STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155200	A. BUILDING 00 B. WING	10/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY NURSING CENTER	1564 S UNIVERSITY BLVD UPLAND, IN 46989

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00387633 Complaint IN00387633 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Survey dates: October 3, 4, 5, 6 and 7, 2022 Facility number: 000107 Provider number: 155200 AIM number: 100290330 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 7 Medicaid: 48 Other: 9 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 12, 2022	F 0000	University Nursing Center is alleging compliance on 10.28.22 and is requesting paper compliance for the annual recertification and state licensure survey and complaint IN00387633.	
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Moore	Administrator	10/28/2022

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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	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to provide adequate supervision and interventions to prevent falls for 4 of 6 residents reviewed with falls (Residents 37, Resident 36, Resident 48 and Resident 63). Findings include: 1. On 10/3/22 at 10:09 a.m., Resident 37 was in the common area sitting in a wheel-chair on the secure memory unit. On 10/4/22 at 1:47 p.m., she was lying in bed, non-skid strips were on the floor beside her bed and her call light was within reach. On 10/5/22 at 9:14 a.m., she was lying in bed. On 10/5/22 at 11:26 a.m., she was lying in bed, and called out to the nurse as he walked by her room. Resident 37's record was reviewed on 10/4/22 at 3:29 p.m. Diagnoses included, but were not limited to, abnormalities of gait and mobility and dementia with behavioral disturbance. Current physician orders included the following; a. Non-skid strips beside bed, in front of recliner and in front of toilet. The order was dated 7/1/22. b. Scoop mattress, dated 8/10/22. c. An appointment at an orthopedic center was scheduled for 10/19/22.	F 0689	**F 689 Free of Accident Hazards/Supervision Devices** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · Resident 63 no longer resides at the facility. · Resident 36, 37, and 48: Fall care plans and interventions have been reviewed and updated by IDT, increased care rounds to hourly to prevent falls. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; · All residents with repeat falls have the potential to be affected. · Audit to be completed by 10/25/22 per DNS/Designee to identify residents with repeat falls in the past 30 days, to ensure fall interventions are in place and care plans are updated as needed. · DNS/Designee to review residents identified via audit to ensure adequate supervision/interventions in place. What measures will be put into place or what systemic changes will be made to ensure that the	10/28/2022

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	An admission MDS (Minimum Data Set) assessment, dated 7/4/22, indicated she had moderate cognitive impairment. She required extensive assistance with bed mobility, transfers, dressing, personal hygiene, to walk in room and with locomotion on the unit. A current care plan, dated 6/27/22, indicated she was at risk for falls and required assistance or supervision for mobility, transfer, or ambulation, unsteady gait and lack of understanding of one's physical and cognitive limitations. The goal, with a target date of 12/1/22, indicated her risk factors would be reduced in an attempt to avoid significant fall related injury. Interventions included, but were not limited to, non-skid strips beside bed, in front of recliner and in front of toilet and non-skid footwear, approach start date was 6/27/22. Resident reminded to call for staff assist, approach start date was 7/8/22. Scoop mattress, approach start date was 8/9/22. Touch-pad call light when available, approach start date was 8/10/22. Sleep/wake cycle, remind/encourage non-skid footwear and extend non-skid strips at bedside, approach start date was 8/22/22. Ensure non-skid socks at bedtime, approach start date was 9/6/22. Offer to toilet at 6:00 a.m. shift change, night light in room and physician to review medications related to blood pressure, approach start date was 9/21/22. A progress note, dated 6/27/22 at 3:45 p.m., indicated she had admitted from a nearby hospital and was oriented to self only. A progress note, dated 6/27/22 at 6:45 p.m., indicated staff assisted to walk her to the bathroom with assist of a gait belt. She was noted to be weaker on the right side and leaning to the right. She was able to follow simple step		deficient practice does not recur; · All Staff in-service to be complete by 10/25/22 per DNS/Designee on Fall Prevention Program. · Charge Nurse will complete a Fall Event on all residents with a change in plains. · IDT will review all completed Fall Events daily in Clinical Meeting, determine root cause of fall and implement supervision/intervention to prevent reoccurrence. · Resident care plan will be updated with new interventions and added to the resident profile. · DNS/designee will round each shift to ensure fall interventions are in place per care plan. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as falls will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not	

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	instructions only. Resident walked from bathroom back to bed with assist of a four-wheeled walker, gait belt and staff assistance. A Fall Event Note, dated 6/29/22 at 9:23 p.m., indicated she had an unwitnessed fall. She had been found sitting on her buttocks in front of recliner in her room. She had indicated she thought she could take herself to the bathroom. No injuries were noted and there was no change to range of motion status. The interventions initiated to prevent another fall included the resident was placed in a low bed, encouraged to use call light and keep within reach. An IDT (Interdisciplinary Team) Fall Review Note, dated 6/30/22 at 4:22 p.m., indicated she had fallen on 6/29/22 at 9:23 p.m. The immediate intervention included she had been assessed for injury and assisted up to the bathroom. Intervention in place at the time of the fall was non-skid footwear. Root cause of the fall was determined to be that the resident had slipped. Interventions put in place to address the root cause of the fall: non-skid strips beside bed and in front of recliner. A Fall Event Note, dated 7/7/22 at 3:30 p.m., indicated she had an unwitnessed fall, had been found on the floor in the hallway on her back, shoes on and a wheeled walker beside her. She indicated she had been making a turn and decided to sit down. No injuries noted. The intervention initiated to prevent another fall was for close monitoring. An IDT Fall Review Note, dated 7/8/22 at 10:35 a.m., indicated she had fallen on 7/7/22 at 3:30 p.m. The immediate intervention included she had been assessed for injury, was assisted up, denied dizziness with standing and able to bear weight.		met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 10/28/22 Paper Compliance is requested.	

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	No injury had been noted at the time of the fall, on 7/8/22 she was noted to have a skin tear and bruise to the top of her left hand that measured 0.2 cm (centimeters). Interventions in place at the time of the fall were non-skid footwear, non-skid strips at bedside, in front of recliner and in front of toilet. Root cause of the fall was determined to be she had lost her balance/weakness when she had attempted to sit on the rollator walker. Intervention put in place to address the root cause of the fall: she was on therapy caseload and therapy had been asked to screen her related to the type of walker and ability to sit on walker. A Fall Event Note, dated 8/2/22 at 12:30 a.m., indicated she had an unwitnessed fall. She had been found lying on her left side a few feet from her bed, she had taken her shoes off. No injury noted. She had started antibiotics for an UTI (Urinary Tract Infection) on 8/1/22. The intervention initiated to prevent another fall indicated she had been re-oriented to call light use and was to be bed-checked every hour. An IDT Fall Review Note, dated 8/2/22 at 8:33 p.m., indicated she had fallen on 8/2/22 at 4:25 a.m. The immediate interventions included she had been assessed for injury, assisted to the bathroom and then back to bed. Interventions in place at the time of the fall were non-skid strips beside bed, in front of recliner and in front of toilet and non-skid footwear. Root cause of the fall was determined to be the bed was not at an adequate level, she was being treated for an UTI that required two antibiotics for two different organisms and she had increased confusion. Intervention put in place to address the root cause of the fall: occupational therapy to screen for proper bed height. A Fall Event Note, dated 8/4/22 at 7:00 p.m.,			

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	indicated she had an unwitnessed fall. She had been found lying on her back beside her bed, she was not wearing shoes. She indicated she had been sitting on the side of her bed and slipped off onto the floor. The intervention initiated to prevent another fall indicated she had been sent to the emergency room for evaluation and treatment and was placed on one-on-one until emergency medical technicians arrived. A progress note, dated 8/4/22 at 7:17 p.m., indicated there had been no visible injury noted from fall, she had been assisted to recliner with two staff, noted she was not able to bear weight on her right hip and she reported severe pain to there right hip since the fall. A progress note, dated 8/4/22 at 7:50 p.m., indicated she had been transported to the emergency room, continued to be unable to bear weight to right lower extremity but tolerated the transfer well. A progress note, dated 8/5/22 at 6:40 a.m., indicated emergency room nurse reported the resident had been transported to another hospital. An IDT Fall Review Note, dated 8/5/22 at 3:45 p.m., indicated she had fallen on 8/4/22 at 7:00 p.m. The immediate intervention included she was assessed and physician was notified of right hip pain and order received to sent to the emergency room for evaluation and treatment. Interventions in place at the time of the fall were to ensure bed height in position marked by therapy, reminded to call for assist, non-skid footwear, non-skid strips beside her bed, in front of recliner and in front of toilet and was on occupational and physical therapy caseload. Root cause of the fall was determined to be UTI with confusion with			

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	antibiotic therapy in progress and low hemoglobin and red blood cells. Intervention put in place to address the root cause of the fall: all fall interventions to be reviewed and updated upon her return from the hospital. A progress note, dated 8/8/22 at 6:15 p.m., indicated she had returned from the hospital after right hip fracture with surgical pining completed on 8/6/22. Encouraged several times by staff to use call light for any needs and reminded her to wait for staff assistance before she got up. A Fall Risk assessment, dated 8/8/22 at 6:15 p.m., indicated her total fall risk score was 28 points. The scoring key indicated scoring greater than 13 points indicated high fall risk. A progress note, dated 8/9/22 at 10:31 a.m., indicated the IDT had reviewed her related to re-admission, she had re-admitted on 8/8/22 from the hospital after right hip fracture with surgical pining completed on 8/6/22 and was at risk for falls with interventions in place. A progress note, dated 8/10/22 at 1:58 p.m., indicated the IDT had reviewed fall interventions since the resident's readmission to the facility. Recommendations included to have bed in lowest position when occupied, touch-pad call light when available for easy activation, scoop mattress for bed boundaries, therapy screen for positioning in wheel-chair, wheel-chair cushion and assistive devices. Maintenance to readjust the non-skid strips to the length of the side of the bed and to place in front of the recliner that was no longer right beside her bed. An 8/15/22 significant change MDS assessment indicated she had severe cognitive impairment.			

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	She required extensive assistance with bed mobility, transfers, locomotion on the unit, dressing, toilet use and with personal hygiene. A progress note, dated 8/19/22 at 1:10 p.m., indicated the IDT had reviewed the resident. She was noted to have increased confusion. Discussed option for transferring her to the secure memory care unit with her family and they agreed to the transfer. The resident had been notified and also agreed to the transfer. A Fall Event Note, dated 8/19/22 at 2:30 p.m., indicated she had an unwitnessed fall. She had been found lying on the floor towards the end of her bed. No injury noted. A progress note, dated 8/19/22 at 7:05 p.m., indicated she had been transferred from the skilled unit to the memory care unit. A Fall Event Note, dated 8/19/22 at 10:52 p.m., indicated she had an unwitnessed fall. She had been found sitting on the floor with her back against the recliner, no injuries noted. 15 minute safety checks started. An IDT Fall Review Note, dated 8/22/22 at 2:42 p.m., indicated she had fallen on 8/19/22 at 2:30 p.m. The immediate intervention indicated she had been assessed by the nurse and brought to the common area. Interventions in place at the time of the fall were touch-pad call light, scoop mattress, bed in lowest position, resident reminders of call light, non-skid footwear, non-skid strips at bedside, in front of recliner and in front of toilet. Root cause of the fall was determined to be recent move to the secure unit, new environment, new routine and possibly slipped of the edge of the mattress. Interventions put in place to address the			

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	root cause of the fall: extend non-skid strips at bedside toward end of bed and continue previous fall interventions. An IDT Fall Review Note, dated 8/22/22 at 2:48 p.m., indicated she had fallen on 8/19/22 at 10:52 p.m. The immediate intervention indicated she had been assessed by a nurse and 15 minute safety checks had been started. Interventions in place at the time of the fall were low bed, call light reminders, touch-pad call light, scoop mattress, non-skid footwear, non-skid strips beside bed, in front of toilet and recliner. Root cause of the fall was determined to be new environment, recent move to the secure unit, not resting/sleeping well causing increased confusion. Interventions put in place to address the root cause of the fall: sleep/wake cycle initiated and reminders/encouragement to utilize non-skid footwear. A Fall Event Note, dated 8/24/22 at 6:10 p.m., indicated she had an unwitnessed fall. She had been found sitting on her buttocks in her room near the bed and wheel-chair. An abrasion had been noted to her left elbow, red, no drainage and measured less than 1.0 cm. Environmental factors that had been observed in area of the fall indicated a recent room change. The intervention initiated to prevent another fall indicated she had been re-educated about getting help for transfers. No other interventions were put into place. An IDT Fall Review Note, dated 8/25/22 at 4:08 p.m., indicated she had fallen on 8/24/22 at 6:10 p.m. The immediate intervention indicated she had been assessed for injury and assisted up from the floor. She had sustained an abrasion to her left elbow. Interventions in place at the time of the fall included low bed, call light reminders, touch-pad			

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	call light, scoop mattress, non-skid footwear, non-skid strips to beside and in front of toilet. Root cause of the fall was determined to be she was self-transferring out of wheel-chair and the wheel-chair was not locked. Interventions put in place to address the root cause of the fall: anti-rollback device to wheel-chair. A Fall Event Note, dated 9/4/22 at 9:20 p.m., indicated she had a witnessed fall. She had been seen exiting the bathroom and did not have shoes on. The witness indicated she did not have her walker with her, had turned to shut the bathroom door and stumbled. The intervention initiated to prevent another fall indicated non-skid socks had been applied. No injuries noted. NO new interventions were put into place. An IDT Fall Review Note, dated 9/6/22 at 12:43 p.m., indicated she had fallen on 9/4/22 at 9:20 p.m. The immediate intervention indicated she had been assessed for injury, assisted up from floor and back to bed. Interventions in place at the time of the fall included anti-rollback device to wheel-chair, non-skid strips beside bed and in front of toilet and recliner, encourage non-skid footwear, touch-pad call light, low bed and scoop mattress. Root cause of the fall was determined to be she had lost her balance and was without shoes or socks. Intervention put in place to address the root cause of the fall: non-skid socks at bedtime. No new interventions were put into place. A Fall Event Note, dated 9/20/22 at 6:50 a.m., indicated she had an unwitnessed fall. She had been found lying on her right side on the floor of her room. She was fully clothed and had socks on. No injury noted. The interventions initiated to prevent another fall indicated to keep room door			

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	open and a night light. A Fall Event Note, dated 9/21/22 at 5:00 a.m., indicated she had an unwitnessed fall. She had been found outside of the bathroom, lying on her left side. Her pajamas and booties were on, her a walker was on its side, a water pitcher was behind her and she was lying on a blanket with a brief under her head. No injury noted. Environmental factors that had been observed in area of the fall indicated no lights were on. The intervention initiated to prevent another fall indicated neuro checks had been started. No new interventions were put into place. An IDT Fall Review Note, dated 9/21/22 at 1:00 p.m., indicated she had fallen on 9/20/22 at 6:50 a.m. The immediate interventions in place at time of the fall indicated she had been assisted with incontinent care and door opened to provide light in the room. Root cause of the fall was determined to be she had needed to void, was on toileting program and would re-evaluate to meet her needs. Intervention put in place to address the root cause of the fall: she was on a toileting program upon rising, before and after meals and at bedtime. To offer assistance with toileting around 6:00 a.m. An IDT Fall Review Note, dated 9/21/22 at 1:12 p.m., indicated she had fallen on 9/21/22 at 5:00 a.m. She was wearing pajamas and booties and was continually encouraged to wear non-skid footwear. Her blood pressure was noted to be low at the time of the fall. . The immediate interventions in place at time of the fall indicated she would be provided with a night light due to dim environment when room door is shut per resident's preference. Root cause of the fall was determined to be a low blood pressure at the time of the fall, staff reported decline in oral intake,			

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	intakes reviewed and lower consumption had been noted. Intervention put in place to address the root cause of the fall: blood pressure checked daily, physician to review to ensure no medication changes are indicated. Registered dietician reviewed resident to ensure no new recommendations indicated. Continue with toileting program and therapy caseload with occupational and physical therapy. No new interventions were put into place. During an interview, on 10/6/22 at 10:10 a.m., CNA 21 indicated the resident walked with assistance and the use of a gait belt. During an interview, on 10/6/22 at 10:51 a.m., LPN 7 indicated the resident got up on her own, ambulated with a rolling walker and at times used a wheel-chair. 2. On 10/3/22 at 1:59 p.m., Resident 36 was lying in bed on the secure memory unit, a touch-pad call light was within reach, there were non-skid strips beside the bed, the other side of the bed was against the wall, non-skid strips were also in front of her recliner, in front of the toilet, leading to the bathroom and there was an over the toilet safety frame. On 10/4/22 at 9:36 a.m., she was sitting in a lounge chair in a common area. Her clinical record was reviewed on 10/4/22 at 1:54 p.m. Diagnoses included, but were not limited to, vascular dementia with behavioral disturbance and need for assistance with personal care. Current physician orders included, but were not limited to, the following;			

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	a. Non-skid strips in bathroom in front of toilet, the order date was 10/2/20. b. Non-skid strips on floor next to bed, the order date was 10/2/20. c. Non-skid socks while in bed as a fall risk, the order date was 7/1/22. d. Touch-pad call light, the order date was 7/29/22. e. Activity level: Resident transferred with staff assist with use of walker to rise up from sitting position then to use walker to pivot and sit in wheel chair and was to use the wheel chair to move about propelling self most distances, the order date was 8/1/22. f. Non-skids in front of recliner, the order date was 10/4/22. g. Over the toilet safety frame, the order date was 10/4/22. An 4/14/22 quarterly MDS assessment indicated she had moderate cognitive impairment. She required extensive assistance with bed mobility, transfers, dressing, eating, toilet use and personal hygiene, supervision to walk in room and corridor and with locomotion on and off the unit. A current care plan, dated 10/2/20, indicated she was at risk for falls due to history of falls, required assistance or supervision for mobility, transfer or ambulation, unsteady gait and altered awareness of immediate physical environment. The goal, with a target date of 11/3/22, indicated her risk factors would be reduced in an attempt to avoid significant fall related injury. Interventions			

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	included, but were not limited to, non-skid strips in bathroom in front of toilet, non-skid footwear, approach start date was 10/2/20. Encourage non-skid socks when in bed, approach start date was 7/13/21. Therapy to to screen for appropriate assistive device/balance and three day void to identify any changes in urinary status, approach start date was 6/30/22. Up with assist and wheel-chair for mobility, night light, and ensure pathways are clear, approach start date was 7/5/22. Non-skid strips in front of recliner, next to bed and in front of toilet, approach start date was 7/22/22. Touch-pad call light, offer toileting assistance every two hours during hours of sleep, approach start date was 7/29/22. A current care plan, dated 10/2/20, indicated she required assistance with ADLs (Activities of Daily Living), including bed mobility, transfers, eating and toileting related to dementia, anxiety, paranoid disorder and muscle weakness. The goal, with a target date of 11/3/22, indicted she desired to maintain her current functional status. Interventions included, but were not limited to, two assist with toileting, bathing and dressing, approach start date was 4/22/22. Staff assist with transfers while resident utilized walker surface to surface transfers and wheel-chair for mobility on the unit, approach start date was 7/5/22. Over the toilet safety frame, approach start date was 7/22/22 and bed against wall for environmental space, approach start date was 8/24/22. A current care plan, dated 7/1/22, indicated she had a non-displaced fracture to the left hip. The goal, with a target date of 11/3/22, indicated the fracture would heal without complications. Interventions included, but were not limited to, weight bearing as ordered, approach start date was 7/1/22.			

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A Fall Event Note, dated 6/29/22 at 11:04 p.m., indicated the resident had an unwitnessed fall when she returned from the bathroom. She was found beside her bed lying on her left side with her left arm under her upper body, she was dressed and had shoes on. She complained of pain in her left hip. Environmental factors that had been observed in area of the fall included poor lighting. She was unable to to put pressure on her left leg and was unable to walk. Order received to send to emergency room for evaluation and treatment.

A progress note, dated 6/30/22 at 1:30 p.m., indicated the resident had been admitted to the hospital related to non-displaced fracture to her left hip. She would not have surgery and therapy was to assess that day.

An IDT Fall Review Note, dated 6/30/22 at 2:43 p.m., indicated she had fallen on 6/29/22 at 11:04 p.m. She complained on left hip pain and was transferred to emergency room for evaluation and treatment. Interventions in place at the time of the fall included her bed against the wall, encourage non-skid socks, non-skid footwear, non-skid strips beside bed and in front of toilet, keep shoes in easy access for resident, call light within reach and personal items in reach. Root cause of the fall was determined to be the resident. Interventions put in place to address the root cause of the fall: therapy screened for assistive device and loss of balance, complete IDT pain review and three day void upon return to the facility and monitor for signs or symptoms of psychosocial distress and effective pain medication upon return to facility.

A progress note, dated 6/30/22 at 5:18 p.m., indicated the resident would be discharged back

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	to the facility that evening, to be WBAT (Weight Bearing As Tolerated) to left lower leg with walker assistance. A progress note, dated 6/30/22 at 9:30 p.m., indicated she had returned to the facility. A progress note, dated 7/5/22 at 11:49 a.m., indicated IDT reviewed her after her return post fall. She had been screened by therapy with a new order for transfer with assist and wheel-chair for mobility. She was provided a night light. A Fall Event Note, dated 7/28/22 at 5:51 a.m., indicated she had an unwitnessed fall, she had been found sitting on the floor in her room. She was wearing her pajamas and non-skid socks. No injuries noted at that time. Environmental factors that had been observed in area of the fall indicated lights were on. The intervention that had been put in place to prevent another fall was the re-education of the need for two assist when up and to use the call light for help. NO new interventions to prevent falls were put into place. An IDT Fall Review Note, dated 7/29/22 at 3:07 p.m., indicated she had fallen on 7/28/22 at 5:51 a.m. No injuries noted. The immediate intervention included she had been assessed for injury, assisted to the toilet and then assisted back to bed. Interventions in place at the time of the fall included bed against wall, encourage non-skid footwear, non-skid strips beside bed and in front of toilet, keep shoes in easy access for resident, call light within reach and personal items in reach. Root cause of the fall was determined to be she was going to the bathroom without assistance. Interventions put in place to address the root cause of the fall: touch-pad call light for easier activation and offer toileting assistance			

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	every two hours during hours of sleep. During an interview, on 10/6/22 at 10:15 a.m., LPN 7 indicated the resident required assistance but tried to get herself up. She usually walked with a walker but when she was tired she used her wheel-chair. 3. On 10/4/22 at 9:30 a.m., Resident 48 was sitting in a dining room chair participating in an exercise activity on the secure memory unit. On 4/4/22 at 2:24 p.m., she was lining up with other residents to go outside with her rollator walker. On 10/6/22 at 9:07 a.m., she was sitting in a recliner in the common area. Her clinical record was reviewed on 10/4/22 at 3:12 p.m. Diagnoses included, but were not limited to, vascular dementia with behavioral disturbance, restlessness and agitation, muscle weakness and abnormalities of gait and mobility. Current physician orders included, but were not limited to, the following: a. Non-skid strips in front of toilet, the order date was 3/3/20. b. Non-skid strips on floor next to bed, the order date was 3/3/20. c. Non-skid path the the bathroom for fall intervention, the order date was 10/6/22. A 5/31/22 quarterly MDS assessment indicated she had severe cognitive impairment. She required extensive assistance with bed mobility, transfers,			

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	toilet use, was independent with walking in her room and the corridor and with locomotion on the unit. A current care plan, dated 3/3/20, indicated she was at risk for falls related to lack of understanding of one's physical and cognitive limitations, impaired mobility, impaired cognition, dementia, weakness and abnormalities of gait and mobility. The goal, with a target date of 12/28/22, indicated risk factors would be reduced in an attempt to avoid significant fall related injury. Interventions included, but were not limited to, non-skid strips at bedside, non-skid socks on at bedtime, non-skid strips in front of recliner and non-skid strips in front of toilet, approach start date was 3/3/20. Toilet after lunch, remind to lock rollator walker and encourage and remind her to wear non-skid footwear and socks, approach start date was 4/14/22. Sign on walker with name as visual cue, hourly checks when sleeping and ensure walker is in view when in bed and recliner, approach start date was 7/25/22. Offer toileting assistance every two hours during hours of sleep, approach start date was 7/29/22 and non-skid path to bathroom, approach start date was 10/6/22. A progress note, dated 7/10/22 at 3:22 a.m., indicated at approximately 2:30 a.m., a CNA entered the resident's room, she was sitting on the bed naked, a significant amount of blood on the floor and a five to six inch gash in her right leg. The resident was unable to say how the injury had occurred. She was transferred to the emergency room. A progress note, dated 7/10/22 at 5:36 a.m., indicated she returned to the facility with 20 stitches in right calf. New orders included to elevate leg above heart as much as possible over			

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	the next 10-14 days to improve healing, antibiotic ointment to the wound and change dressings daily for the next three days and suture removal on 7/22/22. An IDT Initial Wound Review Note, dated 7/11/22 at 12:19 p.m., indicated a laceration to her right lateral leg. Area tender to touch during assessment. Root-cause determination was found to be rough edge noted to bracket attaching halo to bed. Halo was discontinued with bracket removed. A progress note, dated 7/24/22 at 8:16 a.m., indicated 20 stitches had been removed from the resident's right lower leg, no complaints of discomfort. A Fall Event Note, dated 7/25/22 at 1:22 a.m., indicated she had an unwitnessed fall. She was found in a different resident room, lying on her right side with right arm above her head and left arm propping her up. She had on pajamas and one non-skid sock. Injuries included, a 3.5 X 4.5 cm skin tear to her right upper arm, a 2.0 X 2.0 cm blood blister to her left elbow, a 2.0 X 1.5 cm abrasion to her left elbow and missing fingernail of left pinky finger. Environmental factors that had been observed in area of the fall included that she was not in her room and the lights were not on. The intervention initiated to prevent another fall indicated 15 minute safety checks had been started. An IDT Fall Review Note, dated 7/25/22 at 3:58 p.m., indicated she had fallen on 7/25/22 at 1:22 a.m. The immediate interventions included she had been assessed for injury, assisted up to toilet and incontinent care had been provided. The interventions in place at time of the fall indicated			

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	non-skid footwear, remind to lock rollator walker, toile after lunch, night light in room and bathroom, sign on bathroom door indicating bathroom, exit sign on inside of door to indicate exit route from bathroom, climate appropriate attire when outside, non-skid socks at bedtime, call light in reach, non-skid strips at bedside, in front of recliner and toilet and personal items in reach. Root cause of the fall was determined to be she had ambulated without walker across the hall and had been incontinent at the time of fall. Intervention put in place to address the root cause of the fall: sign on rollator with resident name as visual cue to use walker, ensure walker is within visual field when in bed or recliner and offer resident toilet. A Fall Event Note, dated 7/29/22 at 3:20 a.m., indicated she had an unwitnessed fall. She had been found lying on her right side in front of the bathroom door, she was wearing pajamas and non-skid socks. No injury noted. The intervention initiated to prevent another fall indicated increased observation. An IDT Fall Review Note, dated 7/29/22 at 11:26 p.m., indicated she had fallen on 7/29/22 at 3:20 a.m. The immediate interventions included she had been assessed for injury, assisted up to toilet and back to bed. The interventions in place at time of the fall indicated to ensure walker was in view when in bed, hourly checks when asleep, non-skid footwear, remind to lock rollator, night light in room and bathroom sign on door indicating bathroom and on inside of door indicating exit, non-skid strips in front of toilet, recliner and beside bed, personal items in reach. Root cause of the fall was determined to be she was attempting to open the bathroom door. Intervention put in place to address the root cause of the fall: offer to assist with toileting every two hours during hours			

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	of sleep. Nonew interventions were put into place to prevent falls. During an interview, on 10/6/22 at 10:15 a.m., LPN 7 indicated the resident would get up without assist but she needed assistance. During an interview, on 10/6/22 at 12:50 p.m., the Administrator indicated fall risk assessments were completed quarterly and with significant changes, it was not done after every fall. 4. The clinical record for Resident 63 was reviewed on 10/6/22 at 12:39 p.m. The resident was admitted on 12/30/21 and discharged on 7/18/22. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, delusional disorders, generalized anxiety disorder and depression. Medication orders included, but were not limited to, quetiapine (antipsychotic) 25 milligrams (mg) daily at bedtime (12/29/22 through 5/12/22), quetiapine 12.5 daily at bedtime (5/13/22 through 6/22/22), alprazolam (antianxiety) 0.25 mg twice a day (3/12/22), sertraline (antidepressant) 75 mg daily (4/5/22 through 5/15/22), sertraline 25 mg daily (5/16/22) and sertraline 50 mg daily at bedtime (5/16/22). The resident's quarterly Minimum Data Set assessments (MDS) dated 4/5/22 and 6/9/22 indicated the resident was severely cognitively impaired. He requir ed extensive assistance of two persons for transfers, limited assistance of one person for walking in his room and limited assistance of one person for walking in the corridor.John Hopkins Fall Risk Assessment Tools were completed 12/30/21, 6/1/22 and			

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	6/3/22. Each indicated the resident had a high fall risk with the corresponding scores: 18, 24 and 31. A score of 13 indicated a high fall risk according to the tool.A Nursing Progress Note, dated 4/7/22 at 3:10 a.m., indicated the resident sat down short of the bed and was lowered to the floor by the nurse. No injuries were identified.An Interdisciplinary (IDT) Fall Review Note, dated 4/8/22 at 2:38 p.m., indicated the fall, on 4/7/22, happened when the staff assisted the resident back to bed. The resident sat short of the bed. The staff was unable to prevent the resident from falling and lowered him to the floor. The root cause was the resident's roommate did not like bright lights during the sleeping hours and, the room was dimly lit. The resident was provided a battery-operated night light.A Nursing Progress Note, dated 4/13/22 at 1:20 p.m., indicated the resident stood up from a recliner in the lounge and tried to sit back down. He sat on the arm of the recliner and fell to the floor onto his buttocks. No injuries were identified.An IDT Fall Review Note, dated 4/14/22 at 3:18 p.m., indicated the root cause of the fall, on 4/13/22, was the resident was incontinent at the time of the fall. An intervention to toilet the resident after lunch was put into place.A Nursing Progress Note, dated 4/14/22 at 3:20 p.m., indicated the resident was observed sitting on the floor			

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	on his buttocks leaning against the unit entry doors. A skin tear to his right hand and a hematoma to his right forehead was identified. The resident had been observed ambulating in the hallway prior to the fall.An IDT Fall Review Note, dated 4/15/22 at 11:54 a.m., indicated the root cause of the fall, on 4/14/22, was the resident was bending over toward the floor and lost his balance. An intervention to seek permission from the family for a vision or audiology screen was added.A Nursing Progress Note, dated 5/15/22 at 1:44 p.m., indicated the resident was found sitting on the floor in the dining room. No injuries were identified.An IDT Fall Review Note, dated 5/17/22 at 1:44 p.m., indicated the root cause of the fall, on 5/15/22 at 1:44 p.m., was the resident has dementia, poor safety awareness and an inability to understand education. An intervention to assist to recliner after meals was added to the care plan. No new interventions were put into place.A Nursing Progress Note, dated 5/19/22 at 12:04 a.m., indicated the resident was observed sitting on the floor of the lounge area. A skin tear was noted to the left thumb.An IDT Fall Review Note, dated 5/20/22 at 2:00 p.m., indicated the root cause of the fall was the resident went to sit down in the recliner and missed the recliner. An intervention for staff to offer the resident			

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	assist with sitting was added. No new interventions were put into placeA Nursing Progress Note, dated 5/30/22 at 3:10 p.m., indicated the resident was sitting in the recliner when he stood up, attempted to sit back down, slid to the floor and hit the left side of his forehead on the floor. A laceration, skin tear and hematoma with moderate amount of bleeding were identified.A Nursing Progress Note, dated 5/30/22 at 4:15 p.m., indicated the hospice nurse assessed the resident. The resident was sent to the hospital.An Emergency Department Physician Progress Note, dated 5/30/22, indicated the resident had a laceration to the frontal forehead and required four staples. A Nursing Progress Note, dated 5/31/22 at 2:46 a.m., indicated the resident returned from the hospital at 2:15 p.m. and was unconscious. The resident had been given Ativan (antianxiety) and Ziprasidone (antipsychotic) at the hospital. A Nursing Progress Note, dated 5/31/22 at 3:49 a.m., indicated the resident had four staples to the left side of his forehead.An IDT Fall Review Note, dated 6/1/22 at 10:48 a.m., indicated the IDT felt the resident will continue to fall related to cognitive impairment. The current interventions at the time were continued. No new interventions to prevent falls were put into place. A Nursing Progress Note, dated			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	6/2/22 at 2:54 a.m., indicated the resident was observed sitting on the floor of the lounge area. No new injuries were identified.An IDT Fall Review Note, dated 6/2/22 at 2:52 p.m., indicated the IDT felt the resident would continue to fall. A care plan meeting was scheduled with the family and hospice to see if therapy could be considered or if they would consider hipsters and a helmet if falls continued, but no new interventions to prevent falls or injury were put into place.A Nursing Progress Note, dated 6/7/22 at 11:50 a.m., indicated the resident got up from a chair in the lounge. He started to walk, turned around and fell onto his buttocks beside the recliner. He hit his lip on the back of the chair resulting in a laceration to the lower lip.An IDT Fall Review Note, dated 6/8/22 at 8:42 p.m., indicated the root cause of the fall was the resident had poor safety awareness and was poor at judging the object behind him when sitting due to a decline in cognition. An intervention to have the resident wear hipsters when available was added.A Nursing Progress Note, dated 6/20/22 at 5:25 p.m., indicated the resident was observed to walk in the dining room and fell between the wall and a recliner. Skin tears were identified to the bridge of the nose, the left thumb, and the right elbow.An IDT Fall Review Note, dated 6/21/22 at 2:38 p.m.,			

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	155200	A. BUILDING 00 B. WING	10/07/2022

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	indicated the resident has no safety awareness related to his cognitive decline. No onew interventions to prevent falls or injury were put into place. A care plan, dated 12/30/21, indicated the resident was at risk for falls related to history of falls, age greater than 80, 1 fall within previous 6 months, incontinence, 2 two or more high fall risk drugs, requires assistance or supervision for mobility, transfers, or ambulation, altered awareness of immediate physical environment, end stage dx and was receiving hospice services. The interventions included, but were not limited to, nonskid strips next to bed with approach start date 4/8/22, nonskid strips in front of toilet with approach start 4/8/22, assist resident to recliner after meals with approach start date 5/17/22, offer resident sitting assistance with approach start date 5/20/22, helmet to be worn with approach date 6/21/22 and hipsters on when available with approach start date 6/21/22. During an interview, on 10/7/22 at 12:42 p.m., Registered Nurse (RN) 51 indicated the interventions for falls began with checking the resident's physical needs such as being cold, hungry, or needing to go to the bathroom. He had a lot of excess energy. They would walk with him up and down the hall and that seemed to help the most. They also called his wife to sit with him. Sometimes, if nothing else helped, one			

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	of the staff would sit with him which seemed to help calm him down.A current policy, titled "Fall Management Policy" and provided by the administrator on 10/7/22 at 1:52 p.m., indicated "It is the policy of American Senior Communities to ensure residents residing within the facility receive adequate supervision or assistance to prevent injury related to falls." This Federal tag relates to Complaint IN00387633.3.1-45(a)(2)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview, and record review the facility failed to ensure a medication error administration rate under 5% with 27 opportunities of medication administration observed where 3 of 27 medications were not administered in accordance with physician's orders. (Resident 22) Findings include: On 10/6/22 at 8:31 a.m., Registered Nurse (RN) 52 prepared Resident 22's medications. She placed two capsules of MegaRed Omega-3 Krill oil (supplement), one aspirin 81 milligram (mg) tablet, one clopidogrel (blood thinner) 75 mg tablet, one levetiracetam (for seizures) 500 mg tablet, one lisinopril (for blood pressure) 20 mg tablet, one pantoprazole (for gastro-esophageal reflux disease) 20 mg tablet, one Thera M (multivitamin)	F 0759	**F 759 Free of Medication Error Rts 5 Prcnt or More** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · Speech Therapy completed screen on resident 22. · Resident 22 medication orders clarified to may crush medications. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; · All residents with special	10/28/2022

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	tablet and one vitamin D3 1000 units tablet in a medicine cup. She added applesauce to the cup. She gave the resident the pills floated in applesauce, a few pills at time. Resident 22's medication orders were reviewed on 10/6/22 at 11:00 a.m. His orders included, but were not limited to, aspirin 81 mg daily - special instructions: must be crushed (4/22/22), clopidogrel 75 mg - special instructions: must be crushed (4/22/22) and vitamin D3 - special instructions: must be crushed (4/22/22). During an interview, on 10/6/22 at 11:02 a.m., RN 52 indicated she did not know the clopidogrel, aspirin, or vitamin D were ordered to be crushed. She indicated she always floated Resident 22's medications in applesauce and did not crush them. During an interview, on 10/6/22 at 11:06 a.m., the Director of Nursing (DON) indicated was unaware of the resident's crush orders and would investigate it. During an interview, on 10/6/22 at 12:27 p.m., the administrator indicated the crush orders were probably ordered during the screening process when the resident was receiving speech therapy. She indicated the nurse should have seen the order before giving the medication. A current policy, titled "General Dose Preparation and Medication Administration" and provided by the administrator on 10/7/22 at 2:30 p.m., indicated " ...Facility staff should verify each time the medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident ..."		instructions indicating must crush medications have the potential to be affected by the alleged practice. · Audit completed by ADNS on 10/17/22 to identify any resident with order must crush indication. · Residents identified to have a must crush indication had order clarification per MD and ST screen if indicated. · All Nurses to be in-serviced per ED/Designee by 10/25/22 on medication administration and crush orders. · All Nurses will have skills validation, Medication Pass Procedure, completed by 10/25/22 per IP/Designee. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · All Nurses to be in-serviced per ED/Designee by 10/25/22 on medication administration and crush orders. · Orders will be reviewed daily in clinical meeting which is overseen by DNS to identify any special instructions. · Shift to shift report will indicate if resident has a must crush medication order per physician. · Any may crush medication order will be reviewed to ensure special instructions appropriate for	

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	3.1-48(c)(1)		resident. · ST screens will be completed as indicated. · Medication Pass Procedure, skills validation completed and to be completed annually, IP/Designee to oversee. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · CQI tool identified as Medications will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 10/28/22 PaPaper Compliance is requested	