STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155242	A. BUILDING 00 B. WING	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE OF MUNCIE	4301 N WALNUT ST MUNCIE, IN 47303

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00362423. Complaint IN00362423 - Substantiated. Federal/state deficiency related to the allegation is cited at F689. Survey date: September 23, 2021 Facility number: 000146 Provider number: 155242 AIM number: 100291200 Census Bed Type: SNF/NF: 122 Total: 122 Census Payor Type: Medicare: 9 Medicaid: 78 Other: 35 Total: 122 This deficiency reflects State Finding cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 24, 2021.	F 0000	F 0000 This Plan of Correction is the facility's credible allegation of compliance. The facility respectfully requests a desk review and has provided evidence of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F 0689 SS=G 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

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	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure fall prevention interventions and adequate supervision were in place for 1 of 3 residents reviewed for falls (Resident C). This deficient practice resulted in Resident C sustaining a fracture of the neck of the humerus bone. Findings include: The clinical record for Resident C was reviewed on 9/23/21 at 10:29 a.m. Diagnoses included but were not limited to, left humerus fracture, hemiplegia, hemiparesis, cerebrovascular accident, muscle weakness and lack of coordination. The most recent significant change Minimum Data Set (MDS) assessment, dated 5/19/21, indicated the resident was moderately cognitively impaired. She required two-person assistance with bed mobility and transfers. She had both upper and lower one-side impairment with range of motion. A health care plan, initiated on 1/14/20 and revised 9/23/21, indicated the resident was a fall risk related to impulsive behavior, poor safety awareness and a non-compliance with transfers. An intervention was established on 12/30/20 to attempt to keep the resident in common area while awake. Another health care plan, initiated 6/4/21 and revised 9/23/21, indicated the resident was non-compliant with waiting for assist with transfers, resulting in falls. The non-compliance was related to cognitive impairment. On 6/4/21, a	F 0689	IDR - Based on the verbiage of the 2567 surveyors failed to demonstrate facility was deficient in providing fall prevention interventions and supervision was provided to the extent reasonable. 1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #C returned to the facility. Sling is ordered for comfort PRN. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Newly admitted residents will be considered at risk for falls and a basic fall care plan will be implemented upon admission to minimize risks. Falls will be audited for the past 90 days to ensure interventions are in place, care plans and CNA assignment sheets have updated, and interventions validated to be in place. 3. What measures will be put into place and what systematic changes will be made to ensure	10/08/2021

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	new intervention was established to attempt to keep resident in common area while awake. An Inter-disciplinary Team (IDT) note, dated 12/30/20 at 9:40 a.m., indicated the resident was up without assistance and fell. An intervention was implemented to keep the resident in the common area when awake. A fall risk assessment, dated 7/7/21, indicated the resident had 1 or more falls in the past 6 months and required assistance and supervision with mobility, transfers or ambulation. The fall risk score was 23, which indicated she was high risk for falls. The progress notes indicated the following: 8/1/21 at 4:31 p.m., Resident continues on increased rounding every 15 minutes. 8/8/21 at 4:43 a.m., Resident continues on 15 minute monitoring. 8/9/21 at 6:36 a.m., Resident continues on 15 minute monitoring. 8/10/21 at 12:03 a.m., Resident continues on increased rounding every 15 minutes. 8/16/21 at 8:28 p.m., Resident has made one attempt to stand today in the hall. Resident continues on the 15 minute monitoring. 8/22/21 at 6:35 a.m., Resident continues on 15 minute monitoring. 8/24/21 at 11:53 p.m., Resident continues on 15 minute....Resident sitting at nurses' station at this time because she stated she was not ready for bed yet. 8/29/21 at 4:04 p.m., Resident continues on 15 minute checks. A progress note, dated 8/29/21 at 7:30 p.m., indicated "Patient sitting up right in wheelchair in room." The resident refused to use the call light		that the deficient practice does not recur? Nursing staff will be educated on Fall Prevention process, immediate fall interventions for use to minimize the risk of falls and fall related injuries, documentation requirements and expectations following an event, updating care plan and CNA assignment sheets with new interventions, and ensuring those interventions are in place. Additionally, nursing staff to be educated on proper clinical care to include body assessment, ROM, first aid, documentation of assessment and/or evaluation & clinical care provided, neurological assessment as necessary and notification of M.D., Family, and DON. Falls will be discussed in Daily Clinical Meeting to ensure fall review is complete, interventions are appropriate and documentation complete. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? The DON or Designee will perform fall audits Monday thru Friday x 4 weeks; then 3 x weekly x 6 weeks; then weekly x 6 weeks; and reviewed in QAPI meeting monthly x 3 or until committee determines that substantial	

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	and transferred herself to the bathroom. The resident was getting off the toilet without assistance and fell onto the floor. The resident was observed in an upright position and used the call light after the resident was on the floor. The resident complained of pain in her left arm pain, discomfort, back pain and right side pain when coughing. At 7:55 p.m., the physician was notified and ordered an x-ray. An IDT note, dated 8/30/21 at 10:15 a.m., indicated interventions included reviewing bedtime preference with nursing staff and family. A progress note, dated 8/30/21 at 1:59 p.m., indicated the resident continued to complain of pain on her left shoulder and received Tylenol routinely. The resident was currently out to an appointment. A progress note, dated 8/30/21 at 5:23 p.m., the resident returned from the orthopedic appointment with a new order to leave her arm in the sling and swathe except for bathing. A follow-up appointment was made for 2-weeks. An orthopedic visit, dated 8/30/21, indicated the resident now had 3 proximal humerus fractures identified on the x-rays obtained at the facility. The order included to "sling and swath full-time with the exceptions of bathing...." On 8/31/21 at 3:43 a.m., resident complained of left arm and back pain. On 8/31/21 at 11:45 p.m., resident complained of left arm and back pain and was given Tylenol.		compliance has been achieved for at least 2 consecutive months.	

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	On 9/14/21 at 3:05 p.m., the resident returned from her appointment with an order to begin range of motion with her arm. A progress note, dated 9/20/21 at 6:25 a.m., indicated the resident remained at the nurses' station until ready for bed. During an interview on 9/23/21 at 1:33 p.m., the Director of Nursing (DON) indicated the incident was reported to the Indiana State Department of Health (ISDH), but they did not have any staff statements since all the information was on either the event or Situation, Background, Appearance, Review (SBAR) form. The nurse who wrote the information related to the fall was from an agency and she did not believe she had worked at the facility since. The DON indicated the resident was able to self-propel and may have left the nurses' station and then went into her bathroom and fell. During the exit conference, the Administrator indicated since the care plan stated "attempt" to keep at the nurses' station, he was unsure of the concern. No information was provided on exit related to staff attempting and failing to keep the resident at the nurses' station while she was awake on 8/29/21. A review of a current policy titled, "Falls" provided by the DON on 9/24/21 at 2:30 p.m., indicated the following: "POLICY STATEMENT It is the intent of this facility to provide residents with assistance and supervision in an effort to minimize the risk of falls and fall related injuries. GUIDELINE:			

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	1. All residents will have a comprehensive fall risk assessment....Appropriate care plan interventions will be implemented and evaluated as indicated by assessment. ...4. Interdisciplinary (IDT) / Director of Nursing (DON) or designee reviews during At Risk Meeting. a. Identify additional referrals, consults, and interventions. b. Document resident response to intervention...." This Federal Tag relates to complaint IN00362423. 3.1-45(a)(2)			