light. They all work together to get the showers completed and get the residents who require assistance to get up done. CNA 1 should have used her I-Phone to call for assistance when she knew she needed new clothes for Resident B, instead of leaving her in the bathroom by herself to go get the clean clothes. During an interview, on 7/27/22 at 3:30 p.m., the ED and DNS were in attendance. The ED indicated CNA 1 had worked at the facility at another time, but quit and came back. She was recently re-hired and was still in her 90 day probationary period. At that time, the DNS indicated CNA 1 no longer worked at the facility, but it was not because of the incident with Resident B, it was due to work issues. A current policy, titled "PROCEDURE: MOBILITY/FALL MANAGEMENT," undated and provided by the ED on 7/26/22 at 3:45 p.m., indicated "...After a fall or for a new resident with a history of falls, the Mobility Assessment is completed and intervention(s) added to the resident's Service Plan. Depending on severity and frequency a Negotiated Risk Agreement should also be considered...." A current policy, titled "Assisted Living Resident Occupancy Agreement," revised on 7/1/22 and provided by the ED on 7/26/22 at 1:45 p.m.,			

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	indicated "...RESIDENT'S RIGHTS AND RESPONSIBILITIES: The facility shall adopt and follow a written policy of resident rights...This policy shall not exclude, take precedence over, or in any way abrogate the legal and constitutional rights enjoyed by all adult citizens and shall include, but is not limited to the following: Indiana Resident Rights...(v) Residents have the right to be free from:..(5) neglect...." This State finding relates to Complaint IN00381855.			