| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155236 | A. BUILDING 00<br>B. WING | 12/01/2021 |

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| AVON HEALTH & REHABILITATION CENTER | 4171 FOREST POINTE CIRCLE<br>AVON, IN 46123 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00367326.<br><br>Complaint IN00367326 - Substantiated. Federal/state deficiencies related to the allegations are cited at F684.<br><br>Survey dates: November 29, and December 1, 2021.<br><br>Facility number: 000141<br>Provider number: 155236<br>AIM number: 100283860<br><br>Census Bed Type:<br>SNF/NF: 114<br>SNF: 1<br>Total: 115<br><br>Census Payor Type:<br>Medicare: 13<br>Medicaid: 82<br>Other: 20<br>Total: 115<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on December 9, 2021. | F 0000 | **The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.** | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the | | | |

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

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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| | facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br><br>Based on record review and interview, the facility failed to ensure an incident was documented and reported in a timely manner for 1 of 3 residents incidents reviewed (Resident B).<br><br>Findings include:<br><br>Resident B's record was reviewed on 11/30/21 at 11:07 a.m. Diagnoses on the profile included, but were not limited to, unspecified protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), unspecified dementia without behavioral disturbance (a loss of thinking ability, memory, attention, logical reasoning, and other mental abilities, difficulty in walking, and need for assistance with personal care.<br><br>The resident had been admitted to the facility on 9/20/21, due to a displaced intertrochanteric fracture of the left femur.<br><br>An admission Minimum Data Set (MDS) assessment, dated 9/23/21, indicated the resident had severe cognitive deficit and required extensive assistance of 2 or more persons with transfer.<br><br>A care plan, dated 9/20/21, indicated the resident required assistance with activities of daily living (ADLs) related to her hip fracture. Interventions included, but were not limited to, the resident required physical assistance of 2 staff members and the use of a Hoyer lift for transfers. | F 0684 | The facility will ensure this requirement is met through the following corrective measures:<br>1. Resident B continues to reside at the facility. Her fall plan of care has been reviewed and interventions remain appropriate.<br>2. All residents have the potential to be affected. See below for corrective measures.<br>3. The policy entitled "Fall Investigation and Risk Evaluation" was reviewed and no changes were indicated. Nursing staff will be re-educated on this policy, especially as it relates to the definition of a fall. The DON or her designee will review the 24-Hour Report 5 times weekly and review all falls to ensure appropriate documentation and notification has been completed for 8 weeks and until 100% compliance has been achieved, then weekly for 8 weeks and until 100% compliance has been maintained, then monthly for at least two months to ensure on-going compliance.<br>4. The findings of these audits will be presented at the facility's monthly QAPI meetings and the plan of action adjusted accordingly. | 12/23/2021 |

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| | A late entry progress note, created on 10/6/21 at 11:44 a.m., indicated on 10/1/21 at 12:15 p.m., Licensed Practical Nurse (LPN) 7 was called to the resident's room by Certified Nurse Assistant (CNA) 6. Upon entry the LPN observed the resident had attempted to transfer self from her wheelchair to her bed. The resident was positioned so her left buttock/hip was on edge of her wheelchair. Her left outer calf rested on top of the wheelchair foot pedal, and her left elbow/arm was supporting most of her bodyweight on the mattress of the bed which was at a higher elevation than the wheelchair. The resident's right foot was on the ground between the foot pedals of the wheelchair. Both staff assisted resident to change positions and returned to a proper sitting position in the wheelchair.<br><br>A late entry change of condition evaluation, with a lock date of 10/7/21 at 6:28 a.m., related to the incident dated 10/1/21, indicated the resident had edema to her left lower extremity and complained of pain to her left wrist. The record lacked documentation of an evaluation for this incident prior to this late entry evaluation.<br><br>A physician encounter document, dated 10/1/21, indicated the physician had seen the resident at the request of the staff related to swelling of her left leg and complaints of pain in her left hand. The resident denied any falls at the facility. The physician documented decreased muscle strength to her left upper extremity and pain in the joints of her left hand.<br><br>A progress note, dated 10/1/21 at 8:00 p.m., indicated the resident complained of aching arm pain. | | | |

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| | A physician encounter document, dated 10/4/21, indicated the Nurse Practitioner (NP) had seen the resident for left shoulder pain and x-ray results. The document indicated the resident had been seen by the physician on 10/1/21 and had ordered an x-ray of the resident's hand. The x-ray results indicated moderate osteoarthritis (inflammation of one or more joints, commonly a form of arthritis that affects joints in the hand, spine, knees and hips), but no fracture or dislocations. The document indicated no falls at the facility. The NP documented reduced range of motion to the left shoulder with guarding (favoring) and pain with bruising to her left shoulder. X-rays (2 views) of left shoulder and humerus were ordered.<br><br>A progress note, titled eINTERACT Summary for Providers, dated 10/4/21 at 1:13 p.m., indicated bruising to left shoulder. An order was given for x-ray 2-view to left shoulder and humerus, family aware.<br><br>A late entry physician narrative progress note, dated 10/5/21 at 9:41 a.m., indicated the patient had increased pain to left hand and an x-ray was done and showed no acute fracture, but did show osteoarthritis to this hand. Patient had increased agitation towards staff and did not want to be moved or touched. Patient did have increased bruising and pain to her left shoulder. The primary care nurse practitioner had ordered an x-ray of her left shoulder to determine the origin of pain. There were no falls noted in the chart. Therapy now recommended to use a Hoyer lift for transfers at this time for safety. The patient continued to work with occupational therapy on upper body strengthening and ROM to increase independence with functional mobility and ADLs.<br><br>A physician encounter document, dated 10/5/21, | | | |

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indicated the resident was seen by the physician at the staff's request due to abnormal left shoulder x-ray results of unspecified displaced fracture of the neck of the left humerus. The resident was not able to explain what had happened.

A progress note, dated 10/5/21 at 1:17 p.m., indicated an x-ray had been completed and results returned with a fracture to surgical neck of left humerus. Director of Nursing (DON) and physician notified and new order to schedule ortho appointment given. Daughter was aware.

A reportable incident report was completed and sent to the Indiana Department of Health (IDOH) on 10/5/21 at 12:20 p.m.

On 12/1/21 at 9:42 a.m., a review of the facility's internal investigation documents, provided by the DON on 11/30/21 at 2:30 p.m., was completed. The documents indicated the following timeline of events:

a. On 10/3/21, the document indicated the resident's daughter had approached the Administrator with concerns, due to bruising noted to her mother's arm. The Nurse Practitioner was present in the facility, at that time, and assessed the resident and noted bruising to her left upper arm and shoulder area.

b. On 10/4/21, x-rays on the left arm and shoulder were ordered.

c. The x-rays were completed on 10/5/21, and the resident was found to have an acute fracture of the surgical neck of the left humerus.

d. The facility's investigation was initiated on 10/5/21, which indicated, on the morning of

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10/1/21, the resident had attempted to transfer herself from her wheelchair to her bed. She had been found seated on the edge of her wheelchair with her left arm elevated on her bed next to her. Staff assisted her in transferring to her bed.

e. The DON attempted to interview the resident, but the resident had no recollection of the incident. The resident indicated to the DON that she had no fear of abuse. The DON interviewed 5 other residents on the same hallway and no concerns of abuse were noted.

f. The Interdisciplinary Team (IDT) met on 10/6/21, to review the incident. The resident attempting to transfer herself was determined to be the root cause of the incident. Therapy reviewed the fracture results and determined the fracture appeared to have been consistent with the positioning of the resident's arm on her bed, during the transfer attempt. The resident had gone to the Orthopedic Physician on 10/5/21, and had a sling put into place on her left arm. Range of Motion (ROM) to her left arm and as needed (PRN) pain medication were ordered. In-service training was placed for nursing staff to educated on the current status of the resident and her restrictions.

The investigation documents included an undated statement from CNA 6. The CNA indicated she had entered the room after hearing the resident yell for help and found the resident trying to hold herself up on her bed, which was up in high position. The CNA described the resident as being halfway off her wheelchair and almost on the floor.

An undated statement from LPN 7 indicated he had been called into the resident's room by staff.

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| | He asked the staff if the resident was on the floor and was told no, but she would be soon. Upon entry, he described the resident being in an abnormal position. The resident's far left buttock/hip was on the edge of her wheelchair seat, with her left leg was resting on the left leg panel of the wheelchair. Her left lateral calf was making most direct contact with the leg panel. Her right foot was on the floor between the leg rests of the wheelchair. The resident's body was leaning to her left with her left arm/elbow supporting most of her weight on the mattress of her bed. The mattress was slightly higher than her wheelchair. The LPN indicated he immediately supported the resident by bracing his knee against the resident's left buttocks/hip so that the resident would not slide forward out of her chair. He then placed his forearm just below the left underarm and applied slight pressure towards her right side to remove some of the weight/pressure off of the resident's left arm. CNA 7 adjusted the resident's feet and the 2 staff adjusted the resident. The CNA moved the resident by her right arm and the waistband on right side. The LPN continued pressure going to the right arm from below the left underarm and used the waistband of the resident's pants to the left side to move the resident. The physician saw the resident about 1 hour later for left lower extremity edema. At that time the resident complained of pain to her left wrist to the physician.<br><br>During an interview, 12/1/21 at 2:41 p.m., the DON indicated the event was not considered a fall due to the resident holding herself up and not ending up on the floor.<br><br>During an interview, on 12/1/21 at 11:57 a.m., LPN 7 indicated he immediately visually assessed the resident when he entered the room, and she did | | | |

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| | not appear uncomfortable. He requested the physician to check the resident's left lower extremity due to an indentation on her calf due to swelling in the leg. He believed he told the physician about the incident but could not remember for certain. The resident never said anything to him about her wrist, but she had told the doctor about the wrist pain. He noticed no indication of any problem with her shoulder during his assessment. He had been instructed to write the late entry narrative note and the late entry change of condition report after the fracture had been discovered.<br><br>During an interview, on 12/1/21 at 11:59 a.m., CNA 6 indicated she heard the resident yelling for help inside her room. When she entered the room, she found the resident with her right foot on ground and toe of left foot on the ground with her left calf resting on foot pad of the wheelchair. Her left arm was holding her up, resting on bed. The CNA believed that the resident would have ended up on the floor, if not for her arm on the bed holding her up. She immediately yelled for nurse. The nurse came in, assessed the resident, and then they adjusted the resident to a sitting position in her wheelchair. She could not remember any complaints from the resident of pain at that time. She and LPN checked the resident's arm for redness and bruising and nothing was found. The resident did not complain of pain when touched. The resident did not complain of any pain until the next day, when the resident reported pain to her left arm. At that time, she reported the left arm pain to LPN 7. The CNA was unsure if the physician saw the resident on 10/1/21, the date of the incident.<br><br>During a telephone interview, on 12/1/21 at 12:03 p.m., Physician 5 indicated he saw the resident on | | | |

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| | 10/1/21, per the staff's request. He was asked to see the resident because the family was concerned about her left wrist and left lower extremity. The resident did report wrist pain to him. He assumed that's why he had been asked to see her. He was not made aware of any specific incidents, concerns or anything which had happened with the resident, nor was he made aware of any incidents with the resident after the fact or at the time the fracture was found.<br><br>On 11/30/21 at 2:42 p.m., the DON provided a document, with a revised date of 6/21, titled, "Fall Investigation and Risk Evaluation," and indicated it was the policy currently being used by the facility. The policy indicated, "...Definitions..."Fall" refers to...An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall...Procedure: ...6. Notify the...Physician...and document in the medical record...9. The Interdisciplinary Team will review...11. Document the review in the progress notes in the resident's medical record ...."<br><br>This Federal tag relates to Complaint IN00367326.<br><br>3.1-37(a) | | | |