| STATEMEN | IT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | \mathbf{W} W W W W W W W W W W | ONETDUCTION | $(\mathbf{V}_2) \mathbf{D} \mathbf{A} \mathbf{T} \mathbf{E}$ | CITIDA (EXT | |
|-----------|----------------------|---------------------------------|---|--|--|-------------|--|
| AND PLAN | | | (X2) MULTIPLE C | | (X3) DATE SURVEY | | |
| | | IDENTIFICATION NUMBER | A. BUILDING | 00 | | PLETED | |
| | | 155761 | B. WING | | 10/15 | 10/15/2021 | |
| | | | STREET | ADDRESS, CITY, STATE, ZIP COD | | | |
| NAME OF P | PROVIDER OR SUPPLIE | .R | 2 E TIL | _DEN | | | |
| BROWN | BROWNSBURG MEADOWS | | BROW | NSBURG, IN 46112 | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | N | (X5) | |
| PREFIX | (EACH DEFICIE | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO | BE | COMPLETION | |
| TAG | REGULATORY C | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | | DATE | |
| 0000 | | | | | | | |
| Dida 00 | | | | | | | |
| Bldg. 00 | This visit was for | the Investigation of Complaints | F 0000 | The creation and submission | on of | | |
| | | 0364839 and IN00364985. This | F 0000 | this plan of correction does | | | |
| | | Partially Extended Survey - | | constitute an admission by | | | |
| | | ty of Care - Immediate | | provider of any conclusion | | | |
| | Jeopardy. | , | | in the statement of deficien | | | |
| | 1 5 | | | of any violation of regulatio | | | |
| | Complaint IN0036 | 64490 - Substantiated. | | , , , | | | |
| | Federal/State defic | ciencies related to the | | This provider respectfully requests | | | |
| | allegations are cite | ed at F684, F689 and F690. | | that the 2567 Plan of Corre | | | |
| | | | | be considered the letter of credible allegation and requests a face to face informal dispute resolution. | | | |
| | - | 4839 - Substantiated. | | | | | |
| | | ciencies related to the | | | | | |
| | allegations are cite | ed at F684, F689 and F690. | | | | | |
| | - | 54985 - Unsubstantiated due to | | | | | |
| | lack of evidence. | | | | | | |
| | Survey dates: Octo | ober 12, 13, 14 and 15, 2021. | | | | | |
| | Facility number: 0 | 11367 | | | | | |
| | Provider number: | | | | | | |
| | AIM number: 200 | 851590 | | | | | |
| | Census Bed Type: | | | | | | |
| | SNF/NF: 95 | | | | | | |
| | Total: 95 | | | | | | |
| | Census Payor Typ | e: | | | | | |
| | Medicare: 2 | | | | | | |
| | Medicaid: 77 | | | | | | |
| | Other: 16 | | | | | | |
| | Total: 95 | | | | | | |
| | These deficiencies | reflect State Findings cited in | | | | | |
| | accordance with 4 | - | | | | | |
| | Quality review we | s completed on October 20, | | | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 12/03/2021

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.

Event ID: N8Q011

011 Facility ID: 011367

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| STATEME AND PLAN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155761 | | (X2) MULTIPLE C A. BUILDING B. WING | <u>00</u> | DATE SURVEY COMPLETED 10/15/2021 |
|----------------------------|---|---|---|--|--|
| | NAME OF PROVIDER OR SUPPLIER BROWNSBURG MEADOWS | | | ADDRESS, CITY, STATE, ZIP COD _DEN /NSBURG, IN 46112 | |
| (X4) ID PREFIX TAG | (EACH DEFICII REGULATORY | Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) Completio Date |
| F 0684 SS=J Bldg. 00 | applies to all treat facility residents comprehensive of facility must ensi- treatment and ca- professional state comprehensive and the resident Based on observa- review, the facilit change of conditi- medical attention with significant h altered mental state and death for 2 of of care (Resident The immediate je Resident E fell and a laceration and h tears on his kneess E was moved to h transferred a seco and then back to 1 documentation of pain assessment at documentation the when Resident E swallowing and n on 9/19/21. He was neck pain and he | s a fundamental principle that atment and care provided to . Based on the assessment of a resident, the ure that residents receive are in accordance with ndards of practice, the person-centered care plan, | F 0684 | Facility respectfully requests a face to face informal dispute resolution for F0684. Brownsburg Meadows respectfully requests additional evidentiary information be considered in eliminating or reducing federal tag 0684. The current statement of deficiencies on the 2567 omit significant faciliti information and therefore misrepresents the care and services administered by the provider to its residents. Based on observation, interview, and record review, the facility failed to assess, notify of change of conditions, and ensure emergency medical attention was provided for 2 residents with significant head injuries after falls resulting in altered mental status, pain, change of conditions and death for 2 of 3 residents reviewe | y |

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155761 | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING | | (X3) DATE SURVEY COMPLETED 10/15/2021 | |
|--------------------|---|---|--|--|---|--|
| NAME OF | PROVIDER OR SUPPLIE | ER | STREET 2 E TII | ADDRESS, CITY, STATE, ZIP COD | | |
| BROWNSBURG MEADOWS | | | | /NSBURG, IN 46112 | | |
| (X4) ID | SUMMAR | Y STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | (EACH DEFICIE | NCY MUST BE PRECEDED BY FULL | PREFIX | EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | COMPLETIC | |
| TAG | REGULATORY O | OR LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | DATE | |
| | services) arrived a | t 1:17 p.m. and determined his | | for quality of care (Resident E a | nd | |
| | injuries required u | pgraded services and he was | | Resident B). | | |
| | rerouted to the near | arest trauma hospital. Resident | | , | | |
| | | thing (reflexive breathing when | | - what corrective action(s) w | ill | |
| | | getting enough oxygen and | | be accomplished for those | | |
| | usually indicated when someone was close to death) upon arrival to the hospital triage department and died at 2:06 p.m. as a result of the injuries sustained from the fall. A CT scan | | | residents found to have been | | |
| | | | | affected by the deficient practice | | |
| | | | | | | |
| | | | | Resident E and Resident B no | | |
| | indicated he had s | | | longer reside in the facility | | |
| | | eck fracture at his C4-Cervical | | | | |
| | Spine. | | | - how other residents having | , | |
| | Spine. | | | the potential to be affected by th | | |
| | On $10/4/21$ at 4.30 |) a.m., Resident B rolled off the | | same deficient practice will be | | |
| | | a sustained a large laceration | | identified and what corrective | | |
| | | hich continued to bleed | | action(s) will be taken | | |
| | | en a hospice nurse arrived at | | | | |
| | | eeding continued and did not | | - Residents who fall have | | |
| | | ites of pressure. Resident B had | | the potential to be affected | | |
| | - | logical condition and went from | | - | _ | |
| | | k in sentences to only 1-2-word | | - Residents who have had a | a | |
| | e . | s called to send her to the ER | | fall in the past 30 days were reviewed and assessed for | | |
| | | | | | | |
| | |), but the facility indicated | | change of condition, | | |
| | e 11 | ped, and it was not necessary | | notification, and medical | | |
| | | but. Resident B, who had | | attention | | |
| | | n hospice, but not actively | | - Licensed nursing staff will | " | |
| | | to active death beginning on $10/10/21$. The Director of | | receive education on | | |
| | | on 10/10/21. The Director of | | assessments following a fall, | | |
| | - | (DNS) and the Assistant | | notification of condition | | |
| | | ng Services (ADNS) were | | changes and emergency | | |
| | | nediate jeopardy at 1:25 p.m. on | | medical attention by the | | |
| | | nediate jeopardy was removed on | | DNS/designee on or before | | |
| | | compliance remained at the lower | | 11/2/21 | | |
| | | v level of isolated, no actual | | | | |
| | - | al for more than minimal harm | | | | |
| | that is not immedi | ate jeopardy. | | - what measures will be put | | |
| | | | | into place or what systemic | | |
| | Findings include: | | | changes will be made to ensure | | |
| | | | | that the deficient practice does r | not | |
| | 1. During the surv | ey a confidential interview | | recur: | | |

PRINTED: 12/03/2021

| | R MEDICARE & MEDI | | - | | | | IB NO. 0938-03 |
|----------|---|-----------------------------------|----------------------------|---------------------------|--|------------------|----------------|
| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | JILDING | 00 | COMPI | |
| | | 155761 | B. W. | NG | | 10/15 | /2021 |
| NAME OF | PROVIDER OR SUPPLIE | R | | | ADDRESS, CITY, STATE, ZIP COD | | |
| | | | | 2 E TIL | | | |
| BROWN | ISBURG MEADOW | S | | BROW | NSBURG, IN 46112 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIE | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION | TE | COMPLETI |
| TAG | REGULATORY C | _ | TAG | DEFICIENCY) | | DATE | |
| | indicated Resident E had been admitted to the | | | | | | |
| | | hening and rehabilitation after a | | | - Licensed nursing staff v | vill | |
| | | y for an infection. He had only | | | receive education on | | |
| | | a few days and was doing well, | | | assessments following a fall | , | |
| | | ily were a "little nervous" about | | | notification of condition | | |
| | him getting in and out of bed because he was | | | | changes and emergency | | |
| | | on his feet. The family | | | medical attention by the | | |
| | requested bed rails | but had been told by the | | | DNS/designee on or before | | |
| | | not put bed rails up because | | | 11/2/21 | | |
| | they would be con | sidered a restraint. The family | | | - 2 nurses will respond to |) | |
| | asked a second tin | ne about bed rails but was told | | | resident fall events to ensure |) | |
| | they could only of | fer a "mobility" bar. On 9/18/21 | | | appropriate assessment, | | |
| | the family was not | ified, Resident E had fallen that | | | notification and medical | | |
| | morning around 7: | 30 a.m., and bumped his head. | | | attention are provided | | |
| | Other than "some | | | - DNS or designee will be | ł | | |
| | been put to bed an | d rested comfortably. The | | | notified of resident falls | | |
| | family arrived arou | and 1:00 p.m. and were surprised | | | | | |
| | at the extent of his | injuries. They asked him what | | | IDT will review residents wit | h | |
| | happened. Resider | t E said he tried to get out of | | | falls the next business day to | C | |
| | bed to go to the ba | throom. He had a large | | | ensure proper assessments, | | |
| | bandage on his for | ehead, and his face was black | | | notifications, medical attention | on, | |
| | and blue, but at the | at time, Resident E was | | | and interventions are | | |
| | responsive. He got | out of bed and went to the | | | completed | | |
| | front of the facility | to sit outside for the visit. | | | | | |
| | During the family | visit, Resident E complained of | | | - how the corrective actio | n(s) | |
| | his head and neck | hurting, but the family had | | | will be monitored to ensure the | . , | |
| | been assured by th | e Assistant Director of | | | deficient practice will not recur | | |
| | Nursing Services (| ADNS), they would be able to | | | i.e., what quality assurance | | |
| | | the facility. They gave him | | | program will be put into place: | | |
| | - | ed some cream to rub on his | | | - | | |
| | | vas unsure about leaving him | | | To ensure compliance, the | | |
| | | ed until visiting hours were | | | DNS/Designee is responsible |) | |
| | | the day he seemed to get more | | | for the completion of the Fall | | |
| | | and continued to complain of | | | Management QAPI tool and | | |
| | | d neck, but the ADNS | | | Change of Condition QAPI to | ol | |
| | - | e the family, the Medical | | | weekly times 4 weeks, month | | |
| | | aware of his condition and | | | times 6 and then quarterly to | - | |
| | | Resident E. The next morning, | | | encompass all shifts until | | |
| | | nily returned to visit Resident E | | | continued compliance is | | |
| | | , and were shocked at his | | | maintained for 2 consecutive | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 155761 10/15/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2 E TILDEN **BROWNSBURG MEADOWS BROWNSBURG, IN 46112** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE apparent decline. He no longer responded to quarters. The results of these questions, he kept holding his head, and moaned audits will be reviewed by the in pain, he would not eat or drink anything. The CQI committee overseen by the family insisted he be sent to the emergency room ED. If threshold of 95% is not (ER) for pain control to keep him comfortable, but achieved an action plan will be the ADNS insisted they should keep him in the developed to ensure facility, and he could get COVID if he went to the compliance. hospital. The family told the nurse to call 911. Even though Resident E had a Do Not Resuscitate (DNR) order, the family had chosen not to sign a "do not send to hospital" order so if something emergent happened he could be sent out for emergency medical attention. A confidential written statement, received during the survey, indicated they visited Resident E the day of, but after his fall. "They brought him outside in the wheelchair to get some fresh air. He was in so much pain he kept holding his head and neck. You could also hear fluid in his lungs as well. I got him a milkshake which he loves, and he barely had any of it. I asked the nurse if it was normal for him to sound this way and she told me, 'Tell him he just needs to cough harder, and he'll feel better.' No matter how hard he tried to cough, it was not making anything better. As I sat with him outside, he hunched over, and to be honest I thought he had passed away then. I went in to get the nurse [ADNS] and she said, 'he's fine let's get him back into his room and lay him down.' When he came back-to, a few seconds later, he was very disoriented and drooling. I asked her if it was normal for his pupils to be so small as well. And she said they looked fine as well. We got him back to his room. The blood-stained sheets were still on his bed and blood was still on the floor and had not been cleaned up. This is when I asked them to get him stronger meds because the Tylenol was not working. She promised she would do so and obviously that was not the case " N8Q011 Facility ID: 011367 Page 5 of 57 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

PRINTED:

12/03/2021

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 155761 10/15/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2 E TILDEN **BROWNSBURG MEADOWS BROWNSBURG, IN 46112** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE During an interview, on 10/13/21 at 3:00 p.m., Certified Nursing Assistant (CNA) 18 indicated she was the first staff member who found Resident E after the fall. It was early in the morning, staff had just come on for the morning shift, nurses were giving report and the CNAs began their morning rounds. Resident E was at the end of the hall, but his call light was blinking so she went to him first. She walked in the room and found him lying on the floor on his side and faced his roommate's bed. His call light was observed hanging off the edge of the bed. CNA 18 indicated it would have been within his reach when he was in bed, but from where he was on the floor it was out of his reach. There was a pool of blood around him. She called for help. She asked Resident E what happened, and he indicated he was trying to get something off his table when he fell and hit his head. Registered Nurse (RN) 19 was the first nurse to respond, then the ADNS came in too. The nurses began their assessments while he laid on the floor and elevated his feet on a nearby chair. After they finished, she and another CNA got Resident E up into bed to clean him up. He had been incontinent of a small bowel movement (BM). CNA 18 indicated she did not think it was a good idea for him to go outside for a visit since he had a fall that morning. He did not complain of pain until he came back inside. He rubbed his neck and asked, "can you rub my neck?" CNA 18 indicated she gave him a couple neck rubs. A Corresponding written statement from CNA 18 was provided by the ADNS on 9/13/21 at 10:40 a.m. Her statement, dated 9/20/21, indicated "...[On 9/18/21] I helped [Resident E] up into his chair to go outside with his family. I asked him if he was sure he wanted to get up and go outside. He said N8Q011 Facility ID: 011367 Page 6 of 57 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

12/03/2021

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/15/2021 155761 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2 E TILDEN **BROWNSBURG MEADOWS BROWNSBURG, IN 46112** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE he was fine and wanted to go outside with his family...he drank a milkshake and played with his great-grand kids...he sat outside for about an hour and came back inside. Later I went into the room to check on him and he told me he was ok. He told me that his neck hurt a little and that the boss said I have to give him neck rubs. I rolled a towel and placed in behind his neck. He Laid down and went to sleep " During an interview, on 10/13/21 at 11:21 a.m., RN 19 indicated she was the first nurse who entered Resident E's room after CNA 18 alerted her, he had fallen. RN 19 indicated she observed him lying on his back on his floor with blood on the floor. The ADNS came into the room, and they assessed him initially laying on the floor, then assisted him to a seated position. He had an open wound in the center of his forehead about the size of a half dollar, and a formed hematoma. His blood pressure was low, but that was normal for him. He did complain of a little pain on the back of his neck, but said he had chronic pain. He moved everything normally and range of motion was fine. RN 19 indicated she was a little worried about the neck pain, but the ADNS took over from there. When RN 19 left the building later that day she observed him sitting in a wheelchair outside with his family. During an interview, on 10/13/21 at 12:00 p.m., the Nurse Practitioner (NP) indicated Resident E had only been at the facility for about a week, and she was still getting to know him at that time. He was ill and fragile when he came to the facility and the labs, he had from the hospital were "not great." Families often want their loved ones to go to rehabilitation to see how they do, so that was her understanding of what Resident E's goals were. He had come to the facility after being in the Event ID: N8Q011 Facility ID: 011367 Page 7 of 57 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 155761 10/15/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2 E TILDEN **BROWNSBURG MEADOWS BROWNSBURG, IN 46112** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE hospital for strengthening. He had chronic low blood pressure, so they treated him for that by adding a new medication. The ADNS reported the fall to the NP later that day, and the NP indicated she did not want to give stronger pain medication for someone after a fall, especially if the Tylenol and BioFreeze (an organic menthol medication used to control pain) were working, as the ADNS indicated they were. During an interview, on 10/12/21 at 2:50 p.m., the ADNS indicated she was working as a nurse on the floor the morning of Resident E's fall. She was alerted to the fall by other staff members and immediately went to his room. She observed him lying on the floor, she checked his vital signs which were normal and applied first aid to the hematoma and skin tears. Then she helped to assist Resident E back into bed. There was some bleeding, but it was under control. The ADNS notified the family of the fall, and the on-call NP (Nurse Practitioner) gave orders for STAT (urgent/rush) labs. Throughout the day, he complained of pain in his neck, but Resident E and his family both indicated that was baseline for him because of a history of a neck fusion. The ADNS provided Tylenol and the NP ordered some BioFreeze gel which controlled his pain. His family came that day and sat with him outside for a visit and he had a milkshake. The next morning, I was told a family member told the nurse they wanted him sent to the hospital to get something more effective for his pain. The ADNS put a heat pack and BioFreeze on his neck and told CNA 18 to check on him. The ADNS indicated at some point, she had been notified Resident E was having difficulty swallowing but that was not new for him either. A Corresponding written statement from the N8Q011 Facility ID: 011367 Page 8 of 57 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 155761 10/15/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2 E TILDEN **BROWNSBURG MEADOWS BROWNSBURG, IN 46112** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE ADNS was provided by the ADNS on 10/13/21 at 10:40 a.m. Her statement, dated 9/20/21, indicated "...At 7:22 a.m. on 9/18/21 I was notified that [Resident E] was on the floor. Upon arrival to the unit, resident was laying on his back on the floor, he was responsive and able to state that he was trying to get to his call light, which was attached to his shirt...Resident had [a] hematoma with skin tear to center of forehead and 2 small skin tears to his right leg. Resident not complaining of difficulty or pain with moving extremities, stated that his neck hurt but that it always hurts. Resident's vitals and neuro checks were at his baseline. Resident assisted per 3 staff into bed. Resident given Tylenol for neck pain...NP aware of fall and medical condition including low platelets and hemoglobin, NP gave orders for STAT labs and to monitor resident...[family] came in to visit and writer let them know again that he fell and that he had facial injuries but that his vitals and neuros were stable. [Family] went to room to see resident. Resident stated that he wanted to go to the hospital for 'faster services...' Resident repositioned in bed for comfort and fluids offered. Resident had slight difficulty swallowing fluids from straw ...Resident got out of bed and went outside for family visit...Resident had a short period of confusion and family stated that it has been happening for a while. Resident was outside for about 45 minutes and then requested to go to bed due to neck pain...At 4:09 p.m. [more than eight hours after the fall] I called [NP] since she knows the resident and his history better than the on call. I relayed the situation and she advised that there was not an indication that he needed to be sent out due to his overall prognosis and health status...Family had requested muscle relaxers or stronger pain medication for his neck. [NP] stated that due to his recent fall and confusion, it was not N8Q011 Facility ID: 011367 Page 9 of 57 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 155761 10/15/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2 E TILDEN **BROWNSBURG MEADOWS BROWNSBURG, IN 46112** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE appropriate to give him stronger medication, and to continue to use BioFreeze and Tylenol for pain management as they are currently effective...At 6:26 p.m. I called resident's [family member] to discuss prognosis and treatment plan. I explained that resident was still stable with vitals and neuros at his baseline, explained that his pain was being managed with BioFreeze and Tylenol and warm towel " A third written witness statement from the incoming nurse, RN 20, was provided by the ADNS on 10/13/21 at 10:40 a.m. Her statement, dated 9/20/21, indicated " ... I, [RN 20] took care of [Resident E] on 9/18/21-9/19/21 on evening and night shift. Resident was on follow up fall documentation and neuro checks from previous fall on day shift. Upon start of my shift around 7:30 p.m. resident had his call light on requesting another blanket because he was cold ... around 11:15 p.m., resident placed call light on, and CNA answered it. Resident requested Tylenol for a headache. Writer administered 2 Tylenol around 11:20 p.m. Resident did get one Tylenol stuck under his tongue and requested several drinks of water to get it to go down but did so with no issue. Around 2:00 a.m., CNA came to get writer due to bleeding from skin tear on arm. Writer assessed resident and noted that he had picked at skin tear on left lateral forearm due to part of the steri-strips [thin adhesive bandage] were off and resident had fresh blood under nails. Area was cleansed and dressing placed on area for protection. Resident has also removed ABD pad that was on skin tear to mid forehead. Protective dressing placed on that area also ... Resident did show slight confusion as he was looking for his wife because he thought she was at facility ... Writer assisted CNA with turning and repositioning of resident and providing N8Q011 Facility ID: 011367 Page 10 of 57 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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| | NT OF DEFICIENCIES OF CORRECTION | x1) provider/supplier/clia identification number 155761 | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING | | (X3) DATE SURVEY COMPLETED 10/15/2021 | | |
|--------------------------|---|---|--|---|---|---------------------------|--|
| | NAME OF PROVIDER OR SUPPLIER BROWNSBURG MEADOWS | | STREET ADDRESS, CITY, STATE, ZIP COD 2 E TILDEN BROWNSBURG, IN 46112 | | | | |
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| | | When turned, resident did state, ter asked if something hurt, he aches" | | | | | |
| | Therapy Director participated in Ph Occupational The 3 sessions and mi 9/17/21 due to "m E was alert and on polite and motiva discharge back ho On 10/13/21 at 10 record was review admission assess indicated the resid | ew, on 10/13/21 at 10:47 a.m., the indicated Resident E had ysical Therapy and rapy. He only attended 2 of the ssed his therapy sessions on edical complications." Resident iented. He was very friendly, ted to get stronger so he could me. 2:00 a.m., Resident E's medical red. A comprehensive nursing nent, dated 9/13/21 at 6:09 p.m., lent answered the questions and nted to person, place, time and | | | | | |
| | situation. He indi- problems with his bowel, he had bal | cated he was in good health, had bowels and incontinence of the ance problems and was set, he had weakness, reported | | | | | |
| | were not limited t pressure), ankylog [abnormal immob resulting from lig | agnoses which included, but o, hypotension (low blood sing hyperostosis (an ankylosis ility] of the vertebral column amentous ossification ut significant disc disease), and | | | | | |
| | | n Assessment, dated 9/13/21 at ed a total score of 0 of 10 and no he last 5 days. | | | | | |
| | | sessment, dated 9/17/21 at 2:52 otal score of 0 of 10 and no ne last 5 days. | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| | NT OF DEFICIENCIES | x1) provider/supplier/clia identification number 155761 | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | CON 10/ | te survey Mpleted 15/2021 |
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| | PROVIDER OR SUPPLI | | 2 E TIL | address, city, state, zip co DEN NSBURG, IN 46112 | DD | |
| (X4) ID PREFIX TAG | (EACH DEFICI | Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY) | OULD BE | (X5) COMPLETIO DATE |
| | at 6:32 p.m., india a high fall risk wi points indicated a An admission Bo at 9:34 a.m., had All fields were le A comprehensive | wel Assessment, dated 9/14/21 been opened, but not completed. | | | | |
| | intervention in pl wear non-skid so A CNA assignme Resident E neede ambulation as nee a high fall risk or | ace at that time was for him to cks. nt sheet, dated 9/15/21, indicated d assistance with bathing and eded but did not indicate he was list any fall interventions which | | | | |
| | indicated Resider Interventions for were not limited t | care plan, initiated 9/14/21, t E was at risk for constipation. this plan of care included but o; Notify MD if no BM after 3rd al assessment if no BM times 4 | | | | |
| | reviewed. There which indicated F | ing progress notes were were no nursing progress notes Resident E reported any pain from mission on 9/13/21 at 5:07 p.m., on 9/18/21. | | | | |
| | a.m., indicated Re | event tool, dated 9/16/21 at 8:25 esident E had not had a bowel sys. The physician had not been | | | | |
| | A "Hot Charting" | event tool, dated 9/17/21 at 8:23 | | | | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155761 B. WING 10/15/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2 E TILDEN **BROWNSBURG MEADOWS BROWNSBURG, IN 46112** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE a.m., indicated Resident E had still not had a bowel movement in more than 3 days. The physician had not been notified. Resident E's bowel elimination record was reviewed on the vitals report and indicated he had not had a bowel movement for the last 4 days. A nursing progress note, dated 9/17/21 at 6:32 p.m., indicated Resident E had bright red blood in his urine, but no complaint of pain or discomfort. The MD was notified with no new orders since recent labs had already been sent to oncology. A nursing progress note, dated 9/17/21 at 11:12 p.m., indicated Resident E had blood in his urine, and the MD was notified. No new orders were placed. A nursing progress note, dated 9/18/21 at 7:49 a.m., indicated Resident E had an unwitnessed fall from his bed. He was noted to have a hematoma with an abrasion on his forehead and was disoriented at the time of his fall and complained of pain in his posterior neck. The On-call NP was notified and new orders for STAT labs were placed. Resident E was offered ice for his forehead and given Tylenol for neck pain. A Fall Event tool was opened, on 9/18/21 at 7:49 a.m., and indicated Resident E had an unwitnessed fall with injuries which included: A 5 centimeter (cm) round hematoma with 3 cm long by 1 cm wide abrasion in the center of his forehead. A 2 cm long, by 1 cm wide, and 1 cm long by 1 cm wide abrasions on his right leg and, A 3 cm long skin tear on his left forearm. Immediate interventions put into place at the time of the fall was to complete a review of medication N8Q011 Event ID: Facility ID: 011367 Page 13 of 57 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| | NT OF DEFICIENCIES OF CORRECTION | x1) provider/supplier/clia identification number 155761 | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING | | 00 | (X3) DATE SURVEY COMPLETED 10/15/2021 | |
|--------------------------|--|--|--|---------------------|--|---|---------------------------|
| | PROVIDER OR SUPPLI SBURG MEADOV | | | 2 E TILI | ADDRESS, CITY, STATE, ZIP DEN NSBURG, IN 46112 | COD | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION 3 CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETIC DATE |
| | and labs. | | | | | | |
| | | documentation a full skin check or after the fall event. | | | | | |
| | assessment for the | documentation a full pain e new injuries and neck pain e fall had been completed on or t. | | | | | |
| | p.m., indicated Ro the facility would ensure the resider | as note, dated 9/18/21 at 7:23 esident E's family was reassured do everything possible to t was comfortable and well NP gave a new order for k pain. | | | | | |
| | prescribed BioFre | , dated 9/18/21 at 2:00 p.m., eze (menthol 5% gel) to apply as k of the neck for pain and | | | | | |
| | record) was review documented on the | R (medication administration wed. BioFreeze was not e MAR as having been there were no additional pain on the MAR. | | | | | |
| | a.m., indicated Re earlier that shift fo using his call ligh | is note, dated 9/19/21 at 4:50 esident E had received medication or a headache and had been t appropriately. He asked to be ral times due to inability to find ition. | | | | | |
| | opened on 9/19/2 indicated Residen like he was gargli | erapy Referral" event was l at 11:58 a.m. The referral t E was choking and sounded ng when he took a drink of water his medicine. Resident E also | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 155761 10/15/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2 E TILDEN **BROWNSBURG MEADOWS BROWNSBURG, IN 46112** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE stated he was having trouble swallowing. The referral indicated family was notified, but the physician was not notified. A nursing progress note, dated 9/19/21 at 1:25 p.m., indicated Resident E continued to complain of neck pain and had difficulty swallowing. Resident stated his pain was unbearable and asked for Tylenol. His family asked if he could have something stronger for pain. The On-call was notified and wanted to obtained STAT x-rays before prescribing pain medication. The family was notified and agreed at that time, but when the nurse went to place order for the x-ray, the family changed their mind and stated they wanted Resident E to be sent to the hospital for his neck to be looked at. 911 was called. A nursing progress note, dated 9/19/21 at 1:28 p.m., indicated 911 arrived and took the resident via stretcher. Before the ambulance left, EMT (emergency medical technician) came back in and told the nurse they would take him to a different hospital due to the level of trauma that he was. The most recent comprehensive assessment was a 5-Day MDS (minimum data set) assessment dated 9/19/21. The MDS indicated Resident E was moderately cognitively impaired and required extensive assistance for most of his ADLS (activities of daily living) from at least 1-2 staff members. An EMS "Run Report," dated 9/19/21, indicated the local fire department responded to the call for a neck injury. At 1:16 the report indicated the first set of vital signs. They were unable to obtain a blood pressure, his respirations were 5 (per minute) and his oxygen saturation was 88%. 11 minutes later at 1:27 p.m., his vitals were re-taken. N8Q011

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| | NT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155761 | (X2) MULTIPLE CO A. BUILDING B. WING | DNSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 10/15/2021 | | |
|---------|-------------------------------------|---|--|---|---|-----------|--|
| NAME OF | PROVIDER OR SUPPLIE | ER | | ADDRESS, CITY, STATE, ZIP CO | DD | | |
| BROWN | BROWNSBURG MEADOWS | | 2 E TIL BROW | NSBURG, IN 46112 | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORR | ECTION | (X5) | |
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| TAG | | OR LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | | DATE | |
| | was upgraded to a | trauma 1 after a fall at ECF. His | | | | | |
| | family reported th | ey asked the facility to call EMS | | | | | |
| | as they noted Resi | dent E was not acting "right." | | | | | |
| | He was brought to | the ED with agonal breathing | | | | | |
| | and O2 (oxygen) s | saturations in the 80s. His eyes | | | | | |
| | were open spontar | neously but he did not regard | | | | | |
| | faces or respond to | b his name. Attempted to go to | | | | | |
| | CT scanner for im | aging, however patient did code | | | | | |
| | in scanner, time of | f death at 2:06 p.m. Injuries | | | | | |
| | noted on the patient | nt upon arrival included, 1. | | | | | |
| | Scalp bruising 2. I | Periorbital Ecchymosis (or | | | | | |
| | | s commonly seen in surgical | | | | | |
| | | sults from accidental injuries to | | | | | |
| | | Ill) 3. Significant Ecchymosis | | | | | |
| | | g under the skin due to trauma of | | | | | |
| | | ninal region and 4. Right hip | | | | | |
| | | e of death listed: fall, acute | | | | | |
| | - | y failure, cardiac arrest. The | | | | | |
| | | an indicated Resident E | | | | | |
| | - | hyperextension teardrop-type | | | | | |
| | | with 3 column involvement, | | | | | |
| | | cant mechanism of injury in the | | | | | |
| | | e fracture through hyperostotic | | | | | |
| | U | rtebral body.2. During an | | | | | |
| | | 1/21 at 9:50 a.m., Resident B's | | | | | |
| | | Attorney (POA) indicated the | | | | | |
| | | l when his mother fell or when | | | | | |
| | | from the hospice nurse she fell | | | | | |
| | | id she was bleeding "all over the | | | | | |
| | | s were called to stop the | | | | | |
| | - | d wound was on her upper left | | | | | |
| | - | the middle. It was pressure | | | | | |
| | | indicated she would not come | | | | | |
| | | would lead to her passing. The | | | | | |
| | | g talked to him and indicated | | | | | |
| | | | | | | | |
| | _ | son changing her brief, there | | | | | |
| | | 2 staff members to change her | | | | | |
| | | off the bed. His mother lay in her | | | | | |
| | | pain and she finally stopped | | | | | |
| | breathing. Hospice | e provided a low dose of | | | | | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155761 B. WING 10/15/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2 E TILDEN **BROWNSBURG MEADOWS BROWNSBURG, IN 46112** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE morphine, but when staff would come in to turn her or pull her up in bed she would scream and yell. Hospice increased the dose from 4 doses a day to 6 doses a day. He indicated he believed she was not close to death prior to the fall from the bed, and the fall brought about her death. Resident B's record was reviewed on 10/13/21 at 4:15 p.m. Resident B's code status was DNR (do not resuscitate). Her diagnoses included, but were not limited to, heart failure, chronic obstructive pulmonary disease, and need for assistance with personal care. She started with Hospice on 9/12/19. A progress note, on 9/29/21 at 11:37 a.m., indicated Resident B was stable and all vital signs were stable. No complaints of pain. A progress note, on 10/3/21 at 2:15 p.m., indicated Resident B's vitals were stable, continued on hospice, no changes in her condition have been noted at this time. A progress note, on 10/4/21 at 4:30 a.m., indicated the resident was laying on her back after a fall from the bed. There was a 3 centimeter (cm) by (x)0.5 cm laceration to the left side of her forehead. Pressure and ice was applied to area and the area stopped bleeding. Steri-strips (adhesive approximation dressing) were applied with a dry dressing. An abrasion was noted on her mid-back. PRN (as needed) pain medication was provided. Staff were unable to get an accurate blood pressure because the resident was yelling out. Three staff members assisted her back to bed with a sheet. A neurological assessment was completed and within normal limits. A Certified Nursing Assistant (CNA) was providing incontinent care, when she turned the resident on Event ID: N8Q011 Facility ID: 011367 Page 19 of 57 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/15/2021 155761 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2 E TILDEN **BROWNSBURG MEADOWS BROWNSBURG, IN 46112** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE her left side, Resident B fell from the bed. She hit her head on the bedside table. The resident was on an air mattress. The physician and the Director of Nursing Services (DNS) were notified. Hospice was notified and the hospice company would notify the family. Hospice would be out to assess Resident B in the morning. A progress note, on 10/4/21 at 6:30 a.m., nursing charted Resident B's heart rate was accelerated to 110 with respirations at 24. Her oxygen saturation was 86%. Oxygen was applied and increased it to 96%. Hospice notified. A progress note, on 10/4/21 at 11:30 a.m., indicated Resident B was responding to verbal stimuli. Her pupils were responding to light and vital signs were stable at this time. A hematoma (clotted swelling of solid blood within the tissues) was present to the forehead. The laceration was approximately with steri-strips, with bleeding noted to the forehead laceration. Pressure was applied and the bleeding stopped. Dressing was applied and son was notified. A progress note, on 10/4/21 at 5:46 p.m., indicated Resident B's son and POA arrived for a visit post-fall. Resident B was able to communicate with yes and no answers. The son indicated his mother would not want to ride in an ambulance and go to the hospital. Comfort care continued. A progress note, on 10/4/21 at 11:46 p.m., indicated Resident B's vitals were stable while on 3L (liters) of oxygen. Resident had new bleeding from the wound sustained from a fall earlier today. The head dressing was changed. The resident did not respond to verbal stimuli and did not open eyes throughout the evening shift. N8Q011 Event ID: Facility ID: 011367 Page 20 of 57 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

| | I OF HEALTH AND HUN | | | | | | IN NO. 2020 220 |
|--------------------------|---|---|-------|---|--|-------------------|---|
| STATEMEN | R MEDICARE & MEDIC. NT OF DEFICIENCIES OF CORRECTION | XID SERVICES XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155761 | r í | ILDING | DNSTRUCTION 00 | (X3) DATE COMP | AB NO. 0938-039 E SURVEY LETED 5/2021 |
| | PROVIDER OR SUPPLIER | | B. WI | STREET | ADDRESS, CITY, STATE, ZIP COD DEN NSBURG, IN 46112 | 10/10 | J/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT TAG DEFICIENCY) | | BE | (X5) COMPLETIO DATE |
| | 10/4/21 at 10:55 Resident B's bila had changed from 1:00 p.m. neuro of B's consciousnes The next neuro of was incomplete. was 2 mm, with t | rological assessment, on a.m., LPN 17 charted teral (both eyes) pupil size in 3 mm to 2 mm. LPN 17's charting indication Resident is was no longer oriented. harting due at 8:00 p.m. It indicated the right pupil no measurement for the left is note, on 10/5/21 at 1:05 | | | | | |

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Resident B. A fall care plan, revised 10/6/21, indicated Resident B was at risk for falls due to decreased mobility and

a.m., indicated the resident was responsive to name and touch. Lung sounds were diminished. Neurological signs and vitals were within normal limits. Resident took a few sips of water. A Fall Review note, dated 10/5/21 at 8:32 a.m., indicated Resident B was on a low air loss mattress. One staff member was assisting the resident with her soiled brief. She turned the resident to be changed and resident rolled, and the bed deflated on one side, the resident hit her head on the bedside table, and slid off the bed. The resident received a laceration to her forehead. The determined root cause of the fall was the staff member who turned the resident on the low air loss mattress did so without the mattress being on the Firm setting. The new intervention put into place was two staff members on bed mobility for

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N8Q011

Facility ID: 011367

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| FERS FOR | F OF HEALTH AND HU! R MEDICARE & MEDIC | AID SERVICES | | | ОМ | B NO. 0938-039 |
|----------|---|---------------------------------|----------------------------------|---|----------------------|----------------|
| TATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CO | | (X3) DATE : | SURVEY |
| ND PLAN | OF CORRECTION | IDENTIFICATION NUMBER 155761 | A. BUILDING <u>00</u> B. WING | | COMPLETED 10/15/2021 | |
| AME OF I | PROVIDER OR SUPPLIER | | STREET A | | | |
| ROWN | ROWNSBURG MEADOWS | | | NSBURG, IN 46112 | | |
| X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORREC | TION | (X5) |
| REFIX | | CY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF | LD BE | COMPLETIC |
| TAG | | LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | | DATE |
| | | prosis, osteoarthritis, daily | | | | |
| | | r age 80, decreased | | | | |
| | | ssist with mobility, history of | | | | |
| | , . | -risk medications, diagnosis | | | | |
| | | izes glasses, incontinent, | | | | |
| | | rome and receiving hospice | | | | |
| | - | proaches, dated 10/5/21, | | | | |
| | were use 2 staff | members to assist for bed | | | | |
| | mobility and inc | ontinent care and to use | | | | |
| | bolsters with the | low air loss mattress. On | | | | |
| | 10/6/21 at 2:56 a | .m., Resident B was | | | | |
| | responsive to tou | ich. Lungs sounds were | | | | |
| | diminished. On 1 | 10/6/21 at 11:55 a.m., | | | | |
| | Resident B's lung | g sounds were diminished. | | | | |
| | Resident B was 1 | not drinking any fluids. On | | | | |
| | 10/6/21 at 10:34 | p.m., the resident was | | | | |
| | responsive to tou | ich and voice. Lung sounds | | | | |
| | diminished. On 1 | 10/9/21 at 5:17 a.m., the | | | | |
| | resident had no s | igns or symptoms of | | | | |
| | | th, but wheezing was | | | | |
| | | 1 at 1:52 p.m., the resident | | | | |
| | | wallow anything.On | | | | |
| | | p.m., the resident was not | | | | |
| | | anything, continued on 3L | | | | |
| | | responsive to name and | | | | |
| | | 21 at 9:37 p.m., Resident | | | | |
| | | e to pain and voice this | | | | |
| | - | luled morphine was given. | | | | |
| | | found unresponsive at 9:15 | | | | |
| | | th another nurse. Hospice | | | | |
| | - | and she would contact the | | | | |
| | | . On $10/13/21$ at $12:15$ | | | | |

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| CENTERS FO | R MEDICARE & | MEDICAID SERVICES |
|------------|--------------|-------------------|
| | | |

| AND PLAN | PLAN OF CORRECTION IDENTIFICATION NUMBER 155761 | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING | | (X3) DATE SURVEY COMPLETED 10/15/2021 | |
|------------------------------|---|--------------------------------|--|--|---|---|------------|
| IAME OF PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD 2 E TILDEN BROWNSBURG, IN 46112 | | | | |
| X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | | - | (X5) |
| PREFIX | (EACH DEFICIE | NCY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A | HOULD BE | COMPLETION |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | p.m., the MDS | (Minimum Data Set) | | | | | |
| | Coordinator As | sistant provided information | | | | | |
| | for the most rec | ent quarterly assessment, | | | | | |
| | dated 7/27/21. I | Resident B's assessment | | | | | |
| | indicated she w | as a 2 person assist for bed | | | | | |
| | mobility, this in | cluded being turned to her | | | | | |
| | side and toiletin | g. She was always | | | | | |
| | incontinent of b | ladder and bowel. During an | | | | | |
| | interview, on 10 |)/12/21 at 2:56 p.m., the | | | | | |
| | Assistance Dire | ctor of Nursing Services | | | | | |
| | (ADNS) indicat | red only CNA 5 was in | | | | | |
| | Resident B's roo | om during the check and | | | | | |
| | | biled brief on 10/4/21 at 4:30 | | | | | |
| | • | 1 at 9:35 a.m., an | | | | | |
| | | Resident B's previous room | | | | | |
| | | id used an AdvaCare | | | | | |
| | | bed. During an interview, on | | | | | |
| | - | 15 a.m., an AdvaCare | | | | | |
| | | ce representative indicated | | | | | |
| | | have been on the Firm setting | | | | | |
| | | resident with care. When the | | | | | |
| | - | ned on her side the air-fields | | | | | |
| | | on that setting. During an | | | | | |
| | |)/13/21 at 1:16 p.m., CNA 5 | | | | | |
| | | ent into Resident B's room | | | | | |
| | | change of her soiled brief. | | | | | |
| | | the resident on her side after | | | | | |
| | | , to put the new brief on, and | | | | | |
| | | he fell. The resident slid off | | | | | |
| | | oor. There was a flat sheet | | | | | |
| | | the flat sheet fell with her. | | | | | |
| | | ad hit the bedside table. | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155761 | | A.B | UILDING VING | nstruction 00 | (X3) DATE SURVEY COMPLETED 10/15/2021 | | |
|--|---------------------|---|-----------------|------------------|--|-----------|------------|
| | PROVIDER OR SUPPLIE | | | 2 E TILI | ADDRESS, CITY, STATE, ZIP DEN NSBURG, IN 46112 | COD | |
| X4) ID | SUMMARY | Y STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CO | DECTION | (X5) |
| REFIX | (EACH DEFICIE | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE | SHOULD BE | COMPLETION |
| TAG | REGULATORY C | DR LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | | only person in the room | | | | | |
| | when the reside | ent fell. She knew she should | | | | | |
| | have had 2 staff | f people to assist with | | | | | |
| | toileting the res | eident, but the facility was | | | | | |
| | short of staff. C | One aide to each hallway and | | | | | |
| | the nurse was b | ousy with another resident. | | | | | |
| | There was no o | ne else to help. CNA 5 | | | | | |
| | immediately we | ent to the resident and lifted | | | | | |
| | her head up. Sh | e put pressure on the | | | | | |
| | bleeding wound | d and then lower her head to | | | | | |
| | the floor to get | Licensed Practical Nurse | | | | | |
| | (LPN) 6. There | was no room for the Hoyer | | | | | |
| | | f used the sheet to lift the | | | | | |
| | · · | nto bed. The resident's vital | | | | | |
| | signs were chec | cked. The resident was | | | | | |
| | - | ad, My head." LPN 6 | | | | | |
| | | head wound and put a | | | | | |
| | - | The resident indicated, "Am I | | | | | |
| | - | m I going to die?" LPN 6 | | | | | |
| | | as going to be ok; you are | | | | | |
| | | e. You are going to be ok. | | | | | |
| | | sure was really elevated. The | | | | | |
| | - | away on Sunday, 10/10/21 | | | | | |
| | - | During an interview, on | | | | | |
| | - | 4 p.m., the Hospice | | | | | |
| | | se (RN) indicated when the | | | | | |
| | - | he hospice company after | | | | | |
| | - | ed the on-call service at 4:30 | | | | | |
| | | dent B's fall. It always | | | | | |
| | · · | • | | | | | |
| | - | e findings from the facility | | | | | |
| | - | all hospice staff. The facility is fine with the hospice nurse | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MUI | TIPLE CO | ONSTRUCTION | OMB NO. 0938-0. (X3) DATE SURVEY | | |
|--|---------------------|--|----------|-------------|---|-------------------------------------|-----------------|--|
| | OF CORRECTION | IDENTIFICATION NUMBER | A. BUI | | 00 | <u> </u> | LETED | |
| | | 155761 | B. WIN | G | | 10/15 | 5/2021 | |
| NAME OF | PROVIDER OR SUPPLIE | R | | | ADDRESS, CITY, STATE, ZIP COD | | | |
| | ISBURG MEADOW | | | 2 E TIL | DEN NSBURG, IN 46112 | | | |
| | - | | | | | | 1 | |
| (X4) ID PREFIX | | ' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL | D | ID REFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | | (X5) COMPLET | |
| TAG | ί. | REF MOST BETREEEDED BTTOLE | 1 | TAG | CROSS-REFERENCED TO THE APPROI DEFICIENCY) | | DATE | |
| | | orning to come in. Resident B | | | | | | |
| | 0 | ident of the day, the Hospice | | | | | | |
| | | 0:56 a.m., to do an | | | | | | |
| | | e resident's head wound was | | | | | | |
| | covered with ke | erlix (gauze wrapping), it was | | | | | | |
| | | blood and the resident was | | | | | | |
| | moaning. The H | Iospice RN removed the | | | | | | |
| | - | and the left side of the | | | | | | |
| | C C | 10 steri-strips, and the | | | | | | |
| | | ut 2 ¹ / ₂ inches wide. Blood | | | | | | |
| | was still tricklin | ng out between the saturated | | | | | | |
| | steri-strips. She | put pressure on the head | | | | | | |
| | wound and it wa | as still soaking through the | | | | | | |
| | gauze. The Hos | pice RN indicated, "The | | | | | | |
| | bleeding was pr | etty bad." Prior to the fall, | | | | | | |
| | Resident B was | completely immobile and | | | | | | |
| | was totally unat | ble to move herself. All her | | | | | | |
| | movement had | to be done by aides. She | | | | | | |
| | could only mov | e her head a bit. She could | | | | | | |
| | speak in comple | ete sentences and say her | | | | | | |
| | name. After the | fall, she could only blink her | | | | | | |
| | eyes and say "p | lease, please." She was | | | | | | |
| | laying on her rig | ght side and the right side of | | | | | | |
| | her face and hai | r were saturated with blood. | | | | | | |
| | The Hospice RN | N was worried about the | | | | | | |
| | amount of blood | d loss. She wanted to know | | | | | | |
| | why the facility | didn't send her out because | | | | | | |
| | she needed stitc | hes. The Hospice RN held | | | | | | |
| | | 20 minutes and the wound | | | | | | |
| | - | ing the gauze with blood. The | | | | | | |
| | | led the Resident's son and | | | | | | |
| | - | lity had told him about the | | | | | | |

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Event ID:

N8Q011 Facility ID: 011367

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CE

| | | 155761 | A. BUILDING B. WING | G <u>00</u> | | 19LETED 15/2021 |
|-------------------|------------------------------------|---|------------------------|---|--|--------------------|
| | PROVIDER OR SUPPLI SBURG MEADOV | | 2 E ⁻ | EET ADDRESS, CITY, STAT TILDEN DWNSBURG, IN 461 | | |
| (X4) ID PREFIX | (EACH DEFICIE | Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL | ID PREFIX | (EACH CORRECTIVE CROSS-REFERENCED | AN OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY) | (X5) COMPLETIO |
| TAG | | DR LSC IDENTIFYING INFORMATION | TAG | | | DATE |
| | | ndicated no. He wanted his | | | | |
| | | the ER for stitches. Before | | | | |
| | e | services personnel could | | | | |
| | | The DNS indicated to the | | | | |
| | | not transport her because she | | | | |
| | - | the son again and the son said | | | | |
| | | ing had stopped, he thought | | | | |
| | | ospital would be too | | | | |
| | - | is mother's body. The | | | | |
| | | nted to know why she wasn't | | | | |
| | - | ed. They called their chief | | | | |
| | e 1 | e RN had to explain to him | | | | |
| | - | ent was not being transported. | | | | |
| | - | N indicated RN 17 informed | | | | |
| | - | had changed the dressing 5 | | | | |
| | - | e Hospice RN arrived. So, | | | | |
| | | ange was the sixth dressing | | | | |
| | - | 30 a.m. At this time, the | | | | |
| | | ill actively bleeding. The DNS | | | | |
| | | ospice nurse and indicated the | | | | |
| | son didn't want | you to send her out. The | | | | |
| | | to the son the wound had | | | | |
| | stopped bleedin | ng. On 10/5/21, the Hospice | | | | |
| | | 0:06 a.m., she observed | | | | |
| | Resident B's he | ad was still wrapped with | | | | |
| | | s no visible blood. The Aides | | | | |
| | were trying to | give her water with a straw | | | | |
| | | vould trickle right back out of | | | | |
| | | resident did not eat anything. | | | | |
| | | aring straight ahead. She was | | | | |
| | - | pils were not the same size, | | | | |

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 12/03/2021

 FORM APPROVED

 OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| | NT OF DEFICIENCIES | x1) provider/supplier/clia identification number 155761 | A. BUILDING B. WING | e construction G <u>00</u> | (X3) DATE SURVEY COMPLETED 10/15/2021 | |
|--------------------------|-------------------------------------|---|------------------------|---|---|----|
| | PROVIDER OR SUPPLIE SBURG MEADOW | | 2 E | et address, city, state, 2 TILDEN DWNSBURG, IN 46112 | ZIP COD | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN O (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | ION SHOULD BE THE APPROPRIATE | |
| TAG | | s 5 mm (millimeters), and the | IAG | | DA [*] | IE |
| | | | | | | |
| | | 2 mm. The Hospice RN | | | | |
| | | B's son to give an update on he informed him Resident B | | | | |
| | | | | | | |
| | | uneven pupils and no longer | | | | |
| | _ | swallow. She educated him | | | | |
| | | urological decline was | | | | |
| | | head trauma and due to her | | | | |
| | | likely transitioning. Anew | | | | |
| | - | be monitoring her daily. On | | | | |
| | | spice LPN arrived. She | | | | |
| | | ri-strips were gone and | | | | |
| | - | er on the wound. On | | | | |
| | | a.m., the Hospice RN | | | | |
| | | and his spouse were at | | | | |
| | | lside. They asked about | | | | |
| | | N responded the pain could | | | | |
| | be intra-cranial | pressure. All the resident's | | | | |
| | limbs were cont | racted, including bilateral | | | | |
| | knees, shoulders | s, and elbows prior to the | | | | |
| | fall. Their discu | ssion included x-rays and | | | | |
| | with the need to | move the limbs to get | | | | |
| | x-rays, the fami | y declined the x-rays. The | | | | |
| | Hospice RN ind | icated, after Resident B's | | | | |
| | fall, you would | have needed the family's | | | | |
| | permission to gi | ve morphine. The first | | | | |
| | scheduled morp | hine dose was given on | | | | |
| | 10/5/21 as 0.25 | mL (milliliters) every 6 | | | | |
| | hours. The Hosp | oice RN believed the | | | | |
| | resident was in | pain because she was | | | | |
| | moaning, increa | sed vital signs, and body | | | | |
| | - | 0/8/21, the morphine was | | | | |
| | language. On 10 | - | N8Q011 Fac | | f continuation sheet Page 27 o | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| AND PLAN | OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155761 | A. BUILDING <u>00</u> B. WING | | | _ | completed 10/15/2021 | |
|----------|---------------------|---|----------------------------------|----------|--|----------|-------------------------|--|
| | PROVIDER OR SUPPLIE | | | 2 E TILI | ADDRESS, CITY, STATE, ZIP C DEN NSBURG, IN 46112 | OD | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF COR | | (X5) | |
| PREFIX | | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY) | HOULD BE | COMPLETIO | |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCE | | DATE | |
| | | juency to 0.25 mL every 4 | | | | | | |
| | | B's pupils were back to the | | | | | | |
| | | he right eye was drifting, and | | | | | | |
| | | no longer form words. The | | | | | | |
| | - | ed Resident B if she was in | | | | | | |
| | - | eye wound blink several | | | | | | |
| | | ndicated his mother was | | | | | | |
| | 0 | hey changed her and turned | | | | | | |
| | | 1 at 4:15 p.m., Resident B's | | | | | | |
| | | ved. An area of nursing | | | | | | |
| | | led Documentation | | | | | | |
| | | Charting, filled out by LPN 4 | | | | | | |
| | | was a hematoma and | | | | | | |
| | | forehead. The Physician or | | | | | | |
| | NP (Nurse Pract | titioner)/PA (Physician's | | | | | | |
| | · · · · | otified on 10/4/21 at 4:41 | | | | | | |
| | p.m. On 10/13/2 | 1 at 4:33 p.m., Hospice | | | | | | |
| | provided nursing | g notes regarding Resident | | | | | | |
| | B's care after he | r fall. The 10/4/21 | | | | | | |
| | documentation i | ndicated the problem to be | | | | | | |
| | altered neurolog | ical status. "Level of | | | | | | |
| | Consciousness: | Stupor/Semi-Coma | | | | | | |
| | Clinical Findi | ngs: Head wound from fall. | | | | | | |
| | Orientation to p | erson, place and time: | | | | | | |
| | Severely impair | ed. Alertness: Severely | | | | | | |
| | impaired. Type | of accident: Fall with injury. | | | | | | |
| | Circumstances s | urrounding the accident: | | | | | | |
| | Patient was bein | g toileted in bed and was | | | | | | |
| | dropped off the | side of the bed. Treatment | | | | | | |
| | | lt of accident: Minor | | | | | | |
| | treatment by car | egiver. Type of injury: | | | | | | |
| | - | ons, cut/laceration. Narrative | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| | NT OF DEFICIENCIES | x1) provider/supplier/clia identification number 155761 | A. B | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING CENTRE ADDRESS OF THE OF THE OF | | (X3) DATE SURVEY COMPLETED 10/15/2021 | |
|--------|---------------------|---|------|--|--|---|-----------|
| | PROVIDER OR SUPPLIE | | | 2 E TILI | .ddress, city, state, zip c DEN ISBURG, IN 46112 | OD | |
| X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF COR | DECTION | (X5) |
| REFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | | PREFIX | EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A | IOULD BE | COMPLETIO |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | | in bed with eyes closed. | | | | | |
| | | I fall earlier this morning. | | | | | |
| | Has a kerlix ban | dage dressing wrapped | | | | | |
| | around her head | , with a significant amount of | | | | | |
| | sanguineous sat | uration. Hair on right side of | | | | | |
| | head completely | v saturated, mainly due to | | | | | |
| | positioning, wou | and is on left forehead. | | | | | |
| | Patient is contra | cted and can't move on her | | | | | |
| | own[RN 17] in | ndicated she was | | | | | |
| | accidentally dro | pped off the side of the bed. | | | | | |
| | Was unable to s | ee the wound due to the | | | | | |
| | amount of active | e bleeding. Counted 8-9 | | | | | |
| | steri-strips in pla | ace on left forehead, which | | | | | |
| | covered the wor | and they were saturated | | | | | |
| | with blood seep | ing out around the strips. | | | | | |
| | The right forehe | ad had significant swelling | | | | | |
| | and bruising. Th | e Hospice RN applied | | | | | |
| | pressure for app | roximately 20 minutes to | | | | | |
| | active bleed and | was unable to get the | | | | | |
| | wound clotted o | ff. RN 17 and Hospice RN | | | | | |
| | | uze and kerlix. Patient was | | | | | |
| | | ying, 'please,' during care. | | | | | |
| | | e supervisor. Also, phoned | | | | | |
| | - | see if he wanted her sent to | | | | | |
| | - | t, possibly sutures, to stop | | | | | |
| | | e stated that he would like to | | | | | |
| | - | t. By the time the | | | | | |
| | | ved her dressing was | | | | | |
| | - | Once the paramedics | | | | | |
| | - | om, the facility DNS | | | | | |
| | | id stated that the son did not | | | | | |
| | | ut after all, due to the fact | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8Q011 Facility ID: 011367

PRINTED: 12/03/2021 FORM APPROVED OMB NO. 0938-039

> (X5) COMPLETION DATE

TE SURVEY MPLETED 15/2021

DEPARTMENT OF HEALTH AND HUMAN SERVICES

uncontrollably then he wanted her sent out.

dramatically and believed to be transitioning. She would no long open her mouth to be fed. Staff was giving her water though a straw, but the patient wouldn't swallow, and the water just ran back out of her mouth. Morphine scheduled to be given every 6 hours. On 10/6/21, the Hospice notes indicated the level of consciousness was unresponsive with pupils unequal. Forehead swollen and bruised from trauma wound

The Hospice RN indicated she was questioned by the paramedics as to the change of mind, explained that the son declined due to information received from the facility and it was decided by him and facility on whether or not to send her out for treatment. Before leaving the Hospice RN was asked to explain the situation to the paramedics chief " On 10/5/14, the Hospice notes continued to indicate the resident's level of consciousness was stupor/semi-coma, unequal pupils, and multiple bruises and swelling across entire forehead. The left pupil was measured at 5 mm and the right pupil was 2 mm. The resident's baseline had decreased

| ENTERS FOR | R MEDICARE & MEDIC | AID SERVICES | | | | |
|------------|---|--------------------------------|-----------------------|------------|--|----------|
| STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | DNSTRUCTION | (X3) DA' |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING <u>00</u> | | 00 | COM |
| | | 155761 | B. W | ING | | 10/ |
| | PROVIDER OR SUPPLIEF | | | 2 E TIL | ADDRESS, CITY, STATE, ZIP COD DEN NSBURG, IN 46112 | • |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | |
| PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ATE |
| TAG | REGULATORY OF | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | |
| | that they had the | bleeding under control. She | | | | |
| | stated it was clot | ted off and slowing down. | | | | |
| | The Hospice RN | called the son again and he | | | | |
| | clarified he want | ed her to stay at the facility | | | | |
| | for now but if sh | e continued to bleed | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N

N8Q011 Facility ID:

Facility ID: 011367

If continuation sheet Pag

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12/03/2021 : APPROVED

| | OF HEALTH AND HU MEDICARE & MEDIC | | | | | FO | NTED: 12/03/2 DRM APPROVED AB NO. 0938-039 |
|--------------------------|--|---|--------------------------------|-------------------|---|------|--|
| | OF DEFICIENCIES F CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155761 | (X2) MUL A. BUIL B. WINC | DING | DINSTRUCTION | COMP | e survey leted 5/2021 |
| | OVIDER OR SUPPLIE | | | 2 E TIL | ADDRESS, CITY, STATE, ZIP COD DEN NSBURG, IN 46112 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIE) | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | PF | ID EFIX FAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | E | (X5) COMPLETION DATE |
| | the fall. Patient moaned out in p PRN pain medic facility nurse. Patransitioning. Un was saying yes a but unable to at Hospice notes in consciousness w were unequal. P Patient without Patient pupils w out in pain when pain medication Urine output dir sounds. On 10/8 continued. Arriv B's level of cons stupor/semi-con ahead with right appeared to be e | tient without any intake since pupils are unequal. Patient ain when touched or moved. cation was given by the atient appeared to be nit manager indicated patient and no to questions earlier this time. On 10/7/21, the adicates the level of vas unresponsive and pupils atient had a flat affect. any intake since the fall. ere unequal. Patient moans in touched or moved. PRN given by the facility nurse. minished with sluggish bowel /21, the Hospice notes val time 11:15 a.m. Resident sciousness was na. Patient staring straight eye drifting outward. Pupils equal. Patient had pain upon nent. Had no intake of food 0/3/21. Orders received to | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

interview, on 10/14/21 at 8:45 a.m., LPN 6 indicated CNA 5 was providing care for Resident B. She stepped out in the hallway and called her name. She went to the room, and saw the resident was on floor. Resident B's head was bleeding. She immediately did an assessment. Someone got towels and

Event ID:

N8Q011

Facility ID: 011367

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES C

| CENTERS FOR MEDICARE & MEDICAID SERVICES |
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| | NT OF DEFICIENCIES | x1) provider/supplier/clia identification number 155761 | A. B | UILDING ING | DNSTRUCTION 00 | CON | te survey 19leted 15/2021 | | |
|-------------------|---------------------|---|------|---|--|------|---------------------------------|--|--|
| | PROVIDER OR SUPPLIE | | | STREET ADDRESS, CITY, STATE, ZIP CO 2 E TILDEN BROWNSBURG, IN 46112 | | | D | | |
| (X4) ID PREFIX | | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPF | D BE | (X5) COMPLETION | | |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | | |
| | | plied to the wound. She | | | | | | | |
| | | areas of injury. Another | | | | | | | |
| | | PN 6 was still applying | | | | | | | |
| | - | head. The staff in the room | | | | | | | |
| | grabbed the shee | et, and hoisted her on her | | | | | | | |
| | bed, Then, she v | vas able to observe an | | | | | | | |
| | abrasion to the r | esident's back. Someone | | | | | | | |
| | went to get ice. | LPN 6 indicated she did | | | | | | | |
| | neuro checks (ne | eurological assessment). | | | | | | | |
| | After some time | , the forehead wound | | | | | | | |
| | stopped bleeding | g, but as with a head wound | | | | | | | |
| | it continued to s | eep out more blood. She | | | | | | | |
| | measured the wo | ound size, applied | | | | | | | |
| | steri-strips, and | a dry dressing. All head | | | | | | | |
| | wounds seep out | t more blood. When she | | | | | | | |
| | came back that r | night for her next shift, | | | | | | | |
| | | a different dressing. At first | | | | | | | |
| | | moaning, so she gave her | | | | | | | |
| | |) morphine concentrate - | | | | | | | |
| | | se solution (MSIR). It was | | | | | | | |
| | | n. The neuro checks started | | | | | | | |
| | | new shift came in at 6:00 | | | | | | | |
| | | 1 at 10:13 a.m., the DNS | | | | | | | |
| | | the policy of the facility to | | | | | | | |
| | | or other responsible party. | | | | | | | |
| | | bed Resident B's bleeding | | | | | | | |
| | | and it started bleeding | | | | | | | |
| | | able to stop it from bleeding | | | | | | | |
| | - | indicated she believed the | | | | | | | |
| | - | not talk to the family before | | | | | | | |
| | - | During an interview, on | | | | | | | |
| | | 9 a.m., Resident B's son | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N8Q011 Facility ID: 011367

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DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155761 | A. BUILDING <u>00</u> B. WING | | (X3) DATE SURVEY COMPLETED 10/15/2021 | | |
|--------|---------------------|---|----------------------------------|--|---|------------|--|
| | PROVIDER OR SUPPLIE | | 2 E TIL | NDDRESS, CITY, STATE, ZIF DEN NSBURG, IN 46112 | , COD | | |
| X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF C | | (X5) | |
| REFIX | | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY) | E APPROPRIATE | COMPLETION | |
| TAG | | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY | | DATE | |
| | | l agree to have his mother go | | | | | |
| | - | The Hospice RN called him | | | | | |
| | | ne bleeding was under | | | | | |
| | | was not sent out. He never | | | | | |
| | | o the DNS. Within 24 hours | | | | | |
| | | nother was in transition, and | | | | | |
| | the family decid | led to let her pass in comfort. | | | | | |
| | He believed it w | vas a wrongful death, she did | | | | | |
| | not fall out of b | ed, she was dropped by the | | | | | |
| | aide, and this st | arted the transition to death. | | | | | |
| | His mother was | a two person assist for | | | | | |
| | toileting, and or | nly one person did the check | | | | | |
| | and change resu | Ilting in her being dropped to | | | | | |
| | - | orehead wound was about | | | | | |
| | the size of 2 go | If balls. He saw the DNS | | | | | |
| | - | 0 p.m., on the same day as | | | | | |
| | | ed the DNS "you aren't going | | | | | |
| | | est fell. He indicated the DNS | | | | | |
| | - | ve messed up. We messed | | | | | |
| | | interview, on 10/14/21 at | | | | | |
| | | DNS indicated another | | | | | |
| | , | erson was at the facility. She | | | | | |
| | | • | | | | | |
| | - | e Supervisor. She had | | | | | |
| | | acility for years, and still saw | | | | | |
| | | The Hospice Supervisor | | | | | |
| | | n and told him the bleeding | | | | | |
| | | rol. She was in a different | | | | | |
| | - | ling and came over when the | | | | | |
| | | rrived. The DNS told the | | | | | |
| | - | e facility staff had gotten the | | | | | |
| | bleeding under | control again. The DNS | | | | | |
| | indicated the H | ospice RN thought Resident | | | | | |

 PRINTED:
 12/03/2021

 FORM APPROVED

 OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| CENTERS FOR MEDICARE & MEDICAID SERVICI | ES |
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| | ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER 155761 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING | | | | (X3) DATE SURVEY COMPLETED 10/15/2021 | |
|---|---|--|--|--------------|----------------|---|---|-------------------|
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD BROWNSBURG MEADOWS 2 E TILDEN BROWNSBURG, IN 46112 BROWNSBURG, IN 46112 | | | | | | | | |
| (X4) ID PREFIX | | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL | | ID PREFIX | (EACH CORRECTI | PLAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA1 | -E | (X5) COMPLETIO |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION | | | TAG | DEFICIENCY) | | - | DATE |
| | B needed stitche | es, but she didn't. The | | | | | | |
| | ADNS, LPN 4, | and the DNS got the | | | | | | |
| | forehead wound | to stop bleeding by | | | | | | |
| | applying a large | amount of collagen powder. | | | | | | |
| | The DNS indica | ted the forehead wound was | | | | | | |
| | approximately 5 | cm long. During an | | | | | | |
| | interview, on 10 | /14/21 at 1:27 p.m., the | | | | | | |
| | ADNS indicated | l the steri-strips were | | | | | | |
| | removed becaus | e they were no longer | | | | | | |
| | effective becaus | e they were saturated with | | | | | | |
| | blood. They we | e not adhering to her skin | | | | | | |
| | anymore. The co | ollagen was not a physician's | | | | | | |
| | order, it was a n | ursing measure. The hospice | | | | | | |
| | doctor was calle | d by the on-call | | | | | | |
| | service.During a | in interview, on 10/14 21 at | | | | | | |
| | 11:54 a.m., the l | Hospice Clinical Director | | | | | | |
| | indicated their a | fterhours on-call services | | | | | | |
| | indicated the first | st call from the facility was | | | | | | |
| | from LPN 6 at 6 | :17 a.m. and a second call | | | | | | |
| | from LPN 6 was | s at 7:08 a.m. The Hospice | | | | | | |
| | Clinical Directo | r indicated the afterhours | | | | | | |
| | on-call service d | lid not notify the physician. | | | | | | |
| | On 10/14/21 at 2 | 2:54 p.m., the Hospice | | | | | | |
| | Supervisor emai | led the over-night | | | | | | |
| | information to the | ne Hospice Administrator | | | | | | |
| | and the Hospice | Administrator provided | | | | | | |
| | information via | email of their afterhours | | | | | | |
| | on-call services | transcripts. At 6:17 a.m., | | | | | | |
| | received a call f | rom LPN 6 at Brownsburg | | | | | | |
| | Meadows regard | ling Resident B. Resident | | | | | | |
| | - | norning at 4:20 a.m., fell out | | | | | | |
| | | n laceration to left forehead, | | | | | | |
| | 2-99) Previous Versions O | bsolete Event ID: | \8Q011 | Facility II | D: 011367 | If continuation sh | | ge 34 of 57 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155761 | | | UILDING | nstruction 00 | CC | (X3) DATE SURVEY COMPLETED 10/15/2021 | | |
|--|--------------------|--------------------------------|--|---------------|--|---|------------|--|
| NAME OF PROVIDER OR SUPPLIER BROWNSBURG MEADOWS | | | STREET ADDRESS, CITY, STATE, ZIP COD 2 E TILDEN BROWNSBURG, IN 46112 | | | | | |
| X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CO | ORRECTION | (X5) | |
| PREFIX | - | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE | SHOULD BE | COMPLETION | |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | |
| | - | e applied, bandaged. Neuro | | | | | | |
| | | thin normal limits, PRN pain | | | | | | |
| | | re given. Abrasion to center | | | | | | |
| | | e resident was comfortable | | | | | | |
| | and sleeping. T | he family had not yet been | | | | | | |
| | called. Hospice | Supervisor indicated she | | | | | | |
| | updated Reside | nt B's son, he expressed | | | | | | |
| | understanding. | The facility was okay with a | | | | | | |
| | visit later this n | norning. The second call was | | | | | | |
| | at 7:09 a.m., the | e call received was again | | | | | | |
| | from LPN 6 at 1 | Brownsburg Meadows | | | | | | |
| | regarding Resid | lent B with vitals: | | | | | | |
| | Respirations 24 | , Pulse 110, Oxygen | | | | | | |
| | - | % on room air, with oxygen | | | | | | |
| | | al cannula was 96%. Ativan | | | | | | |
| | | rrent policy, titled "Fall | | | | | | |
| | Ū. | ogram," dated 11/2017, was | | | | | | |
| | - | DNS on 10/12/21 at 2:26 | | | | | | |
| | | of the document indicated | | | | | | |
| | - | idents residing within the | | | | | | |
| | | adequate supervision and or | | | | | | |
| | • | | | | | | | |
| | - | event injury related to | | | | | | |
| | | ent specific care requirement | | | | | | |
| | | nicated to the assigned | | | | | | |
| | • | ng resident profile or CNA | | | | | | |
| | - | etIf the resident experience | | | | | | |
| | | he fall, contact facility | | | | | | |
| | | utive Director) per facility | | | | | | |
| | | sician will be contacted | | | | | | |
| | | there are injuries, and orders | | | | | | |
| | | IThe family will be notified | | | | | | |
| | immediately by | the charge nurse of falls with | | | | | | |

PRINTED: 12/03/2021 FORM APPROVED OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155761 | Α. | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING | | | (x3) date survey completed 10/15/2021 | | |
|---|---|---|----|--|------------------------------------|--|---|------------------|--|
| NAME OF PROVIDER OR SUPPLIER BROWNSBURG MEADOWS | | | | STREET A 2 E TILI BROWN | TE, ZIP COD | | | | |
| X4) ID PREFIX | | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL | | ID PREFIX | (EACH CORRECTIV CROSS-REFERENCE | LAN OF CORRECTION E ACTION SHOULD BE ED TO THE APPROPRIATE | СС | (X5) MPLETION | |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION | | | TAG | DEF | (CIENCY) | | DATE | |
| | | ent policy, titled "Resident | | | | | | | |
| | | lition Policy," dated | | | | | | | |
| | | ovided by the ADNS on | | | | | | | |
| | 10/12/21 at 10:3 | 8 a.m. A review of the | | | | | | | |
| | document indica | ted "all changes in resident | | | | | | | |
| | condition will be | e communicated to the | | | | | | | |
| | physician and fa | mily/responsible party, and | | | | | | | |
| | that appropriate, | timely, and effective | | | | | | | |
| | intervention take | es placeAll nursing | | | | | | | |
| | actions, physicia | an contacts, and resident | | | | | | | |
| | assessment infor | rmation will be documented | | | | | | | |
| | in the medical re | ecordAny sudden or | | | | | | | |
| | serious change i | n a resident's condition | | | | | | | |
| | manifested by a | marked change in physical | | | | | | | |
| | or mental behav | ior will be communication to | | | | | | | |
| | the physicianT | The responsible party will be | | | | | | | |
| | notified that the | re has been a change in the | | | | | | | |
| | resident's condit | ion and what steps are being | | | | | | | |
| | takenAll symp | otoms and unusual signs will | | | | | | | |
| | be documented i | in the medical record and | | | | | | | |
| | communicated t | o the attending physician | | | | | | | |
| | promptlythe n | urse in charge is responsible | | | | | | | |
| | for notification of | of physician and | | | | | | | |
| | family/responsit | ole party prior to end of | | | | | | | |
| | assigned shift w | hen a significant change in | | | | | | | |
| | the residents' con | ndition is notedDocument | | | | | | | |
| | resident change | of condition and response in | | | | | | | |
| | - | ord. Documentation will | | | | | | | |
| | include time and | l family/physician | | | | | | | |
| | | immediate jeopardy that | | | | | | | |
| | - | 1 was removed on | | | | | | | |
| | - | he facility provided | | | | | | | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES s

| CENTERS FOR MEDICARE & MEDICAID SERVICE |
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| | VT OF DEFICIENCIES | x1) provider/supplier/clia identification number 155761 | A. BUILDING B. WING | <u>00</u> |) date survey completed 10/15/2021 |
|----------------------------|---|--|------------------------|---|--|
| | PROVIDER OR SUPPLI SBURG MEADOV | | 2 E TIL | address, city, state, zip cod DEN NSBURG, IN 46112 | |
| (X4) ID PREFIX TAG | (EACH DEFICII | Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL 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 0689 SS=G Bldg. 00 | licensed nursin residents for ch prevention and policy and proof facility-wide pr who use a low assisted by two implemented. T at the lower sco actual harm wi minimal harm r jeopardy.This J Complaints IN IN00364490.3. 483.25(d)(1)(2) Free of Accident Hazards/Superv §483.25(d)(1)(1) Free af Accident Hazards/Superv §483.25(d)(1) Th remains as free possible; and §483.25(d)(2)Ea adequate supert to prevent accid Based on intervie failed to ensure R present to prevent hitting her head, n the fall, notifying condition resultin change of conditi | 1-37(a) t ision/Devices dents. t ensure that - he resident environment of accident hazards as is ach resident receives vision and assistance devices | F 0689 | Facility respectfully requests a face to face informal dispute resolution for F0689. Brownsburg Meadows respectfully requests additional evidentiary information be considered in eliminating or reducing federal tag 0689. The current statement of deficiencies on the 2567 omit significant facili | |

| | R MEDICARE & MEDI | | | | | OMB NO. 0938-03 |
|----------|---------------------|--|-----------|---|----------------------------|-----------------|
| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | | PLE CONSTRUCTION | . , | TE SURVEY |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDI | NG <u>00</u> | | PLETED |
| 155761 | | B. WING | | 10/1 | 5/2021 | |
| NAME OF | PROVIDER OR SUPPLIE | R | | REET ADDRESS, CITY, STATE, ZIP | COD | |
| | | | | | | |
| BROWN | ISBURG MEADOW | · 5 | | ROWNSBURG, IN 46112 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CO | ORRECTION | (X5) |
| PREFIX | , | NCY MUST BE PRECEDED BY FULL | PREF | CROSS-REFERENCED TO THE | SHOULD BE E APPROPRIATE | COMPLETI |
| TAG | | R LSC IDENTIFYING INFORMATION | TA | | | DATE |
| | Finding includes: | | | information and there | | |
| | | | | misrepresents the ca | | |
| | | w, on 10/11/21 at 9:50 a.m., | | services administered | | |
| | | nd Power of Attorney (POA) | | provider to its resider | nts. | |
| | | ty did not call when his mother | | | | |
| | | ed. He knew from the hospice | | Based on interview a | | |
| | | tt 4:00 a.m. and she was | | review, the facility fail | | |
| | - | the place." Paramedics were | | Resident B had adeq | | |
| | · · | bleeding. Her head wound was | | present to prevent he | • | |
| | | prehead, across to the middle. It ped. Hospice indicated she | | off her bed, hitting he | | |
| | · · · | ut of this, and it would lead to | | notifying the family at | | |
| | | Director of Nursing talked to him | | the fall, notifying the | - | |
| | | e was one person changing her | | with a change of con- resulting in altered m | | |
| | | have been 2 staff members to | | pain, change of cond | | |
| | | nd she fell off the bed. His | | death for 1 of 3 reside | | |
| | - | bed for a week in pain and she | | for accidents (Reside | | |
| | - | eathing. Hospice provided a low | | | in D). | |
| | | but when staff would come in | | What corrective actio | n(s) will be | |
| | - | her up in bed she would scream | | accomplished for tho | | |
| | - | increased the dose from 4 doses | | found to have been a | | |
| | a day to 6 doses a | day. He indicated he believed | | deficient practice | , | |
| | she was not close | to death prior to the fall from | | - Resident B no l | onger | |
| | | ll brought about her death. | | resides at the facility | - | |
| | Desident Disesse | d was reviewed on 10/13/21 at | | | | |
| | | t B's code status was DNR (do | | How other residents l potential to be affected | - | |
| | - | er diagnoses included, but were | | same deficient practic | - | |
| | | rt failure, chronic obstructive | | identified and what co | | |
| | | , and need for assistance with | | action(s) will be taker | | |
| | | started with Hospice on | | - Residents who | | |
| | 9/12/19. | Surrea with Hospice on | | staff assistance with | - | |
| | | | | mobility have the po | | |
| | A progress note. o | n 9/29/21 at 11:37 a.m., | | be affected | | |
| | | B was stable and all vital signs | | - Residents who | require | |
| | were stable. No co | e | | staff assistance with | | |
| | | | | mobility were review | | |
| | A progress note. o | n 10/3/21 at 2:15 p.m., indicated | | appropriate interven | | |
| | | were stable, continued on | | including level of sta | | |
| | | es in her condition have been | | assistance; care pla | | |

| TERS FO | R MEDICARE & MEDI | CAID SERVICES | | | OM | IB NO. 0938-039 |
|---------|---------------------|--|-----------------|---|------------------|-----------------|
| | INT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE C | | (X3) DATE SURVEY | |
| ND PLAN | NOF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | 00 | COMPI | |
| | | 155761 | B. WING | | 10/15 | /2021 |
| NAME OF | PROVIDER OR SUPPLIE | ER | | ADDRESS, CITY, STATE, ZIP COD | | |
| | | 10 | 2 E TIL | | | |
| BROWN | ISBURG MEADOW | 15 | BROW | /NSBURG, IN 46112 | | |
| X4) ID | SUMMARY | Y STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIE | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI | IATE | COMPLETION |
| TAG | | OR LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | | DATE |
| | noted at this time. | | | resident profiles were | | |
| | | | | reviewed and/or updated to | | |
| | | n 10/4/21 at 4:30 a.m., indicated | | reflect current bed mobility | | |
| | | ying on her back after a fall | | interventions | | |
| | | re was a 3 centimeter (cm) by (x) | | - Nursing staff will recei | ve | |
| | | to the left side of her forehead. | | education on providing | | |
| | | vas applied to area and the area | | assistance for bed mobility | | |
| | | Steri-strips (adhesive | | following the care plan/ | | |
| | | essing) were applied with a dry | | profiles, including | | |
| | - | sion was noted on her mid-back. | | obtaining/waiting for addition | onal | |
| | | pain medication was provided. | | staff member(s) when 2 or | ام م | |
| | | to get an accurate blood | | more staff are needed for be | 90 | |
| | - | he resident was yelling out. ers assisted her back to bed with | | mobility and safe use of | | |
| | | gical assessment was | | specialty mattresses per | the | |
| | | thin normal limits. A Certified | | manufacturer guidelines by DNS/designee on or before | uie | |
| | - | (CNA) was providing | | 11/2/21 | | |
| | - | when she turned the resident on | | - Licensed nursing staff | will | |
| | | lent B fell from the bed. She hit | | receive education on | WIII | |
| | , | dside table. The resident was | | assessments following a fa | | |
| | | The physician and the Director | | notification of condition | •, | |
| | | es (DNS) were notified. Hospice | | changes and emergency | | |
| | e | he hospice company would | | medical attention by the | | |
| | | Hospice would be out to assess | | DNS/designee on or before | | |
| | Resident B in the | - | | 11/2/21 | | |
| | A prograss pote | n 10/1/21 at 6:30 a m muraina | | what measures will be a | | |
| | | n 10/4/21 at 6:30 a.m., nursing B's heart rate was accelerated to | | - what measures will be p into place or what systemic | ut | |
| | | ons at 24. Her oxygen saturation | | changes will be made to ensu | uro | |
| | - | was applied and increased it to | | that the deficient practice doe | | |
| | 96%. Hospice not | | | recur; | 55 1101 | |
| | | 10/4/01 - 11 00 | | | | |
| | | n 10/4/21 at 11:30 a.m., | | - Nursing staff will recei | ve | |
| | | t B was responding to verbal | | education on providing | | |
| | | s were responding to light and | | assistance for bed mobility | | |
| | | able at this time. A hematoma | | following the care plan/ | | |
| | | of solid blood within the tissues) | | profiles, including | | |
| | _ | forehead. The laceration was | | obtaining/waiting for addition | onal | |
| | | h steri-strips, with bleeding | | staff member(s) when 2 or | I | |
| | noted to the foreh | ead laceration. Pressure was | | more staff are needed for be | ad | 1 |

| STATEME | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLI | E CONSTRUCTION | (X3) DAT | E SURVEY |
|---------|---------------------|---------------------------------------|---------------|--------------------------------|--------------|-------------------------|
| ND PLAN | OF CORRECTION | RRECTION IDENTIFICATION NUMBER 155761 | | | | pleted 5/2021 |
| | | | CTDE | ET ADDRESS, CITY, STATE, ZIP (| | |
| NAME OF | PROVIDER OR SUPPLIE | ČR. | | TILDEN | | |
| BROWN | ISBURG MEADOW | 'S | | WNSBURG, IN 46112 | | |
| X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF COI | PRECTION | (X5) |
| REFIX | (EACH DEFICIE | NCY MUST BE PRECEDED BY FULL | PREFIX | | SHOULD BE | COMPLETION |
| TAG | REGULATORY C | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | | DATE |
| | applied and the blo | eeding stopped. Dressing was | | mobility and safe use | e of | |
| | applied and son wa | as notified. | | specialty mattresses | per | |
| | | | | manufacturers' guide | elines by | |
| | A progress note, o | n 10/4/21 at 5:46 p.m., indicated | | the DNS/designee on | or before | |
| | Resident B's son a | nd POA arrived for a visit | | 11/2/21 | | |
| | ~ | B was able to communicate | | - Licensed nursing | g staff will | |
| | with yes and no an | swers. The son indicated his | | receive education on | | |
| | mother would not | want to ride in an ambulance | | assessments followir | ng a fall, | |
| | and go to the hosp | ital. Comfort care continued. | | notification of condit | ion | |
| | | | | changes and emerge | ncy | |
| | A progress note, o | n 10/4/21 at 11:46 p.m., | | medical attention by | the | |
| | indicated Resident | B's vitals were stable while on | | DNS/designee on or I | before | |
| | 3L (liters) of oxyg | en. Resident had new bleeding | | 11/2/21 | | |
| | from the wound su | stained from a fall earlier today. | | - Charge nurses v | vill | |
| | The head dressing | was changed. The resident did | | communicate with nu | ursing staff | |
| | not respond to ver | bal stimuli and did not open | | on their units each sh | hift about | |
| | eyes throughout th | e evening shift. | | residents who need 2 | 2 or more | |
| | | | | staff to assist with be | ed mobility | |
| | Resident B's neuro | blogical assessment, on 10/4/21 | | using the resident pr | ofile | |
| | at 10:55 a.m., LPN | 17 charted Resident B's bilateral | | interventions and wil | l make | |
| | | ize had changed from 3 mm to 2 | | observational rounds | s during | |
| | | 0 p.m. neuro charting indication | | their shift to ensure o | compliance | |
| | | ciousness was no longer | | - Nurse managers | s will | |
| | oriented. The next | neuro charting due at 8:00 p.m. | | make daily observation | onal | |
| | was incomplete. It | indicated the right pupil was 2 | | rounds to ensure stat | ff are | |
| | mm, with no meas | urement for the left pupil. | | providing the approp | riate level | |
| | | | | of assistance for bed | mobility | |
| | | n 10/5/21 at 1:05 a.m., indicated | | per resident profile | | |
| | | sponsive to name and touch. | | interventions and that | | |
| | - | diminished. Neurological signs | | on a low air-loss mat | | |
| | | thin normal limits. Resident took | | being assisted by 2 s | | |
| | a few sips of water | r. | | - Staff observed n | | |
| | | | | following resident pro | | 1 |
| | | e, dated 10/5/21 at 8:32 a.m., | | interventions will rec | | 1 |
| | | B was on a low air loss | | immediate education | | |
| | | f member was assisting the | | regarding following p | | |
| | | oiled brief. She turned the | | interventions. Contin | | |
| | | nged and resident rolled, and | | non-compliance will | | |
| | | n one side, the resident hit her | | further education and | d/or | |
| | head on the bedsid | le table, and slid off the bed. | | disciplinary action. | | |

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N8Q011 Facility ID: 011367

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| STATEME | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE C | ONSTRUCTION | (X3) DAT | E SURVEY |
|----------|--|--|-----------------|---|-------------------------|-----------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | 00 | СОМ | PLETED |
| | | 155761 | B. WING | | 10/1 | 5/2021 |
| NAME OF | PROVIDER OR SUPPLI | ER | | ADDRESS, CITY, STATE, ZIP C | OD | |
| | | | 2 E TIL | | | |
| BROWN | SBURG MEADOW | 15 | BROW | /NSBURG, IN 46112 | | - |
| (X4) ID | SUMMAR | Y STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF COR | | (X5) |
| PREFIX | (EACH DEFICIE | ENCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A | IOULD BE IPPROPRIATE | COMPLETIC |
| TAG | | DR LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | | DATE |
| | | ved a laceration to her forehead. | | | | |
| | | bot cause of the fall was the staff | | | | |
| | | ed the resident on the low air | | - how the corrective | • • | |
| | | so without the mattress being on | | will be monitored to en | | |
| | | The new intervention put into | | deficient practice will n | | |
| | - | ff members on bed mobility for | | i.e., what quality assure | | |
| | Resident B. | | | program will be put into | | |
| | | 10/6/21 indicated | | To ensure compli | | |
| | - | evised 10/6/21, indicated risk for falls due to decreased | | DNS/Designee is resp | | |
| | mobility and stren | | | for the completion of Management QAPI too | | |
| | | y diuretic use, over age 80, | | times 4 weeks, month | - | |
| | | , needs assist with mobility, | | and then quarterly to | iy times o | |
| | | e of high-risk medications, | | encompass all shifts | until | |
| | - | nnia, utilizes glasses, | | continued compliance | | |
| | - | ss leg syndrome and receiving | | maintained for 2 cons | | |
| | | New approaches, dated 10/5/21, | | quarters. The results | | |
| | - | embers to assist for bed mobility | | audits will be reviewe | | |
| | | are and to use bolsters with the | | CQI committee overse | - | |
| | low air loss mattre | ess. | | ED. If threshold of 95 | - | |
| | | | | achieved an action pla | | |
| | On 10/6/21 at 2:50 | 6 a.m., Resident B was responsive | | developed to ensure | | |
| | | ounds were diminished. | | compliance. | | |
| | On 10/6/21 at 11:55 a.m., Resident B's lung sounds | | | | | |
| | | Resident B was not drinking any | | | | |
| | fluids. | | | | | |
| | On 10/6/21 at 10:3 | 34 p.m., the resident was | | | | |
| | | h and voice. Lung sounds | | | | |
| | diminished. | | | | | |
| | On 10/9/21 at 5:17 | 7 a.m., the resident had no signs | | | | |
| | | nortness of breath, but wheezing | | | | |
| | was noted. | , 6 | | | | |
| | On 10/9/21 at 1:52 to swallow anythi | 2 p.m., the resident was not able | | | | |
| | | | | | | |
| | On 10/10/21 at 1:4 | 44 p.m., the resident was not able | | 1 | | |

12/03/2021 PRINTED: DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155761 B. WING 10/15/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2 E TILDEN **BROWNSBURG MEADOWS BROWNSBURG, IN 46112** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE to swallow anything, continued on 3L oxygen and was responsive to name and touch. On 10/10/21 at 9:37 p.m., Resident B was responsive to pain and voice this afternoon. Scheduled morphine was given. The resident was found unresponsive at 9:15 p.m. Verified with another nurse. Hospice nurse informed and she would contact the resident's family. On 10/13/21 at 12:15 p.m., the MDS (Minimum Data Set) Coordinator Assistant provided information for the most recent quarterly assessment, dated 7/27/21. Resident B's assessment indicated she was a 2 person assist for bed mobility, this included being turned to her side and toileting. She was always incontinent of bladder and bowel. During an interview, on 10/12/21 at 2:56 p.m., the Assistance Director of Nursing Services (ADNS) indicated only CNA 5 was in Resident B's room during the check and change of her soiled brief on 10/4/21 at 4:30 a.m. On 10/13/21 at 9:35 a.m., an observation of Resident B's previous room indicated she had used an AdvaCare Rhythm Multi bed. During an interview, on 10/13/21 at 11:15 a.m., an AdvaCare Customer Service representative indicated the bed should have been on the Firm setting for assisting the resident with care. When the resident was turned on her side the air-fields were not filled on that setting. During an interview, on 10/13/21 at 1:16 p.m., CNA 5 indicated she went into Resident B's room for a check and change of her soiled brief. She was putting the resident on her side after cleaning her

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Facility ID: 011367

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 155761 10/15/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2 E TILDEN **BROWNSBURG MEADOWS BROWNSBURG, IN 46112** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE up, to put the new brief on, and that was when she fell. The resident slid off the bed to the floor. There was a flat sheet on the bed and the flat sheet fell with her. Resident B's head hit the bedside table. CNA 5 was the only person in the room when the resident fell. She knew she should have had 2 staff people to assist with toileting the resident, but the facility was short of staff. One aide to each hallway and the nurse was busy with another resident. There was no one else to help. CNA 5 immediately went to the resident and lifted her head up. She put pressure on the bleeding wound and then lower her head to the floor to get Licensed Practical Nurse (LPN) 6. There was no room for the Hoyer Lift, so the staff used the sheet to lift the resident back into bed. The resident's vital signs were checked. The resident was saying, "My head, My head." LPN 6 cleaned up the head wound and put a dressing on it. The resident indicated, "Am I going to die? Am I going to die?" LPN 6 indicated she was going to be ok; you are not going to die. You are going to be ok. Her blood pressure was really elevated. The resident passed away on Sunday, 10/10/21 about 9:15 p.m. During an interview, on 10/13/21 at 1:54 p.m., the Hospice Registered Nurse (RN) indicated when the facility called the hospice company after hours, they called the on-call service at 4:30 a.m., after Resident B's fall. It always depended on the findings from the facility whether they call hospice staff. The facility indicated it was fine with the hospice nurse waiting until morning to come in. Resident B was the first resident of the day, the Hospice RN arrived at 10:56 a.m., to do an assessment. The resident's head wound was covered with kerlix (gauze wrapping), it was saturated with blood and the resident was moaning. The Hospice RN removed the dressing N8Q011 Facility ID: 011367 Page 43 of 57 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 155761 10/15/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2 E TILDEN **BROWNSBURG MEADOWS BROWNSBURG, IN 46112** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE and found the left side of the forehead had 8-10 steri-strips, and the wound was about 2 1/2 inches wide. Blood was still trickling out between the saturated steri-strips. She put pressure on the head wound and it was still soaking through the gauze. The Hospice RN indicated, "The bleeding was pretty bad." Prior to the fall, Resident B was completely immobile and was totally unable to move herself. All her movement had to be done by aides. She could only move her head a bit. She could speak in complete sentences and say her name. After the fall, she could only blink her eyes and say "please, please." She was laying on her right side and the right side of her face and hair were saturated with blood. The Hospice RN was worried about the amount of blood loss. She wanted to know why the facility didn't send her out because she needed stitches. The Hospice RN held pressure for 15-20 minutes and the wound was still saturating the gauze with blood. The Hospice RN called the Resident's son and asked if the facility had told him about the seriousness of the wound his mother sustained. He indicated no. He wanted his mother to go to the ER for stitches. Before the emergency services personnel could leave with her. The DNS indicated to the paramedics to not transport her because she just talked to the son again and the son said since the bleeding had stopped, he thought the trip to the hospital would be too traumatic for his mother's body. The paramedics wanted to know why she wasn't being transported. They called their chief and the Hospice RN had to explain to him why the Resident was not being transported. The Hospice RN indicated RN 17 informed her the facility had changed the dressing 5 times before the Hospice RN arrived. So, her dressing change was the sixth dressing change since 4:30 a.m. At this time, the resident was still actively bleeding. The DNS talked to the hospice nurse and indicated the son N8Q011 Facility ID: 011367 Page 44 of 57 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING | | (X3) DATE SURVEY COMPLETED 10/15/2021 | |
|---|---------------------|-----------------------------------|--|--|-----------|---|--|
| NAME OF | PROVIDER OR SUPPLIE | R | STREET ADDRESS, CITY, STATE, ZIP COD 2 E TILDEN | | | | |
| BROWN | SBURG MEADOW | 'S | | NSBURG, IN 46112 | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CO | PRRECTION | (X5) | |
| PREFIX | (EACH DEFICIE | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE | | COMPLETIC | |
| TAG | | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | | DATE | |
| | - | g and bruising. The Hospice RN | | | | | |
| | | or approximately 20 minutes to | | | | | |
| | | as unable to get the wound | | | | | |
| | | and Hospice RN applied more | | | | | |
| | - | Patient was moaning and saying, | | | | | |
| | | e. Notified Hospice supervisor. | | | | | |
| | | ent's son to see if he wanted her | | | | | |
| | | tment, possibly sutures, to stop | | | | | |
| | Ũ | tated that he would like to have | | | | | |
| | | e time the paramedics arrived | | | | | |
| | | aturated again. Once the | | | | | |
| | | l at her room, the facility DNS | | | | | |
| | | stated that the son did not | | | | | |
| | | after all, due to the fact that | | | | | |
| | | ing under control. She stated it | | | | | |
| | | d slowing down. The Hospice | | | | | |
| | | again and he clarified he wanted | | | | | |
| | | acility for now but if she | | | | | |
| | | uncontrollably then he wanted | | | | | |
| | | Iospice RN indicated she was | | | | | |
| | | paramedics as to the change of | | | | | |
| | - | at the son declined due to | | | | | |
| | | ed from the facility and it was | | | | | |
| | - | d facility on whether or not to | | | | | |
| | | eatment. Before leaving the | | | | | |
| | | sked to explain the situation to | | | | | |
| | the paramedics chi | let" | | | | | |
| | On 10/5/14, the He | ospice notes continued to | | | | | |
| | indicate the reside | nt's level of consciousness was | | | | | |
| | stupor/semi-coma, | unequal pupils, and multiple | | | | | |
| | - | ng across entire forehead. The | | | | | |
| | left pupil was mea | sured at 5 mm and the right | | | | | |
| | | The resident's baseline had | | | | | |
| | decreased dramati | cally and believed to be | | | | | |
| | | would no long open her mouth | | | | | |
| | | s giving her water though a | | | | | |
| | | ent wouldn't swallow, and the | | | | | |
| | | c out of her mouth. Morphine | | | | | |
| | | ven every 6 hours. | | | | | |

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| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155761 | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | COM 10/ | te survey Mpleted 15/2021 |
|---|--|---|--|--|------------|---------------------------------|
| NAME OF PROVIDER OR SUPPLIER BROWNSBURG MEADOWS | | | 2 E TILI | address, city, state, zip c DEN NSBURG, IN 46112 | OD | |
| (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 COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY) | HOULD BE | (X5) COMPLETIO DATE |
| | of consciousness unequal. Forehead trauma wound fro intake since the fa Patient moaned o moved. PRN pair facility nurse. Pat Unit manager ind and no to question time. On 10/7/21, the F of consciousness were unequal. Pat without any intak were unequal. Pat touched or moved the facility nurse. sluggish bowel so On 10/8/21, the F time 11:15 a.m. F consciousness was staring straight af outward. Pupils a pain upon touch of food or water sind increase frequence During an intervi- 6 indicated CNA Resident B. She s called her name. S the resident was of bleeding. She imi Someone got tow the wound. She lo | Iospice notes continued. Arrival Resident B's level of s stupor/semi-coma. Patient nead with right eye drifting ppeared to be equal. Patient had or movement. Had no intake of ce 10/3/21. Orders received to | | | | |

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| STATEME | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATI | E SURVEY |
|---------|-----------------------|---|----------------------------------|---|-------------------------|------------|
| ND PLAN | OF CORRECTION | IDENTIFICATION NUMBER 155761 | A. BUILDING <u>00</u> B. WING | | COMPLETED 10/15/2021 | |
| NAME OF | PROVIDER OR SUPPLIE | R | STREET | ADDRESS, CITY, STATE, ZIP COD .DEN | • | |
| BROWN | ISBURG MEADOW | S | BROW | NSBURG, IN 46112 | | |
| X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIE) | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | | COMPLETION |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY | | DATE |
| | During the survey | a confidential interview | | - what corrective action(s | s) will | |
| | indicated Resident | E had been admitted to the | | be accomplished for those | | |
| | facility for strength | nening and rehabilitation after a | | residents found to have beer | า | |
| | recent hospital stay | y for an infection. He had only | | affected by the deficient prac | ctice | |
| | been at the facility | a few days and was doing well, | | - Resident E no longer | | |
| | but he and his fam | ily were a "little nervous" about | | resides in the facility | | |
| | him getting in and | out of bed because he was | | | | |
| | | on his feet. On 9/18/21 the | | | | |
| | | d, Resident E had fallen that | | - how other residents hav | vina | |
| | | 30 a.m., and bumped his head. | | the potential to be affected b | • | |
| | - | pruises," he was fine and had | | same deficient practice will b | - | |
| | | d rested comfortably. The | | identified and what corrective | | |
| | - | and 1:00 p.m. and were surprised | | action(s) will be taken | 5 | |
| | | injuries. They asked him what | | - All residents have the | | |
| | | It E said he tried to get out of | | potential to be affected | | |
| | bed to go to the ba | | | - | nact | |
| | bed to go to the ba | diroom. | | - The BM record for the | - | |
| | During on interview | w, on 10/13/21 at 3:00 p.m., | | 7 days for all residents will | | |
| | - | - | | reviewed and bowel progra | | |
| | - | Assistant (CNA) 18 indicated aff member who found | | followed for residents with | outa | |
| | | | | BM 3 days or more | | |
| | | e fall. It was early in the | | - Nursing staff will be | | |
| | - | just come on for the morning | | educated by the DNS/desig | nee | |
| | | giving report and the CNAs | | on the bowel management | | |
| | - | ng rounds. Resident E was at the this call light was blinking so | | program on or before 11/2/2 | 21 | |
| | | rst. She walked in the room and | | What measures will be put ir | nto | |
| | | the floor on his side and faced | | place or what systemic chan | | |
| | | d. His call light was observed | | will be made to ensure that t | - | |
| | | ge of the bed. CNA 18 indicated | | deficient practice does not re | | |
| | | within his reach when he was | | - Nursing staff will be | | |
| | | here he was on the floor it was | | educated by the DNS/desig | nee | |
| | | here was a pool of blood | | on the bowel management | | |
| | | alled for help. She asked | | program on or before 11/2/2 | 21 | |
| | | appened, and he indicated he | | - Charge nurses will rev | | |
| | | omething off his table when he | | the facility bowel report for | | |
| | | d. After the nurses finished | | | | |
| | | | | their assigned residents ea | CII | |
| | | she and another CNA got | | shift and follow the bowel | 4 - | |
| | _ | bed to clean him up. He had | | program for residents with | out a | |
| | | f a small bowel movement | | BM for 3 days or more | | |
| | (BM). | | | - The facility bowel repo | ort | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/15/2021 155761 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2 E TILDEN **BROWNSBURG MEADOWS BROWNSBURG, IN 46112** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE will be reviewed during the IDT On 10/13/21 at 10:00 a.m., Resident E's medical clinical meeting to ensure record was reviewed. A comprehensive nursing compliance with the bowel admission assessment, dated 9/13/21 at 6:09 p.m., management program indicated the resident answered the questions and was alert and oriented to person, place, time and situation. He indicated he was in good health, had How the corrective action(s) will be problems with his bowels and incontinence of the monitored to ensure the deficient bowel, he had balance problems and was practice will not recur, i.e., what unsteady on his feet, he had weakness, reported quality assurance program will be no pain and had weakness. put into place; He had current diagnoses which included, but To ensure compliance, the were not limited to, hypotension (low blood **DNS/Designee is responsible** pressure), ankylosing hyperostosis (an ankylosis for the completion of the Bowel [abnormal immobility] of the vertebral column Management QAPI tool weekly resulting from ligamentous ossification times 4 weeks, monthly times 6 [hardening] without significant disc disease) and and then quarterly to anemia. encompass all shifts until continued compliance is An admission Bowel Assessment, dated 9/14/21 maintained for 2 consecutive at 9:34 a.m., had been opened, but not completed. quarters. The results of these All fields were left blank. audits will be reviewed by the CQI committee overseen by the A CNA assignment sheet, dated 9/15/21, indicated ED. If threshold of 95% is not Resident E needed assistance with bathing and achieved an action plan will be ambulation as needed but did not indicate he was developed to ensure a high fall risk or list any fall interventions which compliance. should be in place, nor did the assignment sheet indicate Resident E was incontinent of bowel. A comprehensive care plan, initiated 9/14/21, indicated Resident E was at risk for constipation. Interventions for this plan of care included, but were not limited to, Notify MD if no BM after 3rd day and Abdominal assessment if no BM times 4 days, notify MD of findings. A "Hot Charting" event tool, dated 9/16/21 at 8:25 a.m., indicated Resident E had not had a bowel Event ID: N8Q011 Facility ID: 011367 Page 55 of 57 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

12/03/2021

PRINTED: 12/03/2021 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| | NT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155761 | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | CON 10/ | te survey Mpleted 15/2021 |
|--------------------------|--|--|--|---|------------|---------------------------------|
| | PROVIDER OR SUPPLI SBURG MEADOV | | 2 E TILI | ADDRESS, CITY, STATE, ZIP (DEN NSBURG, IN 46112 | COD | |
| (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 COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY) | HOULD BE | (X5) COMPLETIC DATE |
| | | sys. The physician had not been | | | | |
| | a.m., indicated Re | event tool, dated 9/17/21 at 8:23 esident E had still not had a in more than 3 days. The been notified. | | | | |
| | reviewed on the v | el elimination record was itals report and indicated he had novement for the last 4 days. | | | | |
| | 5-Day MDS (min 9/19/21. The MD moderately cogni extensive assistan | comprehensive assessment was a imum data set) assessment dated S indicated Resident E was tively impaired and required ace for most of his ADLS <i>v</i> living) from at least 1-2 staff | | | | |
| | copy of current fa Elimination," data "It is the policy management com resident maintain elimination patter responsible party admission assess historyA bowel during the nursing include bowel sou firmness, and data assessments will resident's specific the EMR (electro movements will b and/or recorded d | On 10/13/21 at 3:54 p.m., the ADNS provided a sopy of current facility policy, titled "Bowel Elimination," dated 1/2015. The policy indicated, It is the policy of [name of the facility's nanagement company] to ensure that each esident maintains a safe and healthy bowel elimination pattern. Each resident and/or esponsible party will be interviewed during the dimission assessment about his/her usual bowel historyA bowel assessment will be completed huring the nursing admission assessment to nclude bowel sounds, abdominal distention, firmness, and date of last bowel movement. Bowel esident's specific plan of care and documented in the EMR (electronic medical record). Bowel novements will be recorded on the facility EMR and/or recorded daily by direct care staff. A esident bowel report will be completed by the | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/15/2021 155761 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2 E TILDEN **BROWNSBURG MEADOWS BROWNSBURG, IN 46112** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE had a bowel movement for 3 consecutive days. Any resident not having a bowel movement for 3 consecutive days, will be given a laxative or stool softener, as prescribed by the physician, at the end of the 3rd day... If by the 4th afternoon, the resident has not had results, the nurse will do an abdominal assessment, chart the results of the assessment, and notify the physician for further order " On 10/13/21 at 3:54 p.m., the ADNS provided a copy of current facility policy, titled "Resident Change of Condition," dated 11/2018. 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...Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behaviors will be communicated to the physician. If unable to contact the attending physician or alternate physician in a timely manner, notify the Medical Director for medical intervention. The responsible party will be notified that there has been a change in the resident's condition and what steps are being taken. All nursing actions/interventions will be documented in the medical record as soon as possible after resident needs have been met...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 " This Federal tag relates to Complaints IN00364839 and IN00364490. 3.1-41(a)(3) N8Q011 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Facility ID: 011367 Page 57 of 57 If continuation sheet

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