STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DEMAREE CROSSING ASSISTED LIVING AND MEMORY CARE	1255 DEMAREE ROAD GREENWOOD, IN 46143

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00408290. Complaint IN00408290 - State deficiencies related to the allegations are cited at R0052. Survey date: May 19 and 22, 2023 Facility number: 014079 Residential Census: 55 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed May 25, 2023.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview, and record review, the facility failed to protect the residents right to be free from neglect for 1 of 3 residents reviewed for falls. Staff did not follow the facility post-fall procedure for a resident that fell on the secured memory care unit. This deficient practice resulted in delayed hospital treatment and the resident's death. (Resident B) Finding includes:	R 0052	This Plan of Correction is submitted under regulations applicable to long term care providers. This Plan of Correction is not to be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. The preparation/ submission and/or execution of this Plan does not constitute agreement by the	06/23/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Erin Beiriger	Executive Director	06/09/2023

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	During an interview on 5/19/23 at 8:33 a.m., Maintenance Staff 1 indicated he was made aware of Resident B's fall during morning meeting on 3/2/23. He believed the details of the fall that were reported by QMA 1 (Qualified Medication Aide) did not make sense. During an interview on 5/19/23 at 9:23 a.m., the Administrator indicated Resident B had a fall, on 3/1/23 around 11:30 p.m. QMA 1 told several different stories regarding Resident B's fall. The facility had video footage that showed Resident B lying on the floor, just inside his room. QMA 1 left the room and shut the door with Resident B still on the floor. QMA 1 did not tell anyone Resident B had a fall for 2 hours. QMA 1 should have called the Regional Nurse to report Resident B's fall so the Regional Nurse could have assessed the situation and decided what to do before QMA 1 got Resident B off the floor. During an interview on 5/19/23 at 10:15 a.m., the Memory Care Director indicated she got a call from QMA 1, on 3/2/23 at approximately 1:00 a.m. QMA 1 indicated to her that Resident B had a fall and QMA 1 put him back into bed himself. The Memory Care Director told QMA 1 that he never should have gotten Resident B up without calling a nurse. At that time, QMA 1 told the Memory Care Director "Oh yeah, I forgot". QMA 1 told her Resident B was fine and the Memory Care Director told QMA 1 to call the Regional Nurse. The Memory Care Director went to see Resident B at the hospital that morning. The Nurse Practitioner came into Resident B's hospital room and indicated Resident B had a massive brain bleed and was going to die. Resident B was going to be made comfortable. On 5/19/23 at 11:18 a.m., observed video footage,		facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied. Submission of this Plan is evidence of compliance. Plan of Correction: R0052 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The involved staff worker, QMA1, was suspended and later terminated following investigation results. The Health & Wellness Director or designee will provide additional training to the staff on following proper procedures regarding resident incidents, Indiana Resident Rights and Abuse. Training will be completed by 6/23/23. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Executive Director will audit those residents who have had falls in the last 90 days to see if there are any other residents who were potentially affected by cited regulation 052 410 IAC16-2-5-1.2 (1-6) Resident Rights Offense by 6/23/23 and will make any necessary corrections. The Health & Wellness Director or designee will complete a fall	

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	dated 3/1/23 11:18 p.m. to 3/2/23 at 2:24 a.m., the following was observed: - On 3/1/23 at 11:35 p.m., QMA 1 exited Resident B's room. Resident B was observed lying on the floor with his knees bent just inside his room. QMA 1 walked out of the room and shut the door while Resident B was still on the floor. This was confirmed by the Administrator. - On 3/1/23 at 11:38 p.m., QMA 1 opened the door to Resident B's room. As QMA 1 entered the room, Resident B was on the floor just inside the door. - On 3/2/23 at 1:35 a.m., QMA 2 and CNA 1 (Certified Nursing Aide) walked into camera view. QMA 2 and CNA 1 walked near Resident B's door and stopped. They waited outside Resident B's room. The door to Resident B's room remained closed. - On 3/2/23 at 1:38 a.m., QMA 1 opened the door and exited Resident B's room, turned off the lights, and shut the door as he exited Resident B's room. - On 3/2/23 at 2:02 a.m., QMA 1, QMA 2, and CNA 1 walked back into camera view toward Resident B's room. QMA 1 was talking on his phone. All 3 staff members entered Resident B's room. - On 3/2/23 at 2:22 a.m., Paramedics walked into camera view and entered Resident B's room. Once paramedics were inside the room, the lights were turned out. During an interview on 5/19/23 at 2:59 p.m., CNA 1 indicated she worked the night Resident B fell. She was not made aware that anyone had a fall until 3/2/23 at approximately 1:30 a.m. QMA 1		evaluation of residents who fall for the next 30 days and incorporate any necessary interventions for those residents in their service plans. What measures will be put into places or what systemic changes the facility will make to ensure that the deficient practice does not recur? An accurate phone tree with the correct phone numbers for on-call clinical and leadership staff will be posted at nurse's stations and in procedure binders for ease of access. Staff will be retrained on Indiana State Resident Rights and on Abuse & Neglect regulations. Health & Wellness Director or designee will train staff at time of hire and semiannually on Abuse and Neglect process. Staff will also complete scheduled training on these process through Relias. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The residents who have fallen will be discussed during weekly IDT meeting and the Health & Wellness Director or designee will put the necessary interventions in place for those identified residents in their service plan. During the monthly safety committee meeting the leadership team will review residents who	

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	called the Regional Nurse. Then, QMA 1, QMA 2, and CNA 1 walked into Resident B's room, Resident B was already back in bed. QMA 2 strongly encouraged QMA 1 to send Resident B to the hospital, but he did not want to send him. QMA 2 called 911. QMA 1 was supposed to call a nurse before getting Resident B off the floor. During an interview on 5/19/23 at 3:36 p.m., QMA 2 indicated she worked the night Resident B fell. QMA 1 told QMA 2 and CNA 1 about Resident B's fall, on 3/2/23 around 1:30 a.m. QMA 1 exited Resident B's room and said, "this mother f***** fell." He was talking about Resident B. QMA 1 called the Memory Care Director. Then, QMA 2 told QMA 1 that he had to call the Regional Nurse because the Memory Care Director was not a clinical person. QMA 1 called the Regional Nurse and QMA 1, QMA 2, and CNA 1 walked to Resident B's room to check on him. Resident B was already in bed and covered with a blanket from his feet to his neck. QMA 2 started to pull down the blanket and noticed 2 "baseball sized" bruises to Resident B's left arm, another large bruise to his left inner thigh, and a bruise on top of his left foot. QMA 2 thought Resident B's arm was broken, so she encouraged QMA 1 to send Resident B to the hospital as he was on the phone with the Regional Nurse. QMA 1 did not want to send Resident B to the hospital. QMA 2 called 911 at approximately 2:10 a.m. that morning. QMA 1 should have called the Regional Nurse when the fall happened. QMA 1 should not have gotten Resident B up without called a nurse first. The clinical record for Resident B was reviewed on 5/22/23 at 9:45 a.m. The diagnoses included, but were not limited to, hypertension and chronic embolism and thrombosis of vein. Resident B was not cognitively intact.		have fallen including response times to make any necessary systemic changes for improvement. The Executive Director or designee will perform random weekly audits for 4 weeks and then monthly for 3 months of completed staff trainings for compliance and will take the necessary corrective action. By what date the systemic changes will be complete? 9/10/23	

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	A progress note, dated 3/2/23 at 2:34 a.m., indicated Resident B had a witnessed fall in his room on this sift. Resident was sent to the hospital to be checked out do to large hematomas on his left forearm and various small injuries. (This was approximately 3 hours after the fall.) A Progress Note, dated 3/2/23 at 9:00 a.m., this writer visited with Resident B this morning at the hospital, where he was taken after a fall earlier in the morning. Upon arrival this writer walked into Resident B's room with the nurse practitioner (NP) and a social worker. Resident B's wife, son, and daughter-in-law were present. After greeting the family, the NP conducted an assessment, and explained to the family that at this time they were focusing on keeping Resident B comfortable. The NP further explained that their focus would be to make necessary medication changes to ensure Resident B remained calm and comfortable. The NP discussed what end of life would look like and what the family could expect. The social worker encouraged the family to reach out for support as needed. This writer then greeted the family and asked what happened and was informed that when Resident B was brought into the emergency room, he was taken for a CAT (computer axial tomography) scan and it was determined that Resident B sustained a massive brain bleed, that he went into the test alert and oriented and when he came out, he was not responsive. After visiting for a short time, this writer encouraged the family to call if they needed anything. A progress note, dated 3/3/23 at 2:15 p.m., indicated this writer was made aware that Resident B had passed away, and the family would let the staff know when the services would be.			

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	On 5/19/23 at 2:11 p.m., the Administrator provided a copy of a facility policy, titled Abuse and Neglect Reporting Policy: Including suspected/confirmed Resident to Resident abuse, dated 11/1/22, and indicated this was the current policy used by the facility. A review of the policy indicated neglect is the failure or omission of a caregiver to provide the care or services necessary to maintain the health or safety of a vulnerable adult including supervision and medical services. Residents must not be subjected to abuse, neglect or mistreatment by anyone. This State tag relates to Complaint IN00408290.			