STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155291	A. BUILDING 00 B. WING	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAGLE VALLEY MEADOWS	3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00430399. Complaint IN00430399 - Federal/state deficiencies related to the allegations are cited at F689. Survey dates: March 24, and 25, 2024 Facility number: 000188 Provider number: 155291 AIM number: 100266310 Census Bed Type: SNF/NF: 75 Total: 75 Census Payor Type: Medicare: 3 Medicaid: 45 Other: 27 Total: 75 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 3, 2024.	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Eagle Valley Meadows respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after April 17, 2024.	
F 0689 SS=D 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 §483.25(d)(2)Each resident receives			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Holder	Executive Director	04/17/2024

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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	adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure failed to ensure fall interventions were personalized, implemented, and care planned for 1 of 3 residents reviewed for accidents (Resident B). Findings include, An Indiana State Department of Health Survey Report System report, dated 3/6/24 at 8:26 a.m., indicated Resident B had an unwitnessed fall with injury, and was unable to explain how incident happened. Resident B had an acute oblique distal clavicle fracture and was sent to the emergency room (ER) once results received. All interventions were in place prior to fall to include call light in reach and non-skid footwear, call before you fall signage, and body pillow. On 3/11/24 a follow up indicated the root cause of the fall was determined to be resident attempting to go to work. An anonymous interview indicated Resident B had fallen 3 times while in the care of the facility where she had resided less than 3 weeks. On Sunday 3/3/24 the family was informed the resident had fallen during the night and had a small cut they had put a Band-Aid on, no other injuries. Family members visited Resident B on Monday evening and she seemed fine. She had physical therapy (PT), occupational therapy (OT), and speech therapy (ST) on Monday and Tuesday mornings. When the family visited on Tuesday the resident had bruising around her left eye and was complaining of shoulder pain. The facility gave the resident an ice pack for the shoulder pain, the family requested an x-ray. On Wednesday morning 3/6/24 Resident B's family was informed the x-ray showed a fractured clavicle	F 0689	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B is no longer a resident at the facility. **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 having falls have the potential to be affected by the alleged deficient practices. 1x audit was completed for all residents with falls over the past 30 days to ensure fall interventions are in place and are reflective in the care plan and are individualized to meet the needs of the resident. RAI Specialist to conduct an in-service with IDT and nurse managers on or before 4/17/24 regarding policy for Care Plans. Inservice nursing staff on timely documentation and verifying interventions completed by DNS/designee on or before 4/17/24.	04/17/2024

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	bone. When the family arrived at the facility Wednesday morning the resident was badly bruised around the left side of her neck, face, ear, and had a knot on her head. The Executive Director (ED) said the resident had not fallen again and the bruising was delayed from the fall on Sunday. Therapists said the bruising and knot on her head were not present on Tuesday. Resident B was transported to a local hospital where she was diagnosed with a broken nose and urinary tract infection (UTI). During an interview on 3/25/24 at 1:29 p.m., Resident B's family member indicated, the resident had fallen during the night Sunday 3/3/24 around 11 p.m. When he visited during the day on Monday the resident had a small laceration and a tiny Band-Aid on her forehead, there was no bruising, no complaints that her nose or shoulder hurt, and she was moving her arms without problem. When the family member visited on Tuesday the laceration was still covered, he could not remember if there was bruising. On Wednesday morning 3/6/24 he received a call from facility stating the resident was being sent to a local hospital due to an x-ray showing a broken clavicle. After the resident was settled in the hospital the husband went back to the facility and spoke with the therapists caring for Resident B, all of whom indicated they had not observed bruising on Tuesday morning during therapy. X-rays were ordered on Tuesday afternoon or evening after Resident B had complaint of shoulder pain. The family member indicated he did not believe the resident could have completed some of the therapy activities on Monday and Tuesday with a broken clavicle. The family member indicated the Speech Therapist had a disagreement with the Executive Director (ED) of facility in front of him. The Speech Therapist		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** RAI Specialist to conduct an in-service with IDT and nurse managers on or before 4/17/24 regarding policy for Care Plans. Inservice nursing staff on timely documentation and verifying interventions completed by DNS/designee on or before 4/17/24. Observational rounds will be conducted daily by Customer Care Representatives/designee to ensure fall interventions are in place. Resident falls to be audited by the IDT team weekly to ensure consistency with orders, care plan and interventions in place per resident needs. **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:** To ensure compliance the DNS/Designee will complete a Fall Management CQI audit tool for six months with audits being	

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	thought the resident had another fall; the ED indicated she believed the floor nurse that no other fall had happened after 3/3/24. The emergency room (ER) physician indicated Resident B had to have had another fall in facility, there was no way the injuries were a delayed reaction from a fall 3 day prior on Saturday 3/3/24. Upon arrival at the ER the resident was also found to have a broken nose. Resident B's family member indicated the resident had a history of falls while living at home and on 1/6/24 had surgery to relieve pressure to the brain after a fall with a subdural hematoma (pool of blood between the brain and it's outermost covering). Resident B fell tell twice in the first few days in the facility, and staff had spoken to him about moving the resident to the secured memory wing for increased observation and programming but never did. The family member indicated he was upset Resident B had been put into a dangerous situation in the facility with no close monitoring or useful interventions such as bed or chair alarms or fall mats beside the bed in case she fell. A pillow had been added to her bed, but the resident would just push it out of the way or climb over it, and he did not remember seeing a sign in the resident's room that indicated call before you fall. Resident B was alert, confused, impulsive, did not understand she was in danger of falling, and did not understand to use a call light to call for help even when instructed to do so. When Resident B left the facility on 3/6/24 there was a huge knot bigger than a golf ball on the top of her head, and black and dark purple bruising that extended from the top of her head, around the back of her head, her left ear, over the left side of the neck, extended to her collar bone on the chest, and her left eye was black and blue and almost swollen shut. Resident B was not on blood thinners. Now 21 days after the resident was reported as having fallen, she		completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The Fall Management CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee. **By what date the systemic changes will be completed:** 4/17/2024	

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	continued to have a large knot on the top of her head and bruising from the top of her head down onto left shoulder, although the color had faded and was mostly green and yellowish. A hospital report, admission date 3/6/24, indicated an 83-year-old female, with a history to include dementia and recent subdural hematoma status post emergent craniotomy on 1/6/24, presenting for evaluation of clavicle injury after a fall. The patient was currently living in a nursing home. Most recently had a fall 3 days ago. Imaging was done this morning at the facility and showed findings concerning left clavicle fracture. Family deny any mental status changes though note patient has significant bruising of the face for which she has not had any head imaging. Given current facility was unable to care for patient, suspect she will likely require admission to hospital. CT scans (computed tomography scan used to obtain internal images of the body) of the head and face indicated large left frontal scalp/subgaleal hematoma, mildly displaced fractures of the right nasal bone, and extensive left facial, periorbital, and ventral neck soft tissue edema. Assessment plan diagnoses included dementia, sepsis (worsening alerted mental status, increased falls, tachycardia, or elevated pulse up to 102 upon admission) secondary to UTI, scalp hematoma, nasal fractures, and recurrent falls. Resident B's record was reviewed on 3/24/24 at 7:23 a.m. Diagnoses on Resident B's profile included, but were not limited to, dementia without behavioral disturbance, repeated falls, and a prior intracranial injury. An Admission MDS (Minimum Data Set) assessment completed on 2/23/24, assessed the resident as having the ability to make herself			

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	understood and to understand others. BIMS score 9/15 indicated moderate cognitive impairment. Partial to moderate assistance to go from sit to stand position, and substantial assistance of staff required to transfer from chair to chair or chair to bed. History of falls in the past month and 6 months prior to admission and 2 or more falls since admission. Physician's orders for Resident B, dated 2/16/24, ordered PT, ST, and OT 5 times a week for 4 weeks, and Aspirin delayed release 81 milligram (mg), 1 tablet, daily. Specific activity level for being up ad lib (as wanted or needed) or in a wheelchair had not been checked. An Observation (assessment) tab in EMR, dated 2/16/24 at 1:35 p.m., included a Johns Hopkins Fall Risk Assessment Tool Admission assessment that indicated a history of one or more falls within the previous 6 months, score 20 indicated high risk for falls. An Event (incident) tab in the electronic medical record (EMR), dated 2/17/24 at 8:26 a.m., indicated resident found on buttocks, no injuries noted, on blood thinners, neuro checks initiated, resident stated she was trying to get her remote control from her dresser and slipped and fell. New interventions: educated the resident to use call light before transferring. A fall care plan for Resident B, initiated 2/17/24, indicated the resident was at risk for falls due to a history of falls, age greater than 80, incontinence, medications, requires assistance with ADLs, mobility, transfers and ambulation, unsteady gait, altered awareness of immediate physical environment, post traumatic seizures, muscle weakness, lack of coordination, unsteadiness on			

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	feet, abnormalities of gait and mobility, and dementia. The goal was for fall risk factors to be reduced in an attempt to avoid significant fall related injury. Standard approaches observed for all residents at risk for falls dated 2/17/24 included therapy screen, personal items in reach, non-skid footwear, environmental changes, and call light in reach. A late progress note, created on 2/19/24 at 10:32 a.m., by Licensed Practical Nurse (LPN) 5, effective date 2/17/24 at 8:45 a.m., indicated Resident B was found on floor while during rounds, resident states she was trying to get her remote from her dresser and her legs became weak. Resident brought to common area. A late progress note, created on 2/19/24 at 10:40 a.m. by LPN 5 with an effective date of 2/17/24 at 3:39 p.m., indicated a post fall follow up note. Vital signs had been obtained and recorded; neuro checks were being completed. There were no changes noted in neuro checks that shift, no changes in resident condition including range of motion (ROM) or new pain noted that shift, and fall interventions were in place per the plan of care. A late progress note, created on 2/19/24 at 10:40 a.m. by LPN 5 with an effective date of 2/18/24 at 10:40 a.m., indicated a post fall follow up note. Vital signs had been obtained and recorded, neuro checks were being completed, no changes noted in neuro checks that shift, no changes in resident condition including range of motion (ROM) or new pain noted that shift, and fall interventions were in place per the plan of care. A late progress note, created on 2/19/24 at 10:42 a.m. by LPN 5 with an effective date of 2/18/24 at			

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	6:41 p.m., indicated a post fall follow up note. Vital signs had been obtained and recorded, neuro checks were being completed, no changes noted in neuro checks this shift, no changes in resident condition including range of motion (ROM) or new pain noted that shift, and fall interventions were in place per the plan of care. An Interdisciplinary Team (IDT) fall review note, dated 2/19/24 at 11:22 a.m., indicated the resident had fallen in her room. Immediate/short term interventions put in place at time of the fall: resident assessed and assisted to common area. Determined root cause of fall: resident had diagnosis of dementia causing her to need consistent re-direction and assistance for activities of daily living (ADL's) and resident was new to facility and maybe a contributing factor as well. Intervention put in place to address root cause of fall: body pillow to maintain tactile boundaries. A progress note, dated 2/20/24 at 6:08 a.m., indicated Resident B was seen on her left side lying on the floor near her wheelchair and to her bed. Resident could not say anything about the fall due to her mental condition, she was placed near to nurse's station for monitoring. Staff were to anticipate her needs and continue to monitor. An IDT fall review note, dated 2/20/24 at 11:14 a.m., indicated the resident was found lying on the floor in her room. Immediate/short term interventions put in place at time of the fall was that the resident was assessed and assisted to wheelchair and in common area with staff supervision. Determined root cause of fall: resident had diagnosis of dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance,			

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	psychotic disturbance, mood disturbance, and anxiety causing resident to require more supervision, encouragement, and staff cues. Intervention put in place to address root cause of fall: IDT believed resident would benefit from possible room/unit move to the cottage (secured memory care unit) as the cottage provides a small structured unit which may assist in keeping resident from sustaining unwitnessed falls as the environment on the cottage is serene and peaceful, also staff will be able to keep resident in common area for sufficient staff supervision. An Event (incident) tab in the electronic medical record (EMR), dated 2/20/24 at 6:08 a.m., indicated an unwitnessed fall without injury. Resident found on side, no injuries noted, on blood thinners, neuro checks initiated, resident trying to transfer from bed to wheelchair. New interventions: resident in common area with staff supervision. Fall Event form, dated 3/3/24 at 11:30 am, indicated unwitnessed fall in resident room, found lying on her right side, resident could not explain the situation prior to fall due to her mental status having dementia. Unsure if resident hit her head, resident not experiencing pain, resident not experiencing pain with range of motion or movement, and no documentation of injury to include abrasions or bruising. An Event (incident) tab in the electronic medical record (EMR), dated 3/3/24 at 11:30 p.m., indicated resident found lying on right side, laceration, on blood thinners, cannot explained the situation prior to fall due to her mental status having dementia. Monitor Resident every 15 minutes and onward.			

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	A New Skin Event form, dated 3/4/24 at 11:10 a.m., indicated Resident B had a laceration to forehead post fall, new wound in middle of forehead related to a fall, measured 2 cm x 2 cm. New treatment was to cleanse area pat dry apply steri-strips. Preventative measures put into place: weekly skin assessments, proper fall interventions in place. A progress note, dated 3/4/24 at 1:27 a.m., indicated Resident B had earlier experienced an un-witnessed fall, she was seen by Registered Nurse (RN) 8 right side lying with blood from her injured forehead. Resident was immediately helped and moved to her wheelchair. Wound care was completed for a 2 centimeter (cm) laceration to her forehead. Pressure was applied to her wound until bleeding stopped, then steri-strips were placed. Staff would continue to monitor and anticipate resident needs. A progress note, dated 3/4/24 at 8:07 a.m., indicated Resident B had been up that morning with ST. The 2 cm laceration to her forehead remained present and steri-strips in place. An IDT fall review note, dated 3/4/24 at 10:45 a.m., indicated the resident was found lying on the floor in her room. A laceration noted to her forehead. No x-ray obtained, and no ER evaluation. Immediate/short term interventions put in place at time of the fall: resident assessed and assisted to wheelchair and brought to common area. Determined root cause of fall: poor safety awareness determined by resident's current diagnosis of dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Resident required significant staff redirection, cueing and supervision as it related to falls. Intervention put			

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	in place to address root cause of fall: resident to be out of room when up. Orders updated with new interventions, and care plan updated. An Initial Wound Review Note, dated 3/4/24 at 11:19 a.m., indicated laceration to middle forehead. New interventions initiated: steri-strips to area and to be observed every shift. A physician's order for Resident B, dated 3/4/24, ordered non-skid strips at bedside, and monitor steri-strips to forehead for signs or symptoms of infection/warmth/redness, and allow to fall off do not pull off. An Observation (assessment) tab in EMR, dated 3/4/24 at 8:52 a.m., included a Weekly Skin and Vital Sign Assessment that indicated a laceration to forehead, no bruises. A progress notes, dated 3/5/24 at 2:19 a.m., RN 8 documented resident was cooperative during the delivery of care, no noted signs or symptoms of delayed injuries related to fall. Steri-strips to her forehead still intact and no noted increased redness and swelling to affected area, Staff anticipated to her needs and wants, will continue to monitor. A late progress note created on 3/5/24 at 8:20 p.m. by LPN 5, effective date 3/5/24 at 2:19 p.m., indicated swelling and bruising to left side of face remains related to fall. A progress note, dated 3/5/24 at 8:55 p.m., indicated swelling and bruising on the left side of face remained related to fall. A progress note, dated 3/6/24 at 12:09 a.m., indicated no noted increased redness and			

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	swelling to her skin laceration at her forehead, noted bruises and swelling to her left eye related to previous fall, no complaints of pain or discomfort. A Lab/Radiology Results Notification, dated 3/6/24 at 8:26 a.m., indicated left shoulder acute oblique distal clavicle fracture. Order obtained to send resident to ER for evaluation and treatment. A physician's order for Resident B, dated 3/6/24, indicated to send Resident B to the ER for evaluation and treatment. A progress note, dated 3/6/24 at 8:38 a.m., indicated x-ray of left shoulder complete and noted with acute oblique clavicle fracture. The family was made aware and in facility to accompany resident to ER. Resident was noted with increased bruising to left side of face. Laceration to mid forehead remained clean, dry, and intact (CDI). Resident B expressed pain to the area to forehead with pain medication provided. The resident transported by facility transport in a wheelchair to a local hospital. A late entry progress note created on 3/6/24 at 6:27 p.m. by LPN 5, effective date 3/05/2024 at 3:43 p.m., indicated resident had complaint of pain to left shoulder, physician notified and order for x ray given. An Observation (assessment) tab in EMR, dated 3/6/24 at 8:32 a.m., included a Hospital-ER Transfer Form that indicated send Resident B to the ER for eval and treat. Primary diagnosis unspecified intracranial injury with loss of consciousness status unknown, sequela. Condition requiring transfer: acute clavicle fracture, laceration to forehead and increased			

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	bruising to face. Resident has diagnosis of dementia. Facility transport to hospital (not ambulance or family). Baseline: alert, oriented, and follows commands. Non-ambulatory. At risk of falls. A late entry Weekly Skin and Vital Sign Assessment, created on 3/6/24 at 6:23 p.m. by LPN 4, indicated an open area/laceration mid forehead. No documentation of bruising. Speech Therapy notes indicated, a. On 3/4/24, indicated fall risk, safety poor, no contraindications present. Patient with confusion noted. Had fall with a 2 cm head laceration overnight, dressing in place. Resident stated she was dancing at a wedding and fell. The resident actively participated with skilled interventions and compliant with skilled interventions. Total treatment 25 minutes. b. On 3/5/24 indicated fall risk, safety poor, no contraindications present. Patient seen in room, actively participated with skilled interventions and complaint with skilled interventions. Skilled instructions included use memory book; maximum cues needed for orientation/recall. Total treatment 27 minutes. c. On 3/6/24 indicated fall risk, safety poor, no contraindications present. Patient needed cues for sequencing and reasoning this date, worse than baseline function. Resident with complaints of pain to head and noted swelling/bruising, brought resident to nursing for assessment and treatment. Total treatment 25 minutes. Physical Therapy notes indicated, a. On 3/4/24 indicated precautions for fall risk, no contraindications present. Resident with 1 reported fall in room last night sustaining abrasion to left eyebrow. Therapy focused on transfer			

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	training to improve sidestep and proper feet and hand placement to effectively complete sit to stand and gait with front wheeled walker, distance of 25 feet x 2. Resident actively participated in skilled interventions. Total treatment 30 minutes. b. On 3/5/24 indicated precautions for fall risk, no contraindications present. Therapy focused on surface to surface transfers with increased cuing. Resident actively participated with skilled interventions, completed 25 feet x 4 with front wheeled walker. Total treatment 30 minutes. Occupational Therapy notes indicated, a. On 3/4/24 indicated fall risk, decreased safety awareness, no contraindications present. Resident completed bilateral upper extremity strengthening with use of moderate resistance band with supervision, resident completed 2 sets of 15 reps. Resident completed sit to stand transfers with minimum to moderate cuing for hand placement. Good response to session interventions. Total treatment 30 minutes. b. On 3/5/24 indicated fall risk, decreased safety awareness, no contraindications present. Resident approached for treatment session with husband concerned of swollen/bruised side of face. Resident with documented fall Sunday night. Sudden onset bruising. Resident in bed, nurse notified. Resident completed sitting up on side of bed with moderate assistance with extra time and effort. Resident reporting left shoulder pain. Resident returned to supine and notified nurse. Will hold treatment until x-ray is completed on left shoulder. Total treatment 15 minutes. Care plan interventions added after falls included 2/19/24 body pillow, 2/20/24 speak with family about a move to the cottage for a smaller unit, 2/23/24 call before you fall sign, and 3/4/24 out of room when awake. The 2/19/24 intervention of			

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	body pillow was ineffective as the resident had a second fall on 2/20/24, the 2/20/24 intervention of moving the resident to the cottage unit was not completed, call light in reach and fall before you call interventions were not personalized as the resident had dementia and could not understand. The 3/4/24 physician's order for non-skid strips at bedside was not added to the care plan. Colored pictures of the resident injuries were provided by family. The first picture, dated 3/6/24, when Resident B was preparing to leave for the hospital showed dark purple discoloration from approximately 2 inches into the hairline, down through the left eyebrow onto the left cheek. There was also dark purple discoloration above the left side of the top lip and on the front of the throat. The second picture was taken in the ER on 3/6/24 showed dark purple discoloration further into the hairline, down through the left eyebrow onto the left cheek, above the left side of the top lip and on the front of the throat and spreading into surrounding tissue. A third picture, dated 3/8/24, showed extensive dark purple discoloration covering almost the entirety of the residents left top and side of her head, left side of her face, front and left side of her neck down to clavicle and onto left shoulder. There was also a large circular knot on the top left side of her head. The family indicated they had a hard time believing the edema and bruising were from the fall on 3/3/24 considering how it progressively became worse so quickly. The Family member indicated, they had requested bed rails, a fall mat on the floor, and more effective interventions as instructing the resident to use the call light would not have been effective due to her dementia, and there was never a sign in her room that said call before you fall although it would not have been an effective intervention either.			

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	During an interview on 3/25/24 at 9:22 a.m., the Therapy Director indicated he had observed Resident B on 3/4/24 and she had a steri strip on lower part of the forehead above her eyebrow, there was no bruising noted. Documentation of therapy notes on 3/4/24 indicated the resident had participated in therapy without concern to include using Thera bands, sit to stand, and ambulation with a walker, there was no documentation for complaints of shoulder pain or of new or worsening bruising. On the morning of 3/5/34 PT documented resident participation in session, sit to stand and ambulation of 25 ft x 4 with 4-wheeled walker, no documentation of pain or new/worsening bruising. Later on, 3/5/24 OT notes indicated the session was shortened due to resident complaint of shoulder pain, nursing notified, documented bruising. On 3/6/24 ST treated resident early am, resident engaged in card game, pt with complaints of pain to head, noted swelling and bruising. During an interview on 3/25/24 at 3:18 p.m., the Director of Nursing Services (DNS) indicated Resident B had a history of multiple falls at home and was admitted from the hospital post fall at home with injury that she thought required surgery to her head to included drilling burr holes to relieve the pressure. The resident was alert with confusion, had a dementia diagnosis, and she did not believe the resident would have remembered to follow directions such as call before you get up. The DNS indicated she was not sure the documented interventions such as skid strips on the floor were implemented, talk with family regarding secured memory care unit, body pillow was actually implemented, or why the interventions were not replaced with other documented interventions when found to be			

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	ineffective. Indicated she thought the care plans for falls were all the same upon admit, then the Minimum Data Set (MDS) nurse would update the care plans as needed. Nurses were responsible for documentation in the resident medical records in real time, it was not appropriate to back date information from prior dates or weeks ago. The IDT was responsible for adding new care plan interventions when reviewing falls. The DNS indicated Resident B had fallen during the night on 3/4/24 Sunday going into Monday and had received a 2 cm laceration on mid to upper forehead which nursing had covered with steri strips. On 3/5/24 the resident displayed bruising around her left eye, there was no other bruising or a knot on her head. On 3/5/24 during therapy the resident had started complaining of left shoulder pain, an x-ray was ordered, and the results came back on 3/6/24 with a diagnosis of a clavicle fracture. Upon discharge the morning of 3/6/24, Resident B still just had bruising around the left eye, and some mild swelling on top of the left shoulder. The DNS indicated she was informed of the resident having a broken nose when speaking to the family a few days after the resident was discharged to the hospital. When asked if staff had requested a CT scan of the head considering the resident's recent medical history, the DNS indicated she personally had not requested to have resident sent for a head CT after she fell on 3/4/24 and hit her head, but thought nursing might have asked and MD. DNS indicated to her knowledge the resident had not had an additional fall after 3/3/24, she could not account for the extensive bruising the resident experienced that was documented upon arrival to the ER. On 3/25/24 at 2:20 p.m., the DNS provided a Fall			

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	Management Policy, dated 8/2022, and indicated the policy was the one currently being used by the facility. The policy indicated, "It is the policy of [facility name] to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related to falls ...Facilities must implement comprehensive, resident-centered fall prevention plans for each resident at risk for falls or with a history of falls... Post fall 1. Any resident experiencing a fall will be assessed immediately by the charge nurse for possible injuries and necessary treatment will be provided ...5. A fall event will be initiated as soon as the resident has been assessed and cared for. The report must be completed in full in order to identify possible root causes of the fall and provide immediate interventions. 6. All falls will be discussed by the interdisciplinary team [IDT] at the 1st IDT meeting after the fall to determine root cause and other possible interventions to prevent future falls ...The care plan will be reviewed and updated as necessary ..." On 3/25/24 at 2:20 p.m., the DNS provided a Resident Change of Condition Policy, dated 11/2018, and indicated the policy was the one currently being used by the facility. The policy indicated, "It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place ...a. Any sudden or serious change in a resident's condition manifested by marked change in physical or mental behavior will be communicated to the physician ...d. All nursing actions/interventions will be documented in the medical record as soon as possible after resident needs have been met ...3. Non-Urgent Medical Change a. All symptoms and unusual signs will be			

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	documented in the medical record and communicated to the attending physician promptly. Non-urgent changes are a minor change in physical and mental behavior, abnormal laboratory and x-ray results that are not life threatening. b. The nurse in charge is responsible for notification of physician and family/responsible party prior to end of assigned shift when a significant change in the resident's condition is noted ...g. The licensed nurse responsible for the resident will continue assessment and documentation in the medical record every shift until the resident's condition has stabilized." This citation relates to Complaint IN00430399. 3.1-45(a)			