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	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 IN00353693. Complaint IN00353693- Substantiated. Federal/state deficiency related to the allegation is cited at F689. Survey dates: May 14 and 17, 2021 Facility number: 000146 Provider number: 155242 AIM number: 100291200 Census Bed Type: SNF/NF: 124 Total: 124 Census Payor Type: Medicare: 12 Medicaid: 82 Other: 30 Total: 124 This deficiency reflects State Finding cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 20, 2021.	F 0000	The Plan of Correction is the facility's credible allegation of compliance. This 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

Any deficiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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 record review and interview, the facility failed to ensure adequate supervision and interventions were in place to prevent multiple falls for 1 of 3 residents reviewed for falls (Resident B). This deficient practice resulted in Resident B sustaining multiple rib fractures, pain and hospitalization. Findings include: The clinical record for Resident B was reviewed on 5/14/21 at 9:50 a.m. Diagnoses included but were not limited to, multiple fractures of ribs on left side, hemiplegia, hemiparesis, Cerebrovascular Accident (CVA), muscle weakness and lack of coordination. The most recent quarterly Minimum Data Set (MDS) assessment, dated 4/19/21, indicated the resident was moderately cognitively impaired. She required one-person assistance with bed mobility, transfers, dressing and toileting. She had both upper and lower one-side impairment with range of motion. A health care plan, initiated on 1/14/20, indicated the resident was a fall risk related to weakness, impaired balance, CVA and hemiplegia. Interventions included, but were not limited to, toilet every two hours, establish a bedtime routine and offer to lay down after meals. A physician's order, dated 11/30/2020, indicated to toilet the resident every two hours. The order was discontinued on 1/24/21. A progress note, dated 1/11/21 at 11:46 a.m.,	F 0689	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident B returned to the facility on 5/12/21. Resident fall history for the past three months has been reviewed by the Interdisciplinary Team (IDT) to further assess preventative measures. In addition, a medical record review was completed by a Behavioral Specialist to assist with identification of potential interventions and/or care provider actions as interventions in preventing falls. The care plan has been reviewed and updated to reflect the current resident status. 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? The IDT has completed a review of residents with multiple events from 4/1/21 to current date to review current interventions, effectiveness of current interventions, potential revisions if determined necessary, with care plan updates completed to reflect the current status of the resident(s). The facility staff have been provided re-education on Fall Prevention process,	06/14/2021

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	indicated Resident B was found on the floor outside of the dining room, lying on her left side. The resident was asked what happened and she pointed to a piece of paper on the floor and indicated she was trying to pick it up. The staff were educated to make sure the meal tickets were served with the trays. On 12/30/20, the care plan included an intervention included to keep resident in common area while awake. On 1/11/21, the care plan included an intervention to ensure the dining room was free of clutter. A progress note, dated 2/5/21 at 1:32 a.m., indicated the resident was heard yelling for help. She was found on the floor in her room. She indicated she was trying to transfer from her wheelchair to bed. Resident B stated her hip hurt but denied pain once in bed. The resident was in a well-lit room watching TV in her wheelchair before the fall. On 2/5/21 at 9:40 a.m., a new order was received to obtain x-rays of the left hip related to pain from fall. No fractures were noted on the x-ray. An internal fall investigation report, dated 2/5/21, indicated the resident attempted to self-transfer. The CNA reported the resident wanted to stay up and watch television in her room. A John's Hopkins Fall Risk assessment, dated 2/5/21, indicated the resident was a moderate fall risk. A progress note, dated 2/24/21 at 6:50 a.m.,		immediate fall prevention interventions for use to minimize the risk of falls and fall related injuries, documentation requirements/expectations following an event, and care plan review and revision at time of events. In addition, the IDT has been re-educated on completing a root cause analysis of an event to determine an appropriate intervention to prevent further falls. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Residents are at risk for falls/event at any given time on any given day. It is the responsibility of all staff members across disciplines to assist with fall prevention. The Director of Nursing/designee will be responsible to complete auditing of fall preventions currently identified for resident for fall prevention for 100% of current resident population for 7 days on each shift, then 50% of current resident population across shifts 5 times per week for 4 weeks, then 25% of current resident population 5 times a week across shifts for 8 weeks, and then monthly for 3 months. Furthermore, the DON/Designee will be responsible to review falls/events and conduct a root cause analysis with the IDT with 100% fall/events for 4 weeks, and	

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	indicated the resident had a witnessed fall by a CNA. An internal fall investigation report, dated 2/24/21 at 6:05 a.m., indicated the resident slipped while self-transferring in the bathroom trying to getting up from the toilet. The CNA went to turn down the bed and was on her way back when she observed the resident attempt to transfer and lost her balance. The CNA was educated to not leave the resident alone in the bathroom and to follow the care guide for Resident B. A counseling session, dated 2/26/21, indicated the CNA did not follow the care guide and left the resident unattended in the bathroom, which resulted in a fall. An internal fall investigation report dated 3/20/21 at 12:10 p.m., indicated the resident was found on floor in the dining room, reaching for something and fell out of wheelchair. The wheelchair was not locked and it slid out from under the resident. The staff were educated on keeping dining room clean before and after meals. A John's Hopkins Fall Risk assessment, dated 4/21/21, indicated the resident was a high fall risk. A progress note, dated 5/9/21 at 3:42 a.m., indicated a CNA was walking by Resident B's room at 3:15 a.m. and noticed she was not in bed. She heard the resident calling for help and found her on the floor, leaning up against a trash can. The resident stated she was trying to get dressed. She was assisted back to bed and was noted to have an abrasion to her left mid-back and a small		then 50% fall/events for 4 weeks, and then 25% fall/events for 8 weeks. Any issues identified will be immediately addressed with 1:1 re-education, disciplinary action as determined necessary by the Administrator and/or DON, up to and including termination. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The Administrator/designee will be responsible to review the monitoring process in the time frame as stated above. Results of the monitoring review will be forwarded to the Quality Assurance Performance Improvement Committee (QAPI) monthly for 3 months, and then quarterly for 3 quarters. Any further action required or necessary will be as determined by the QAPI committee. 5. By what date the systemic changes for each deficiency will be completed? June 14, 2021	

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	laceration. Resident B was given Tylenol at 3:40 a.m. for pain. She continued to complain of pain with movement. The physician and family were notified of the fall. A change of condition form, dated 5/9/21 at 4:22 a.m., indicated when the resident was moving or taking a deep breath, her condition worsened. The resident had an abrasion to the left mid-back. A pain evaluation completed 5/9/21 at 4:30 a.m., indicated the resident was complaining of pain that was described as aching and burning. The pain was moderate and persistent. She exhibited frowning, grimacing and moaning. A progress note, dated 5/9/21 at 7:33 a.m., indicated the physician ordered a STAT (immediate) portable x-ray. The focus was to be on the ribs and Tylenol was given again at 7:00 a.m. for pain. During an interview on 5/17/21 at 8:33 a.m., the DON indicated the portable x-ray tech arrived to the facility at 1:03 p.m. She indicated she spoke to the contracted diagnostic company and they try to do a stat order in less than 4 hours during the week and for the weekend it was more like 4-6 hours. On 5/9/21 at 3:45 p.m., the family arrived and requested the resident be sent to the hospital. The resident was admitted to the hospital for X-rays and pain. An Interdisciplinary Team (IDT) note, dated 5/10/21 at 10:26 a.m., indicated the resident was getting up to get dressed and fell. She complained of pain and an x-ray was obtained and showed no fractures, but left lower lobe			

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	infiltrate. Review of an Indiana Department of Health report, provided by Director of Nursing (DON) on 5/14 at 8:48 a.m., indicated on 5/9/21 at 3:15 a.m., the resident was found on floor near trash can and the trash can was broken. The abrasion to the mid-back fit the part of the trash can that was broken. The resident was transported at 3:45 p.m. to the local hospital. The resident was found to have fractured ribs 7-12 and thoracic spinal vertebrae fracture on T11 and T12. Resident B returned to the facility on 5/12/21 and required no surgical intervention. On 5/13/21, the care plan included an intervention to keep the bed in the lowest position and a mat next on the floor. A facility investigation indicated the root cause was self-transfer. A witness statement by RN 1, indicated when she arrived the resident was on the floor and the trash can was broken behind her. Tylenol was given for pain and a neurological assessment was initiated. The resident later complained of pain after Tylenol was given and the physician was notified. The resident did not appear in distress, but did appear uncomfortable. A witness state provided by CNA 2, indicated the resident was in her wheelchair when she arrived to work. The resident asked to be laid down and the CNA laid her down at 8:00 a.m. and she slept until 10:30 a.m. The resident then got up and was seated in her wheelchair ready for lunch. She did not appear to be in distress, but uncomfortable.			

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	During an interview on 5/14/21 at 11:30 a.m., CNA 2 indicated when she got to work, the resident was up in her wheelchair. She laid her down after breakfast and she seemed fine. She did complain about the gait belt, but thought it was because of the abrasion on her back. She was one you had to keep an eye on at all times and she will often take herself to the bathroom and forget she needs help. She was surprised at the extent of her injuries. During an interview on 5/14/21 at 11:36 a.m., CNA 3 was asked about the day the resident fell since she had charted her activities of daily living on 5/9/21 prior to her being sent to the hospital. She indicated the resident was hard-headed and would do want she wants to do and did not recall her being in any pain. During an interview on 5/17 at 12:01 p.m., the DON indicated the resident was on increased rounding for falls and she was to be toileted every 2 hours. She indicated staff were documenting the increased rounding in progress notes, but there was no place they were documenting them taking her to the bathroom every 2 hours. A review of a current policy titled, "Falls" provided by the DON on 5/17/21 at 1:53 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: 1. All residents will have a comprehensive fall risk assessment....Appropriate care plan interventions will be implemented and evaluated			

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	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 IN00353693. 3.1-45(a)(1) 3.1-45(a)(2)			