STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155478	A. BUILDING 00 B. WING	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TIMBERS OF JASPER THE	2909 HOWARD DR JASPER, IN 47546

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00440417. Complaint IN00440417: Federal/state deficiencies related to the allegations are cited at F684. Survey dates: August 27 & 28, 2024 Facility number: 000314 Provider number: 155478 AIM number: 100274210 Census bed type: SNF/NF: 74 Total: 74 Census payor type: Medicare: 3 Medicaid: 54 Other: 17 Total: 74 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on September 10, 2024.	F 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective September 25th, 2024 to the Complaint survey completed on August 28th, 2024.	
F 0684 SS=G Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure staff thoroughly and completely assessed a resident after a fall with head injury, failed to ensure the fall was effectively documented with specific fall details to ensure interventions were immediately implemented to	F 0684	Facility requesting IDR to lower S/S of tag and to request past non compliance d/t the removal plan being reviewed w/ the surveyor during the complaint survey.	09/25/2024

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

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	prevent further falls, failed to effectively monitor the neurological status of the resident after a subdural hematoma was identified for 1 of 3 residents reviewed for falls. (Resident D) This deficient practice resulted in the resident experiencing right-sided shaking, slurred speech, altered mental status, and an active brain bleed that required a craniotomy to repair. Finding includes: A facility investigation of Resident D's fall on 6/13/24 included a handwritten, untimed, note signed by Therapy Assistant 4, dated 7/2/24. The note indicated that Resident D was walking with a staff member on 6/13/24 and went to kick a ball and fell. Nursing staff came to take the residents vital signs and staff assisted the resident up. Resident D stated she was fine and continued the walk. The investigation did not include new fall interventions were implemented to prevent further falls. On 8/27/24 at 9:45 A.M., a clinical record review indicated Resident D's diagnoses included, but were not limited to, hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right dominant side, repeated falls, seizures, and weakness. A Quarterly Minimum Data Set (MDS) assessment, dated 6/17/24, indicated the resident had no cognitive impairment, required supervision of one staff member while walking, had one-sided impairment to both upper and lower extremities, and the resident had not experienced a fall during the assessment period. A care plan for fall risk, dated 6/25/24, included interventions of call light in reach (8/18/23),		**How will the corrective action be accomplished for residents found to be affected by deficient practice?** Resident D no longer resides in the facility. LPN #9 was educated on appropriate fall documentation and assessments after resident falls. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** All residents could potentially be affected by the alleged deficient practice. Facility will audit all residents with a fall in last 90 days, to 6/13 to ensure thorough assessments were completed, appropriate documentation, included added interventions as well as monitoring for neurological status. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All staff to be educated on reporting falls.	

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	environmental changes (8/18/23), non-skid footwear (8/18/23), personal items in reach (8/18/23), therapy screen (8/18/23), bed in lowest position (8/23/23), 42-inch bed with bolster for larger sleep surface to provide tactile boundaries (8/28/23), bright colored tape on call light (9/15/23), non-skid strips in front of toilet (12/8/23), sign in bathroom to remind resident to ask for assistance (12/8/23), and non-skid strips from bed to dresser (12/26/23). The care plan for fall risk and the comprehensive plan of care, dated rom 6/13/24 through Resident D's discharge date of 7/24/24 did not include documentation to indicate the resident experienced an actual fall on 6/13/24 or to show interventions to prevent further falls were immediately implemented after the fall. An untimed, handwritten nurse's note signed by LPN 9, dated 6/13/24, indicated that Therapy Assistant 4 and Resident D approached her during medication pass to make aware that Resident D had lost footing in the therapy gym with resident falling against a door. LPN 9 indicated Resident D stated she did not want her emergency contact, or the DON notified of the fall because she didn't want a setback of being discharged from facility. Neurological checks were initiated. Resident was able to move bilateral upper extremities and bilateral lower extremities without complaints of pain or discomfort. No noted injuries. Resident D's clinical record contained no documentation in physician visit notes or nurse's progress notes that notification to the resident's physician had been made following the fall on 6/13/24. A handwritten neurological check form, dated		Nurses will be educated on completing fall doc, assessments (including neurological status of residents with falls). IDT will be in-serviced on completing fall reviews and updating care plans and adding appropriate fall interventions. Any deficiency in this practice will result in disciplinary action, up to and including termination. IDT to complete daily audits of facility activity report to check for any concerns relating to falls and documentation. **How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** The DNS/Designee will be responsible for the completion of the Fall Management QA tool weekly x 4 weeks, monthly x 6, quarterly x2, until continued compliance is maintained for 3 consecutive quarters. The results of the audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed. **Date of compliance: 9/25/2024**	

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	6/13/24, and signed by LPN 9 indicated Resident D did not demonstrate signs or symptoms of a significant head injury following the fall on 6/13/24. A handwritten note signed by the DON, dated 6/28/24, indicated the DON spoke with Resident D after being made aware on 6/28/24 that the resident had a fall in the therapy gym that was not reported. Resident D stated she went to kick a ball and fell and hit her head but denied pain. Resident D indicated that she did start having headaches at some time after the fall. Resident D indicated that she was able to get up immediately following the fall and requested that the nurse not be notified. Resident D indicated that Therapy Assistant 4 did notify LPN 9 and Resident D requested that the nurse not notify emergency contacts due to a fear that the fall would slow her progress of discharging to an assisted living arrangement. The note did not include sufficient documentation to determine when the resident's headaches began, but indicated the resident was feeling fine up until 6/28/24 when the headaches worsened. The note indicated the physician was updated about the fall on 6/13/24 and worsening headaches and a Computer Tomography (CT) scan was ordered. An untimed, handwritten note signed by LPN 9, dated 7/2/24, indicated Therapy Assistant 4 and Resident D informed her Resident D had stumbled while walking with supervision of Therapy Assistant 4 in the therapy room and hit the back of her head on the therapy door. Resident D stated she was fine and requested that emergency contacts not be informed of the fall. Neurological checks were initiated. Upon being busy this nurse left her shift without completing fall event.			

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	During an interview on 8/27/24 at 11:45 A.M., the Facility Administrator and Director of Nursing (DON) indicated that Resident D did experience a fall event on 6/13/24 while ambulating in the physical therapy room with Therapy Assistant 4. Resident D's nurse was notified of the fall and 15-minute neurological checks and vitals were completed by LPN 9. Resident D was in the process of finding placement and moving out of the facility and requested that the fall not be reported for fear that the fall may alter upcoming plans to move out of the facility. The DON could not indicate why LPN 9 failed to complete the facility's fall protocol, including initiation of a new fall intervention, notification to the physician, or documentation of the fall in the resident's clinical record. A CT scan of Resident D's head, dated 7/8/24 and electronically signed at 8:21 A.M., included study results indicated by chronic headaches. Findings included, "Brain: Left-sided subdural hematoma measuring 14 [millimeters] mm in maximal thickness with some areas of hypodensity (abnormality that appears on CT scans that indicate possible open or fluid-filled spots) along the lower margins. Mild left-to-right midline shift (when the natural centerline of the brain is pushed to one side) measuring approximately 5 mm ... Conclusion: Left-sided subdural hematoma with mild left-to-right midline shift is either acute on subacute or subacute..." The comprehensive care plan, progress notes, neurological assessments, and event reports, dated from 7/8/24 through 7/17/24, did not include documentation to indicate a plan of care was developed related to the subdural hematoma, interventions were implemented to evaluate and monitor the neurological status of Resident D,			

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	interventions to prevent further falls were implemented, or attempts were made to set-up a neurology consultation. Nurse's progress note included the following: A note electronically signed by LPN 9, dated 7/18/24 at 12:54 P.M., indicated that a call was placed to neurosurgeon due to resident's results from recent CT scan of head with requested information sent to the neurosurgeon to evaluate. Neurology office indicated they would notify the facility if surgeon will accept the patient. The nursing notes, dated from 7/19/24 through 7/21/24, did not include documentation to indicate interventions were implemented to prevent further falls, a plan of care was developed related to the subdural hematoma, interventions were implemented to evaluate and monitor the neurological status of Resident D, or attempts were made to set-up a neurology consultation. A note electronically signed by LPN 9, dated 7/22/24 at 3:04 P.M., indicated a call was placed to neurosurgeon's office. Office indicated they are still reviewing referral at that time. The nursing notes, dated from 7/22/24 through 7/23/24, did not include documentation to indicate interventions were implemented to prevent further falls, a plan of care was developed related to the subdural hematoma, interventions were implemented to evaluate and monitor the neurological status of Resident D, or attempts were made to set-up a neurology consultation. A nursing note, dated 7/24/2024 at 7:30 A.M., indicated Resident D was not able to follow directions, had slurred speech, exhibited seizure-like activity, and the resident's vital signs			

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	were within normal limits. The note indicated the physician was notified and a new order was received to send the resident to Hospital 1. A nursing note, dated 7/24/2024 at 9:26 A.M., indicated Hospital 1 notified the facility the resident was transferred to Hospital 2 because active bleeding on the brain was identified. An untimed primary physician's facility visit note, dated 7/24/24, indicated Resident D experienced headaches, a subdural hematoma was identified, and a neurological consultation was pending for insurance approval. The note indicated while waiting for the approval, Resident D was alert, but developed right-sided shaking, slurred speech, and altered mental status. The note did not include documentation to indicate the facility effectively monitored the neurologic status of Resident D while the insurance approval was pending. A Medical Doctor (MD) acute visit note, dated 7/24/24, indicated Resident D had experienced a fall on 6/13/24. The note did not include documentation to indicate when the physician was notified of the fall or to show the facility effectively monitored the neurologic status of Resident D while the insurance approval was pending. The event reports, dated from 6/12/24 through 7/24/24, did not include documentation related to the fall on 6/13/24. Notes from Hospital 2, dated 7/25/24 at 10:28 A.M., indicated patient arrived at the Emergency Department from another Hospital 1 for an enlarging subdural hematoma. Emergency Medical Services (EMS) reported the original subdural			

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	hematoma was found on CT scan on 7/8/24. The notes included, "Plan is for right craniotomy (surgical procedure that involves removing a portion of the skull to access the brain) for evacuation of [subdural hematoma] SDH..." During an interview on 8/28/24 at 10:30 A.M., RN 6 indicated following a resident fall, the nurse should complete a full assessment including vital signs, skin assessments and range of motion. If resident is able and no apparent injuries, assist resident up. If fall is unwitnessed or if it was known that resident had hit their head, complete neurological checks every 15 minutes, which are documented by hand on a neurological check sheet. The nurse should notify the responsible party, the physician, and the DON of the fall event, document the fall in progress notes and create a new intervention to help prevent the fall from occurring again. On 8/28/24 at 10:00 A.M., the Facility Administrator supplied a facility policy titled, Fall Management Policy, dated 03/2024. The policy included, "...Post Fall: Any resident experiencing a fall will be assessed immediately by the charge nurse for possible injury and necessary treatment will be provided... b. Staff member will document notification and actions taken in the clinical record... If there are no injuries, notify the physician by the end of the shift... a fall event will be initiated as soon as the resident has been assessed and cared for. a. The report will be completed in full to identify possible root cause of the fall and provide immediate interventions. All falls will be discussed by the interdisciplinary team [IDT] at the 1st clinical meeting after the fall to determine root cause and other possible interventions to prevent future falls. a. The fall event will be reviewed by the team. b. IDT note			

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	will be written. c. The care plan will be reviewed and updated. d. Fall event charting will be initiated post fall." On 8/28/24 at 11:30 A.M., the Facility Administrator supplied a facility policy titled IDT Comprehensive Care Plan Policy, dated 08/2023. The policy included, "...Create an organized, resident-centered review on a routine basis to improve communication with residents, resident families and/or representative regarding the resident goals, total health status, including functioning status, nutritional status, rehabilitation and restorative potential... cognitive status, psychosocial status, sensory and physical impairments, as well as care services provided to maintain or restore health and well-being, improve functional level or relieve symptoms." The National Institute of Health, National Library of Medicine indicated the treatment/management of a subdural hematoma includes, " ...After stabilization and monitoring of the patient, a secondary plan of care should follow. The management must include the involvement of neurosurgery and neurological consultation with a consensus on the injury and a determination of the immediate and long-term consequences ..." This citation relates to complaint IN00440417. 3.1-37(a) 3.1-37(b)			