STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155692	A. BUILDING 00 B. WING	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE POINTE OF HUNTINGTON	1180 WEST 500 NORTH HUNTINGTON, IN 46750

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00432892. Complaint IN00432892 - Federal/State deficiencies related to the allegations are cited at F684. Survey dates: April 22 and 23, 2024 Facility number: 002910 Provider number: 155692 AIM number: 200345390 Census Bed Type: SNF/NF: 71 Residential: 49 Total: 120 Census Payor Type: Medicare: 8 Medicaid: 29 Other: 34 Total: 71 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 1, 2024.	F 0000		
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care 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 facility must ensure that residents receive treatment and care in accordance with			

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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	professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure staff reported a resident's change in condition to the nurse before proceeding with care and failed to complete a physical assessment after an unwitnessed fall with head injury for a cognitively impaired and dependent resident for 1 of 3 residents reviewed for accidents (Resident B). Findings include: The clinical record for Resident B was reviewed on 4/22/24 at 10:45 a.m. Diagnoses included dementia, spastic hemiplegia to non-dominant left side, hypertension, stage 3 chronic kidney disease, anxiety disorder, and osteoarthritis. The most current, quarterly, MDS (Minimum Data Set) assessment, dated 2/4/24, indicated Resident B was severely cognitively impaired and rarely or never understood. The resident lived on the secured unit and required extensive assistance of 2 persons for transfers and toileting. A progress note, dated 4/18/24 at 6:20 a.m., indicated Resident B was found lying on her left side next to the toilet, with a pool of blood running next to her head. She was unresponsive. Per the CNA, the resident was sitting on the toilet and fell off. RN 2 and two CNAs assisted Resident B off the floor and into a wheelchair. The resident was very heavy during the transfer. During the transfer into the wheelchair, the resident turned blue in color and was not responding. CPR was not initiated as she had elected a DNR (Do Not Resuscitate) order. RN 2 and three CNAs assisted the resident from her wheelchair and onto the bed. RN 2 and LPN 1 determined Resident B was	F 0684	1 Immediate action(s) taken for the resident(s) found to have been affected include: 1:1 education of the facility's Fall Assessment Policy has been completed with the RN who failed to complete a physical assessment of Resident B following the unwitnessed fall. (attachment A) 1:1 education has been completed with the CNA that failed to report a change in Resident B's condition. (attachment B) 2 Identification of other residents having the potential to be affected was accomplished by: All residents have the potential to be affected by a CNA failing to report changes in condition prior to proceeding with care. All residents have the potential to be affected by a nurse failing to complete a physical assessment following an unwitnessed fall. **3 Actions taken/systems put into place to reduce the risk of future occurrence include:** All RN/LPN's have been educated on the facility Fall Assessment Policy with emphasis placed on the need to complete a physical assessment on all residents who sustain a fall and to document that an assessment was completed. (attachment C)	05/17/2024

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	deceased. A progress note, dated 4/18/24 at 6:20 a.m., indicated LPN 1 responded to a code blue light for Resident B. Resident B was noted to by laying on the floor with her bilateral feet near the toilet and her head pointed toward the bathroom door, with blood pooling under the left side of her head with her eyes open. The CNA indicated the resident fell off of the toilet. RN 2 stayed with the resident and 2 CNAs while LPN 1 left to call 911. Staff notified LPN 1 that the residents' respirations had ceased and she was without a pulse, and was blue in color. Her DNR status was confirmed. The clinical record lacked assessment of Resident B after the unwitnessed fall. The most current vital signs were documented on 4/13/24. The "Post Fall Investigation", dated 4/18/24 at 6:30 a.m., indicated vital signs were not within normal range, but did not indicate measurements of vital signs. In a written statement from the facility investigation, on 4/18/24, CNA Student 3 indicated that CNA 4 and herself assisted Resident B out of bed and placed her on the toilet. Resident B looked stable and the CNA stated they normally left the resident unattended while on the toilet. The CNAs left the restroom and started providing care to Resident B's roommate. They heard a "bang" and went into the restroom and found Resident B on the floor and bleeding from her head. CNA Student 3 pulled the code blue light to alert staff that assistance was needed. In a written statement from the facility investigation, on 4/18/24, CNA 4 indicated prior to transferring Resident B to the toilet, the resident		All CNA's have been educated on changes of condition in a resident and the need to always report anything abnormal immediately to a nurse. (attachment D) **4 How the corrective action(s) will be monitored to ensure the practice will not recur:** The DON will complete audits of all falls, witnessed and unwitnessed, to ensure a physical assessment was completed of the resident following the fall. The audit will be conducted on all falls weekly for 4 weeks and then random fall audits monthly for 3 months until compliance is achieved. Validation audits will be reviewed by administration and the Quality Assurance committee until substantial compliance has been achieved.	

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	didn't have her normal color and was almost pale, with a gray undertone. Both herself and Student CNA 3 placed a gait belt around Resident B, causing the resident to start tensing up. This caused the CNAs to have trouble getting their arms around the resident to get her up. They placed the resident on the toilet and adjusted her 2-3 times to make sure she was far enough back. After adjusting her, they both left to strip her bed. CNA 4 walked into the bathroom and saw the resident "a couple inches off the ground". After CNA Student 3 pulled the code blue cord, CNA 4 left to go find help. RN 2 arrived and told them they needed to get Resident B up off the floor. They struggled to get the resident off the floor and into her wheelchair while holding a towel on her head. CNA 4 noticed the resident looked gray. They transferred the resident from her wheelchair into bed. Resident B did not make any sounds while she was falling or laying on the ground. During an interview on 4/22/24 at 1:03 p.m., LPN 1 indicated on 4/18/24, at approximately 6:20 a.m., the code blue light went off. LPN 1 and RN 2 ran to the resident's room. The resident was on the floor with their feet towards the toilet, and the left side of their forehead on the floor, with blood pooling beneath their head. The resident's eyes were open, but the resident was unresponsive. LPN 1 did not hear the resident make any noise. LPN 1 indicated the resident's color was good. LPN 1 left the room and called 911 and the physician. After making the calls, LPN 1 started to return to the room. On the way to the resident's room, LPN 1 was informed by staff the resident had died. When LPN 1 arrived at the resident's room, the resident's "color was off". LPN 1 and RN 2 monitored the resident for breath sounds and heart beat, but Resident B did not have either present.			

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	During an interview on 4/22/24 at 1:27 p.m., Student CNA 3 indicated, on 4/22/24 during the morning care, she and CNA 4 were getting Resident B up for the day. The CNAs transferred the resident to the wheelchair and then to the toilet. They had to adjust the resident on the toilet 2-3 of times before leaving the resident alone in the bathroom. CNA Student 3 indicated the resident had requested privacy. CNA Student 3 had never provided care to Resident B before, and was not familiar with the resident. While providing care to the resident's roommate, they heard a "big bang" and went to the bathroom to investigate. Resident B was observed on the floor and her head was bleeding. The resident did not say anything. CNA Student 3, CNA 4, and RN 2 picked the resident up and placed her in a wheelchair, then transferred the resident from the wheelchair to the bed. The resident did not make a sound during any of the transfers. Once the resident was in bed, RN 2 checked for respirations and found none. During an interview on 4/22/24 at 2:03 p.m., RN 2 indicated, on 4/18/24, she had just gotten to work and received report when the code blue alarm sounded. RN 2 and LPN 1 ran to the resident's room. The resident was on the bathroom floor, with her head bleeding. RN 2 indicated their first reaction was to get the resident to safety and get help. The resident was verbally unresponsive, had a gray pallor, and the resident's eyes were open and not moving. "She was not making any sounds." RN 2 told LPN 1 to call 911 and the physician. RN 2, CNA Student 3, and CNA 4 transferred the resident to the wheelchair and then from the wheelchair to the bed. Once the resident was in bed, she turned blue. The resident was found to have no pulse or heartbeat. She did not			

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	remember if the resident had any independent movement during the transfers. RN 2 did not assess the resident. During an interview, on 4/22/24 at 3:12 p.m., LPN 11 indicated Resident B was verbal at times, but normally would just yell. Resident B required two-person assistance with transfers and activities of daily living. During an interview, on 4/22/24 at 3:27 p.m., CNA 8 indicated Resident B needed complete support with her activities of daily living including transferring on and off the toilet. She did not leave the resident unattended in the bathroom, due to resident leaning toward her left side while sitting on the toilet. During an interview, on 4/22/24 at 4:06 p.m., ADON indicated, during an unwitnessed fall with injury for a cognitively impaired resident, she would start doing assessments and not move the resident to prevent further harm if they were unconscious. During an interview, on 4/23/2024 at 9:46 a.m., the ADON indicated it was not appropriate to move/transfer a resident who was found unresponsive after an unwitnessed fall. The nurse should assess the resident. During an interview, on 4/23/24 at 12:59 p.m., the DON and ADON indicated when a resident fell, an assessment should always be completed. An assessment should contain vital signs and a head to toes assessment. After reviewing the clinical record, neither the DON nor the ADON could find an assessment of Resident B after the fall on 4/18/24. The DON and ADON both indicated there should have been an assessment completed			

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	and staff should not have moved the resident from the floor. During an interview, on 4/23/24 at 1:34 p.m., both the DON and ADON indicated if a resident presented with a change in condition, this information should be discussed with the nurse. Review of a current policy, darted October 2023, titled "Head Injury" was provided by the Administrator on 4/23/24 at 9:15 a.m. The policy indicated the following: " .... Procedure: 1. Assess resident following a known, suspected, or verbalized head injury. The assessment shall include, at a minimum: a. Vital Signs. b. General condition and appearance. c. Neurological evaluation for changes in: i. Physical functioning 11. Behavior iii. Cognition iv. Level of consciousness v. Dizziness vi. Nausea vii. Irritability viii. Slurred speech or slow to answer questions. d. Evaluation of the head, eyes, ears, and nose for significant changes in vision, hearing, smell, or bleeding ...." Review of a current policy, dated 1/2015, titled "Fall Assessment Policy" was provided by the Administrator on 4/22/2024 at 4:20 p.m. The policy indicated the following: " .... Procedure: 1. Call for nurse and stay with the resident 2. Check to see if resident is breathing 3. Do not move resident 4. Reassure resident by talking to him/her in a			

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	calm and supportive manner 5. Apply direct pressure to any bleeding area 6. Check resident's pulse, respiratory rate and blood pressure; If resident is a DIABETIC-MAY check the residents blood glucose level. ...." This citation relates to Complaint IN00432892. 3.1-37(a)			