STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155761	A. BUILDING 00 B. WING	11/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROWNSBURG MEADOWS	2 E TILDEN BROWNSBURG, IN 46112

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00367322. This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaints IN00364490 and IN00364839 completed on October 15, 2021, which resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00367322 - Substantiated. Federal deficiencies related to the allegations are cited at F656. Complaint IN00364490 - Corrected. Complaint IN00364839 - Corrected. Survey dates: November 22, 23, and 24, 2021. Facility number: 011367 Provider number: 155761 AIM number: 200851590 Census Bed Type: SNF/NF: 96 Total: 96 Census Payor Type: Medicare: 6 Medicaid: 74 Other: 16 Total: 96 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	br=""> This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after 12/3/2021.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed on December 2, 2021.			
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the			

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	community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on interview and record review, the facility failed to ensure a resident had a personalized, resident specific fall care plan to assist in the prevention of falls for 1 of 6 residents reviewed for comprehensive fall care plans (Resident G). Findings include: On 11/22/21 at 10:54 a.m., Resident G's medical record was reviewed. Resident G was admitted to the facility on 4/7/21. Her diagnoses included, but were not limited to, cerebral infarction (stroke), bilateral hemiplegia (paralysis on both sides of the body), apraxia (inability to perform purposive actions due to brain damage). She was admitted to hospice on 6/14/21. On 11/22/21 at 12:02 p.m., Resident G's fall care plan, dated 4/8/21, was reviewed. It indicated she was at risk for falls due to her debility after her stroke. The goal was to reduce her fall risk factors to avoid a significant fall related injury. The fall care plan interventions were to have her call light in reach, complete environmental changes as needed, high fall risk, non-skid footwear, personal items in reach, and a therapy screen. Physician 22's notes indicated, on 4/15/21, ataxic movements (abnormal, uncoordinated movement) were present throughout session with more control in right upper extremities. On 5/7/21,	F 0656	**What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** · Resident G no longer resides in facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents have the potential to be affected by the alleged deficient practice. · All residents' John Hopkins fall risk assessments will be reviewed by IDT to ensure accuracy and person-centered approach in place on care plan by 12/3/2021. · All MDS employees will be in-serviced and educated by Regional RAI Consultant on person-centered care planning by 12/3/2021. · All members of the IDT will then be in-serviced by the MDS team by 12/3/2021. **What measures will be put into place or what systemic changes will you make to ensure that deficient practice**	12/03/2021

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	Physician 22's notes indicated Resident G was dependent for rolling side to side. She had bilateral upper extremity (BUE) movement with intermittent shoulder internal rotation, wrist flexion (bending), and elbow extension (unbending). Occasionally, she had writhing (twisting body movements) BUE movements noted. A physician's order, on 4/30/21, indicated Resident G had positioning devices of bilateral (both sides of the bed) mobility bars to enhance in bed mobility. Hospice care plans were provided on 11/24/21 at 12:43 p.m., by the DON. A review of the documents indicated Resident G was care planned on 6/14/21, for cerebrovascular accident (stroke) with minimal risk of injury as evidenced by absence of falls by assessment and use of durable medical assistance devices. A Minimum Data Set (MDS) assessment, dated 6/25/21, indicated Resident G was dependent for eating, toilet, bathing, dressing, rolling, sitting on the side of the bed, standing, and transferring. The areas not applicable were walking and turning. A nursing note, on 7/23/21 at 4:24 a.m., Licensed Practical Nurse (LPN) 12 indicated Resident G was "fidgety," with a noted attempt to exit out of bed without assistance. The resident indicated she needed to get her clothes on so she could drive to Brazil. A nursing note, on 7/29/21 at 6:43 a.m., LPN 12 indicated Resident G had noted anxiety symptoms with multiple attempts to exit bed without assistance. She was "fidgety" and indicated she		**does not recur?** · All MDS employees will be in-serviced and educated by Regional RAI Consultant on person-centered care planning by 12/3/2021. · All members of the IDT will then be in-serviced and educated by the MDS team by 12/3/2021. · The MDS Coordinator/Designee will audit a minimum of 5 residents' John Hopkins Fall Risk Assessments weekly x 4 weeks, monthly x 3 months, and then quarterly until compliance is maintained. · The Regional RAI Consultant/Designee will provide ongoing training, oversight, resources, and competencies as needed upon identifying on-going areas of concern or areas not meeting threshold. **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?** · QA tool-Person-Centered Care Plan for Falls-will be completed by MDS/Designee until compliance is maintained; increasing frequency if thresholds are not met. · The MDS/designee will be responsible for the completion of the QA Tool weekly x 4 weeks,	

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	had a doctor's appointment. A nursing note, on 8/1/21 at 4:10 p.m., Registered Nurse (RN) 17 indicated Resident G had an unwitnessed fall and was found lying on her stomach on the floor. She was assessed and had noted a cut on bridge of the nose that measured 0.5 centimeters (cm), the right lower lip was open, and "lumps" noted on her forehead, right under eye, and right eyebrow. Resident G had been observed to be more active than usual within the past few days, always wanted to get out of bed. The Nurse Practitioner (NP), hospice company, and family were informed about the fall incident. Hospice notes, dated 8/1/21 at 5:44 p.m., indicated the visit was made for follow up due to a fall with injury. The facility nurse reported to the hospice nurse the resident rolled out of bed and was found face down on the floor. Patient had a 0.5 cm laceration (deep cut) on the bridge of her nose. Her forehead had a 1.5 cm by (x) 2 cm hematoma (swollen and bruised), right eyebrow 2 cm x 1.5 cm hematoma, and right cheek 1.5 cm x 1.5 cm hematoma. She had reddened skin behind right calf due to movement of right leg which swings off the chair. An Inter-Departmental Team (IDT) note, written by Unit Manager (UM) 6, on 8/2/21 at 2:15 p.m., determined the root cause of Resident G's fall was she was restless, and she experienced anxiety. The intervention put in place to address the root cause of the fall was to place the bed against the wall. The injuries Resident G sustained were discoloration around left and right eyes, and an abrasion above her nose. A nursing note, on 8/2/21 at 2:15 p.m., RN 18 indicated Resident G had discoloration below		then monthly x 3 months, and then quarterly thereafter until compliance is maintained with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. · The facility will review, update and make changes to the POC as needed with input and oversight from the Regional RAI Consultant for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 12/3/2021**	

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	bilateral eyes, the bridge of her nose was swollen and discolored, and her bottom lip was discolored. A nursing note, on 8/3/21 at 6:50 a.m., LPN 12 indicated Resident G had noted attempt to exit her bed without assist. Her legs were noted on the side of the bed. Facility care plans were provided, on 11/23/21 at 10:57 a.m., by the DON. A review of the care plans indicated Resident G required assistance with activities of daily living, such as bilateral mobility bars to assist with bed mobility and assist with bathing, ambulation, dressing, grooming and hygiene as needed. Resident G exhibited cognitive impairment. She was severely impaired. On 11/22/21 at 12:02 p.m., Resident G's fall care plan was updated on 8/3/21 after her fall, to include placement of the resident's bed up against a wall. During an interview, on 11/23/21 at 1:43 p.m., RN 18 indicated Resident G had jerking motions, and she was able to move. During an interview, on 11/23/21 at 1:55 p.m., RN 19 indicated Resident G was able to move herself a little bit. She was able to move her left leg. She could swing her left arm and her left leg when she was in the Broda chair (specialty wheelchair). During an interview, on 11/23/21 at 2:16 p.m., LPN 12 indicated she found Resident G on the floor after her fall. When Resident G first arrived at the facility, she did not move much, but later she was able to move more. She was able to move her left side. She was not on a specialty bed but had mobility bars. Sometimes, Resident G would say she had to go to the store, cook a meal, or drive			

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	the car. During an interview, on 11/23/21 at 2:41 p.m., RN 17 indicated Resident G's baseline before the fall was restless, looking for her keys. She was able move both arms. She was able raise them up, and then drop them. Her arms were weak. With her decline, she was still restless and tried to get herself out of bed. She was unable to use a call light because of her limited cognition. She did not understand to call for help, she was confused. In her Broda chair, her left leg would be out of the footrest area, and she would swing it. She was able to swing her left arm too. This movement was possibly a voluntary movement. She was restless and she would try and sit up but was unable to do it. During an interview, on 11/24/21 at 10:08 a.m., Minimum Data Set Coordinator indicated the MDS department put in care plans for nursing. There was a template that was initially used, and they would have kept individualizing it with each assessment. Initially, they might not know the resident needs, but kept updating the care plan the longer they were at the facility. For Resident G her fall care plan was a template fall care plan until after her fall. During an interview, on 11/24/21 at 11:11 a.m., the DON indicated Resident G did not have a specialty bed or bolsters (a long, thick pillow at the sides of the bed to prevent a fall) because none of her movements were significant or substantial enough to move her body. She was not strong enough. During an interview, on 11/24/21 at 10:11 a.m., the Director of Nursing (DON) indicated after an admission assessment, they did standard			

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	interventions on the fall care plans. Everyone had non-skid footwear, even though Resident G was unable to walk. Everyone had personal items in reach, even though Resident G could not grab things. Environmental changes for Resident G meant they included a green dress she had made, so she had it to look at. Therapy screening was standard. If a resident needed an intervention added, they would have added it as appropriate. Fall risk changes would have been added as noticed. If the nurses would have noticed anything, they would have intervened then. If she had a huge improvement change it would have triggered with the aides as they assisted her with activities of daily living (ADLs). Then, it would have triggered in the MDS department, and in therapy. If anything new was warranted, it would have prompted a change in her fall care plan. If Resident G had started moving her left side more, a change should have happened in the fall care plan. A current policy, titled, "IDT Comprehensive Care Plan Policy," dated 10/2019, was provided by the DON on 11/22/21 at 1:30 p.m. A review of the document indicated, " ...each resident will have a comprehensive person-centered care plan developed based on comprehensive assessment. The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning ...." This Federal tag relates to Complaint IN00367322. 3.1-35(a)			