STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00430205, IN00431337, and IN00431357. Complaint IN00430205 - No deficiencies related to the allegations are cited. Complaint IN00431337 - Federal/state deficiencies related to the allegations are cited at F609, and F684. Complaint IN00431357 - Federal/state deficiencies related to the allegations are cited at F609, and F684. Survey dates: April 3, 4, and 5, 2024 Facility number: 000128 Provider number: 155223 AIM number: 100289650 Census Bed Type: SNF/NF: 74 Total: 74 Census Payor Type: Medicare: 2 Medicaid: 36 Other: 36 Total: 74 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 18, 2024.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission of agreement by the facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is 5/7/2024. **Facility is respectfully requesting paper compliance for all deficiencies in this POC.**	
F 0609 SS=D	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Terra Holler	HFA	05/03/2024

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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Bldg. 00	§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interview and record review, the facility failed to ensure a resident's allegation of abuse, and investigation of bruising on bilateral arms were accurately reported after the resident was found to have bruising on bilateral arms, face, and chest, and a laceration on the lip for 1 of 4 incidents reviewed for reporting (Resident B). Findings include:	F 0609	Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission of agreement by the facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are	05/07/2024

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	An Indiana State Department of Health Survey Report System report, dated 3/19/24 at 5:40 a.m., indicated Resident B was observed by the nurse to have swelling and bruising to her left hand, and bruising to the right hand and right arm. After speaking with the resident, the Administrator (ADM) was unable to identify the source of the bruising. An X-Ray was ordered for the left hand. Resident B was referred to social services for psychosocial support for 7 days. An investigation was initiated, and the facility would update all applicable findings in the follow up report. The investigation was completed without findings. Resident B's x-ray results were negative. Resident care plan updated to reflect combative with care. A witness statement per LPN 22 indicated, on 3/19/24 around 4:30 a.m., she and a CNA heard screaming. At first, they thought it was a resident on ICF (intermediate care facility) unit who normally screamed out. The yelling/screaming continued and LPN 22 asked the CNA to go see if she could find where it was coming from. CNA returned and told the nurse that it was Resident B. LPN 22 went to the resident's room and the resident was up in the wheelchair outside her room. A CNA from another unit had been asked to get Resident B up because she had "called her a [n-----]." The nurse started med pass and noticed the resident's shirt was pulled over top of the left hand. "I could see bruising. I raised sleeves up on both arms when I discovered bruises. I asked CNA about them CNA [9] denied knowing anything about bruising. I asked why [Resident B] was screaming. CNA reported that when she was getting her dressed she said that [n------] were raping her. CNA asked to write statement. Administrator notified".		prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is 5/7/2024. **Facility is respectfully requesting paper compliance for all deficiencies in this POC.** **F609 Reporting of Alleged Violations** It is the policy of this facility to report allegation of abuse accurately. **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B was assessed by the DON/SSD/Psych services on or before 5/7/2024 and no negative outcome. **2 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 have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents of the facility. **3 What measures will be put into place and what systemic**	

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	A witness statement per CNA 9, on 3/19/24 at 4:30 a.m. " ...went to get Resident B up for the day and assist with daily care resident was sleeping said resident name and tapped resident on shoulder and told resident I was going to help with getting her dress did peri care and changed soiled attends went to residents closet got resident clean pants put wheelchair by the bed when I went to put pants on resident [Resident B] started yelling help the [n------] are trying to rape tried to calm resident down resident continued to yell I exited the room, resident was still yelling. Coworker was coming from ICF and I asked could she see if she could get resident to put pants on and told her about the incident, resident was in wheelchair when we entered her room coming out of bathroom resident letted [sic] coworker assist with putting pants nurse informed me that resident has bruise on hand and arm. I did not observe any until nurse informed me. During that time at assisting nurse with asking resident what happened resident started saying and calling me [n------] and stating they are trying to rape me. Resident was asleep during the beginning of my shift and during bed checks resident was not saturated I letted [sic] resident sleep. Resident does get up and transfers in and out of chair at times without assistance." An Indiana State Department of Health Survey Report follow-up, indicated the investigation was complete without findings. Resident B's care plan was updated to reflect the resident was combative with care. The follow up report submitted on 3/25/24 lacked detailed documentation to include the extent of bruising on the hands and arms, bruising to the chest and face, and a laceration to the lip. The report lacked documentation of the suspension of CNA 9 for 5 days pending the investigation, and a care plan was not added to reflect combative with care. Instead an existing		**changes will be made to ensure that the deficient practice does not recur?** The Regional Director of Operations in-serviced the Administrator and Director of Nursing on the Abuse Policy and reporting allegation of abuse accurately on DATE. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The Regional Director of Operations/Designee will audit reported allegations of abuse for accuracy x 6 months. If the facility is within 95% compliance at the end of 3 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. **5 By what date the systemic changes for each deficiency will be completed?**	

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	care plan for Resident B exhibited socially inappropriate behaviors was updated to reflect care in pairs. During an interview on 4/5/24 at 5:12 p.m., the ADM indicated during the investigation of Resident B's bruises, the facility had determined the extensive bruising and lacerated lip were caused by the resident being resistant to care, possibly flailing arms/hand and possibly hitting extremities on bedrail or the wall. She was not sure how the lip laceration or bruise on the chest occurred. CNA 9 had been suspended for 5 days pending investigation then returned to work. This had not been included on the state notifications. When asked why the resident allegations of being abused by the night CNA 9 were not reported, the ADM indicated at first she was not told about the allegations of abuse, just the bruises, and she was going by facility policy to report the bruises of unknown origin. CNA 9 was suspended due to customer service as she provided care in a rushed manner, and concerns with her tone of voice. The DON indicated they did not think to report Resident B's allegations of being raped as she had a history of PTSD from being raped. On 4/5/24 at 5:00 p.m., the ADM provided an Abuse Prevention Policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, "It is the policy of this facility to prevent resident abuses, neglect, mistreatment, and misappropriation of property. Each resident receives care and services in a person-centered environment in which all individuals are treated as human beings ...Employees are required to report any incident, allegation or suspicion of potential abuse, neglect or mistreatment they observed, hear about or		Corrective action completion date: 5/7/2024	

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	suspect to the Administrator or an immediate supervisor who will immediately report the allegation to the Administrator ....All incidents will be documented, whether or not abuse occurred, was alleged or suspected ... The final investigation report will be completed within the required time frame allowed by the State Department of Health of the reported incident. The final report shall include facts determined during the process of investigation, review of the medical records, personnel files and interview of witnesses. The final investigation shall also include a conclusion of the investigation based on known facts. The Administrator or designee is then responsible for forwarding a final written report of the results of the investigation and any corrective action taken to the Department of Public Health..." This Federal tag relates to Complaints IN00431337 and IN00431357. 3.1-28(c)			
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 professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to have a system in place for documentation of falls, non-pressure wounds, and injuries, and failed to ensure assessments and	F 0684	**F 684 Quality of Care** It is the policy of this facility to have a system in place for falls, non-pressure wounds, and injuries	05/07/2024

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	documentation were completed after falls, non-pressure wounds, and allegations of abuse were identified for 3 of 4 residents reviewed for falls and bruises (Residents B, C, and D). Findings include: 1a. An anonymous statement during the survey indicated Resident B was "roughed up" by a CNA (Certified Nursing Assistant) and had a busted lip and handprint marks all over her arms. The resident kept saying a "big gorilla beat me up". On 4/3/24 at 9:30 a.m., the Administrator (ADM) indicated there had been only one (1) state reportable incident related to staff to resident abuse, or injuries of unknown origin, dated 2024, and indicated the reportable was not related to Resident B. An Indiana State Department of Health Survey Report System report, dated 3/19/24 at 5:40 a.m., indicated Resident B was observed by the nurse to have swelling, bruising to her left hand, and bruising to the right hand and right arm. After speaking with the resident, the ADM was unable to identify the source of the bruising. An X-Ray was ordered for the left hand. Resident B was referred to social services for psychosocial support for 7 days. An investigation was initiated, and the facility would update all applicable findings in follow up. The investigation was completed without findings. Resident B's x-ray results were negative. Resident care plan was updated to reflect combative with care. The resident record lacked documentation the resident had psychosocial support for 7 days or that the care plan was updated to reflect resident was combative with care.		for assessing and documenting. **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B was assessed by the DON/SSD/ Psych services on DATE and care plan updated by MDS on DATE related to being combative with care. Resident C's responsible party was updated on resident falls for the last 90 days by the DON on DATE. Resident D's care plan was updated by the MDs nurse related to making false allegations and racial slurs on DATE. **2 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 have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents of the facility. **3 What measures will be put into place and what systemic**	

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	A witness statement per LPN 22 indicated, on 3/19/24 around 4:30 a.m. she and a CNA heard screaming. At first, they thought it was a resident on ICF (intermediate care facility) unit who normally screamed out. The yelling/screaming continued LPN 22 asked the CNA to go see if she could find where it was coming from. CNA returned and told the nurse that it was Resident B. LPN 22 went to the resident's room and the resident was up in wheelchair outside her room. CNA from another unit had been asked to get Resident B up because she had "called her a [n----]." The nurse started med pass and noticed the resident's shirt was pulled over top of the left hand. "I could see bruising. I raised sleeves up on both arms when I discovered bruises. I asked CNA about them CNA [9] denied knowing anything about bruising. I asked why [Resident B] was screaming. CNA reported that when she was getting her dressed she said that [n------] were raping her. CNA asked to write statement. Administrator notified." A witness statement per CNA 9, on 3/19/24 at 4:30 a.m. " ...went to get [Resident B] up for the day and assist with daily care resident was sleeping said resident name and tapped resident on shoulder and told resident I was going to help with getting her dress did peri care and changed soiled attends went to residents closet got resident clean pants put wheelchair by the bed when I went to put pants on resident started yelling help the [n------] are trying to rape ... tried to calm resident down resident continued to yell I exited the room, resident was still yelling. Coworker was coming from ICF and I asked could she see if she could get resident to put pants on and told her about the incident, resident was in wheelchair when we entered her room coming out		**changes will be made to ensure that the deficient practice does not recur?** The Director of Nursing/Designee in-serviced the nursing staff on the Policies “Change in Condition”, “Incidents/Accidents/Falls” and Skin-Weight-Assessment-Team Program (SWAT) to include post fall documentation and monitoring of bruises on DATE. The Administrator/Designee in-serviced Social Services on documentation post allegations of abuse and updating care plans related to behaviors on DATE. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The DON/Designee will audit post fall documentation and notification of responsible party for falls 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. The DON/Designee will monitor bruise documentation 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months.	

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	of bathroom resident letted [sic] coworker assist with putting pants nurse informed me that resident has bruise on hand and arm. I did not observe any until nurse informed me. During that time at assisting nurse with asking resident what happened resident started saying and calling me [n-----] and stating they are trying to rape me. Resident was asleep during the beginning of my shift and during bed checks resident was not saturated I letted [sic] resident sleep. Resident does get up and transfers in and out of chair at times without assistance." A confidential witness statement by CNA 25 indicated, " ...4:30 a.m. called to [Resident B's] room to assist staff and resident. I assisted resident with dressing and peri care and brought resident out of the room with me once completed due to resident appearing upset/frustrated with care. I did not witness any verbal or physical escalation at that time." Confidential interviews were conducted during the survey: a. The resident had gone out to the hospital due to increased behaviors i.e. stating someone broke in her room and something about sex, staff were unable to redirect. The day Resident B got bruises, she was carrying on about someone breaking into her room, these behaviors were different for her. The resident was observed to have bruises on the entire right arm from wrist to shoulder purple and darker in color with some red, the left arm had 4 or 5 little bruises on the forearm that looked like finger marks. She had a busted lip on the left side of her mouth with a small quarter sized purple bruise on her chin below the area on her lip. There was no knowledge the resident had recently had a fall. Had never been interviewed about Resident B's injuries.		The DON/Designee will monitor documentation for post allegation of abuse for psychosocial follow up and behaviors care plans 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of 3 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. **5 By what date the systemic changes for each deficiency will be completed?** Corrective action completion date: 5/7/2024	

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	b. Before she left for the hospital, Resident B had extensive dark purple bruises on both forearms, and a purple bruise on her chin below the bottom lip. Had never been interviewed about Resident B's injuries. c. Resident B was observed with bruises, the left arm was entirely covered in dark purple bruises, right upper forearm, and dark purple bruise on left side of bottom lip. Had never been interviewed about Resident B's injuries. A CNA - Bath/Shower Checklist by Licensed Practical Nurse (LPN) 22, dated 3/19/24 at 7:00 a.m., indicated 10 measurements on a diagram of the body. There was no explanation to indicate the measurements were bruises or another injury. In addition, lacked documentation of discoloration and or swelling to the top of left hand. a. Upper right chest measurements 0.8 centimeters (cm) x (by) 0.5 cm, and 1.5 cm x 0.5 cm. b. Left chin under bottom lip 2.5 cm x 1.0 cm. c. Back of left forearm 3.0 cm x 1.5 cm. d. Back of left hand 10 cm x 12 cm. e. Back of right arm from elbow to wrist 11.5 cm x 5.5 cm, 7.2 cm x 6.5 cm, 3.3 cm x 4.0 cm, 3.5 cm x 3.0 cm, and on the back of the right hand 4.0 x 1.2 cm. Resident B's record was reviewed on 4/3/24 at 10:04 a.m. Diagnoses on Resident B's profile included, but were not limited to, vascular dementia without behavioral disturbance (condition can cause cognitive difficulty with reasoning, judgement, and memory deficits). A physician's order for Resident B, dated 8/25/23, indicated to administer Plavix (blood thinner) 75 milligrams (mg),1 tablet by mouth, one time a day for anti-platelet therapy. Physician's orders for Resident B, dated 3/19/24,			

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	monitor bruising on bilateral upper extremities (BUE) every shift until resolved. Ice pack on BUE twice daily (BID) for 24 hours related to adverse effect of anticoagulants. X-ray of left hand one time only. A progress notes, dated 3/19/24 at 6:58 a.m., indicated left two voicemail's for express mobile to x-ray residents left hand. The resident record lacked documentation of when nursing staff found the resident with bruises and a laceration on her lip, immediate follow up treatment by nursing, root cause of the bruising, the resident representative was notified, or why the resident needed x-rays to the left hand. An eINTERACT Change in Condition Evaluation, dated 3/19/24, indicated bruises identified on 3/18/24, on Plavix. Behavioral assessment was not clinically applicable to the change in condition being reported. Skin assessment was relevant to the change in condition reported, discoloration, left back of hand bruises, right forearm bruises, left forearm bruises. This notification lacked documentation of split lip, bruise on chin or chest, or measurements and extent of bruising. A Physician Progress Note, dated 3/19/24 at 11:09 a.m., Nurse Practitioner (NP) 23 documented the resident was seen in the morning in bed. CNA reported that resident didn't have any bruising yesterday evening, and this morning she had bruising on her left lower lip, and bilateral arms. On exam resident was alert, confused, disoriented, mentation was at baseline. Resident B denied any pain, or discomfort, she stated she didn't sleep well, and it was a rough night. Long term anticoagulant therapy. She presented hematoma's (a solid swelling of clotted blood within the			

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	tissues) on bilateral forearms and back of left hand. The left hand hematoma was still bleeding and increasing in size, and ice pack applied on BUE. Upon chart review she has been on aspirin and Plavix. A progress notes, dated 3/19/24 at 11:33 a.m., indicated large bruises noted on resident's hands, arms, chest, and mouth. DON and administrator were aware. A late entry progress notes, created by LPN 22 on 3/22/24 at 3:57 p.m. and effective date 3/19/24 at 3:37 p.m., indicated a change in condition. Recommendations: x-ray to left hand, ice pack for 24 hours, hold Plavix for 72 hours. A progress notes, dated 3/19/24 at 4:34 p.m., indicated new orders noted and received to hold Plavix for 3 days-bruising BUE; ice pack on BUE for 24 hours; monitor bruising every shift until resolved; decrease cyanocobalamin (Vitamin B-12) to twice a week, and get vitamin B 12 level on 6/17/24. Resident record lacked documentation the resident's bruises on the bilateral arms, edema to BUE, bruises on the chest and chin, or laceration on the chin were followed up by nursing to include root cause, measurements with description, immediate or on-going treatment, or progress towards healing after found on 3/19/24 through discharge 3/24/24. A Pain Review, dated 3/19/24, indicated in the past 5 days the resident received scheduled pain mediation regimen, had not received pain medication, or was offered and declined, and had not received non-medication interventions for pain.			

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	A quarterly MDS (Minimum Data Set) assessment, completed 3/18/24, assessed the resident as having the ability to make herself understood and to understand others. BIMS (brief Interview for mental status) score 7/15 indicating Resident B had severe cognitive impairment. Delirium symptoms included inattention, the resident had difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was said, present but fluctuated in severity. Other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing, or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds), occurred 1-3 days during the assessment period. No rejection of care or wandering. Two or more falls without major injury since the prior assessment. No skin issues documented. A State Operational assessment, completed 3/18/24, assessed the resident as required extensive assistance of 1 person physical assist for bed mobility, transfers, and toilet use. There was no known significant weight loss or weight gain and no skin issues. A care plan, dated 3/13/24, indicated potential for skin discoloration and or bleeding related to aspirin and Plavix use. The goal was for the discoloration to resolve without complications. Interventions included labs per MD orders, medications per MD orders, notify MD and family of any changes in condition and increased skin discoloration, observe for unknown bruising or bleeding, and weekly and as needed skin checks.			

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	A care plan, dated 12/19/23, indicated skin integrity impaired related to bruise left cheek, left lower outer wrist, left upper outer wrist. On 3/20/24 bilateral hands, bilateral arms, lower lip left corner, split lower lip, resident on aspirin and Plavix. Goal will resolve without complications. Interventions notify MD and family of change in condition, observe for signs and symptoms of increase in size of area, observe vital signs as indicated, and treatment per orders. During an interview on 4/4/24 at 10:45 a.m., LPN 16 indicated, if a resident was found to have a new injury to include cuts or bruises, she would notify DON, ADM, MD and family. The injury or bruises would be documented in a skin assessment, incident report that included a progress note section, and document a description of the skin issue(s). Indicated before Resident B left for the hospital, she was observed to have bruises on the back of her hands and a bruise on her lip, the nurse had not heard why. During an interview on 4/4/24 at 3:03 p.m., QMA 10 indicated, Resident B had been transferred to an in-house psych hospital due to an increase in sexual behaviors to include being inappropriate with a male resident. Resident was alert with orientation to self. Resident was observed to have bruising, not sure of cause was not in the facility at the time of occurrence. QMA 10 observed resident to have the entire right arm covered in dark purple bruising, and a small dark purple bruise on her lower lip, but did not remember looking at the other arm. The ADM approached her and questioned if she had known CNA 9 to have been rough in the past. QMA 10 indicated she had heard complaints in the past from residents stating they did not want CNA 9 back in their room taking care of them. The aide had been			

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	suspended but had since returned to work. During an interview on 4/4/24 at 9:43 a.m., RN 26 indicated, if a resident was found on the floor, she could complete a full body assessment, neuro checks to include vital signs (VS), dependent on transfer ability get the resident off the floor, if rotation of lower extremities leave the resident on the floor and call 911. Notify family representative, MD, DON. Complete fall report, change in condition SBAR report, pain assessment, and skin assessment. If witnessed get statements. Documentation in the progress notes to include time and date of fall, description of how resident found, shoes and socks on or off, injury or not, who was notified such as family and MD, witnessed or unwitnessed, neuro checks per schedule. Root cause if known or statement of resident unable to tell what happened, type exactly what resident said. Every fall got an intervention, she would go through the care plan to see what was not already on intervention. Fall follow up was 3 days in the progress notes. If an injury such as a bruise or wound, she would open a wound assessment and it would trigger a weekly assessment. On an initial skin assessment for a wound there should be a description and measurements. During an interview on 4/4/24 at 3:03 p.m., QMA 10 indicated, Resident B had been transferred to an in-house psych hospital due to an increase in sexual behaviors to include being inappropriate with a male resident. Resident was alert with orientation to self. Resident was observed to have bruising, not sure of cause was not in the facility at the time of occurrence. QMA 10 observed resident to have the entire right arm covered in dark purple bruising, and a small dark purple bruise on her lower lip, did not remember looking			

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	at the other arm. The ADM approached her and questioned if she had known CNA 9 of being rough in the past, QMA indicated had heard complaints in the past from residents stating they did not want CNA 9 back in their room taking care of them. The aide had been suspended, but had since returned to work. During an interview on 4/5/24 at 1:50 p.m., the ADON acknowledged when a fall occurred, the process was for the staff nurse to assess the resident for injury to include vital signs and neuro checks if the resident had an unwitnessed fall or injuries. The nurse would open an incident report, complete a skin assessment, pain assessment, and fall assessments, and document the incident in the progress notes, and follow up of the fall for 72 hours. The nurse would send a SBAR (situation, background, assessment, recommendation) to the physician to notify of the fall and receive follow up orders, call the resident representative, and notify the Director of Nursing (DON). The documentation should have been completed by the nurse at the time of the fall or before leaving their shift. 1b. A Fall Risk Review, dated 1/2/24, the Assistant Director of Nursing (ADON) documented no history of falls in the last 3 months. Ambulation with assistance. Physician's orders lacked documentation of activity orders to be up with or without assistance, or with mobility devices. A late entry progress notes by an agency Licensed Practical Nurse (LPN) 22, created on 2/6/24 at 12:22 a.m., effective dated 2/3/24, indicated SBAR Summary for Providers, change in condition related to falls.			

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	Late entry IDT (interdisciplinary team) progress notes, created by the DON on 2/21/24 at 11:13 a.m., indicated the resident had an unwitnessed fall (on 2/3/24). The resident was noted to be in the hallway. ambulating without her wheelchair (WC), the WC was in another resident's bathroom. The resident was unable to state what had happened due to cognitive impairment. The root cause of fall was cognitive impairment causing poor safety awareness. New intervention put into place to keep resident in common areas as she allows. A progress notes, dated 2/15/24 at 4:30 a.m., indicated resident had an unwitnessed fall in bedroom. Resident was noted to be laying on the floor beside her bed. Breathing regular and unlabored. Skin pink, warm and dry. Resident was able to move all extremities without any difficulty. Denies having pain or hitting head. Supervisor, emergency contact, and MD notified. A late entry IDT progress notes, created by the DON on 2/20/24 at 2:34 p.m., effective date 2/16/24 at 2:30 p.m., indicated the resident had an unwitnessed fall. The resident was noted to be on the floor of her room by her bed. The resident was unable to state what happened due to cognitive impairment. No injuries noted. Neuro checks initiated and WNL (within normal limits) at the time of the fall. MD, family, DON and Therapy notified. The root cause of fall was resident poor safety awareness due to cognitive impairment and restlessness. New intervention put into place for to offer/assist resident with getting up and out of bed and bring to the nurse's station and offer a drink of resident choice. A progress notes, dated 2/22/24 at 5:30 a.m.,			

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	indicated a bruise noted on left side of hip the size of a golf ball. A late physician's note, created on 3/18/2024 at 5:08 p.m. and effective date 2/22/24 at 5:07 p.m., indicated no documentation of skin impairment to include a bruise on the left hip. The resident record lacked documentation a skin assessment was completed for the bruise to the left hip, the MD or resident representative were notified timely, or follow up documentation was completed to identify the root cause of the bruise on the hip or on-going assessments were completed unit the hip bruise was resolved. Fall Tracking provided by the ADM on 4/3/24 at 10:30 a.m., dated February and March 2024, indicated Resident B had falls on 2/3 and 2/15. A care plan, date initiated 3/13/24, resident at risk for falls due to syncope. Goal was to be free from falls. Interventions included anti-rollbacks on wheelchair, assist resident with ADL's (activities of daily living -bathing, dressing, eating) as needed, encourage resident to use call light for assistance, from staff, encourage resident to wear non-skid footwear when out of bed, fall screen quarterly and as needed, keep call light within easy reach, notify MD of any changes, 2/5/24 keep in common areas as the resident will allow, and 2/15/24 if resident is restless while in bed offer to get her up and bring her out to the nurse's station and offer a drink. Refer to therapy as needed. During an interview on 4/5/24 at 4:45 p.m., DON indicated in morning meeting during risk management she read resident progress notes, would distribute notes to nurses of findings,			

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	contact responsible parties to fix documentation, and monitored until documentation was fixed. ADM indicated, as new management they knew there were a lot of processes that needed addressed and they were working on them as quickly as possible. During an interview on 4/5/24 at 4:40 p.m., the ADM indicated she could not answer as to why Resident B's bruises on bilateral upper extremities, chest, chin, and laceration on lip were not measured and described and followed up until resolved, or why falls and resident to resident abuse follow up was not in the resident record progress notes. ADM indicated nurse documentation of incidents to include wounds should have been basic knowledge for nurses. The DON indicated the documentation should have been in the chart, and on-going education for nursing staff was being provided. 2. Resident C's record was reviewed on 4/3/24 at 2:05 p.m. Diagnoses on Resident C's profile included, but were not limited to, dementia, and repeated falls. On 4/4/24 at 10:06 a.m., Resident C was out of her room, a fall mat was observed on the floor along the front side of the bed. QMA 11 indicated, the resident had recently had a fall when she rolled out of the bed onto her fall mat and was getting medication on her back due to complaints of back pain. On 4/4/24 at 2:45 p.m., Resident C was observed in a wheelchair sitting in front of nurses' station among peers. QMA 10 was observed to grab the resident's hands and stated "we don't do this in my house" in a stern voice. QMA 10 was then observed to take resident to her room after			

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	resident was asked if she wanted to go to her room and said yes. Fall report, dated February and March 2024, indicated resident documented as having fallen on 3/24/24. No additional falls on the reports. A Fall Risk Review completed on 3/22/24, score of 15 indicated high risk for falls. The resident had a history of falls in the past 3 months. She was non-ambulatory and used assistive devices. . An eINTERACT SBAR Summary for Providers, dated 12/22/23 at 12:32 p.m., indicated change in condition related to falls. The resident record lacked documentation 72 hour post fall follow up was completed, or the family representative had been notified at the time of the incident. A progress notes, dated 3/24/24 at 5:36 a.m., indicated resident fell out of bed onto the mat that was placed there nightly for her safety. Resident was found next to her bed on the mat with her head toward the wall facing her bed and her legs pointing toward the closets in her room. An eINTERACT SBAR Summary for Providers, dated 3/25/24 at 1:48 a.m. indicated change in condition related to falls. A quarterly MDS assessment, completed on 2/27/24, assessed the resident as having the ability to make herself understood and to understand others. BIMS score 99 indicated resident unable to complete mental status assessment. There were no signs or symptoms of delirium, behaviors, rejection of care, or wandering, one fall without major injury since the			

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	prior assessment. No skin issues were documented. State Optional MDS assessment, dated 2/27/24, assessed the resident as having the ability to make herself understood. BIMS score 99 indicated resident unable to complete mental status assessment. There were no signs or symptoms of delirium, behaviors, rejection of care, or wandering. Resident required extensive assistance of 1 person physical assist for bed mobility, transfers, and toilet use. There was no known significant weight loss or weight gain. No wounds or skin concerns were noted. A care plan for falls, dated 11/14/22, indicated the resident was at risk for falls due to history of falls, dementia, heart disease, and anxiety. Goal was for the resident to be free from falls. Interventions included on 11/14/22 assist resident with ADL's as needed, keep call light within easy reach, on 6/2/23 brightly colored room sign with name, on 12/22/23 change to a more appropriate wheelchair. New intervention to increase toileting times and offer to get the resident up when awake was being added. During an interview on 4/5/24 at 1:50 p.m., the ADON acknowledged when a fall occurred, the process was for the staff nurse to assess the resident for injury to include vital signs and neuro checks if the resident had an unwitnessed fall or injuries. The nurse would open an incident report, complete a skin assessment, pain assessment, and fall assessments, and document the incident in the progress notes, and follow up of the fall for 72 hours. The nurse would send a SBAR (situation, background, assessment, recommendation) to the physician to notify of the fall and receive follow up orders, call the resident representative, and			

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	notify the Director of Nursing (DON). The documentation should have been completed by the nurse at the time of the fall or before leaving their shift. 3. An Indiana State Department of Health Survey Report System report, dated 2/23/24 at 12:1, indicated Resident D reported to ADM night shift CNA 12 was rude and hit him during care. Resident was referred to social service for psychosocial support. Investigation initiated, will update all applicable findings in follow up. MD, DON, HFA (Health Facility Administrator), and family aware. No injuries noted. Resident referred to social services for psychosocial support for 7 days. Staff member immediately placed on suspension. Investigation initiated, will update all applicable findings on follow up. Follow up, dated 2/27/24, resident continues with normal routine, no signs, or symptoms of distress. Staff and residents interviewed with no additional concerns noted. Full assessment completed with no findings. Social Services will continue to follow up and monitor for changes. Allegations unsubstantiated. Resident care plan updated for false allegations and racial slurs. MD, DON, HFA, and family aware. The resident record lacked documentation the resident had psychosocial support for 7 days or that the care plan was updated to reflect false allegation and racial slurs. On 4/4/14 at 10:21 a.m., resident was observed to be out of room. Resident D's record was reviewed on 4/5/24 at 11:00 a.m. Diagnoses on Resident D's profile included, but were not limited to, cerebral infarction (stroke).			

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	Progress notes, dated 2/20 - 2/28/24, lacked documentation of resident allegations of abuse by night aide or documentation by Social Service Designee (SSD) regarding psychosocial follow up or monitoring for distress for 7 days. A CNA - Bath/Shower Checklist, dated 2/23/24 at 12:15 (did not specify a.m. or p.m.) indicated discoloration &/or swelling to right outer wrist 1 cm x 1 cm, scratch on right forearm approximately 1 cm x 0.3 cm. The record lacked additional documentation of the skin impairments found on 2/23/24. During an interview on 4/5/24 at 1:50 p.m., the ADON indicated the process was for the staff nurse to assess the resident for injury to include vital signs and neuro checks if the resident had an unwitnessed fall or injuries. The nurse would open an incident report, complete a skin assessment, pain assessment, and fall assessments, and document the incident in the progress notes, and follow up of the fall for 72 hours. The nurse would send a SBAR (situation, background, assessment, recommendation) to the physician to notify of the fall and receive follow up orders, call the resident representative, and notify the Director of Nursing (DON). Policies for fall prevention, fall follow up, and physician notification for change in condition were not provided during the survey process. This Federal tag relates to Complaints IN00431337 and IN00431357. 3.1-37(a)			