STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155761	A. BUILDING 00 B. WING	10/15/2021

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BROWNSBURG MEADOWS	2 E TILDEN BROWNSBURG, IN 46112

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00364490, IN00364839 and IN00364985. This visit resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00364490 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684, F689 and F690. Complaint IN00364839 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684, F689 and F690. Complaint IN00364985 - Unsubstantiated due to lack of evidence. Survey dates: October 12, 13, 14 and 15, 2021. Facility number: 011367 Provider number: 155761 AIM number: 200851590 Census Bed Type: SNF/NF: 95 Total: 95 Census Payor Type: Medicare: 2 Medicaid: 77 Other: 16 Total: 95 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on October 20,	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a face to face informal dispute resolution.	

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

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	2021.			
F 0684 SS=J Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. 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 reviewed for quality of care (Resident E and Resident B). The immediate jeopardy began on 9/18/21, when Resident E fell and sustained immediate injuries of a laceration and hematoma to his forehead, skin tears on his knees, and pain in his neck. Resident E was moved to his bed after the fall, and later transferred a second time to go outside for a visit and then back to his bed. The record lacked documentation of both a skin assessment and pain assessment after his fall. The record lacked documentation the physician had been notified when Resident E began to have trouble swallowing and made choking/gurgling sounds on 9/19/21. He was not transferred for emergency medical treatment until 9/19/21 when his family insisted 911 be called to treat his uncontrolled neck pain and he had become unresponsive and only groaned in pain. EMS (emergency medical	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 facility 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 reviewed	11/02/2021

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	services) arrived at 1:17 p.m. and determined his injuries required upgraded services and he was rerouted to the nearest trauma hospital. Resident E had agonal breathing (reflexive breathing when the brain was not getting enough oxygen and 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 indicated he had sustained a severe hyperextension neck fracture at his C4-Cervical Spine. On 10/4/21 at 4:30 a.m., Resident B rolled off the bed during care and sustained a large laceration on the forehead which continued to bleed significantly. When a hospice nurse arrived at 10:56 a.m., the bleeding continued and did not stop after 20 minutes of pressure. Resident B had a change in neurological condition and went from being able to speak in sentences to only 1-2-word answers. EMS was called to send her to the ER (emergency room), but the facility indicated bleeding had stopped, and it was not necessary for her to be sent out. Resident B, who had previously been on hospice, but not actively dying transitioned to active death beginning on 10/5/21 and died on 10/10/21. The Director of Nursing Services (DNS) and the Assistant Director of Nursing Services (ADNS) were notified of the Immediate jeopardy at 1:25 p.m. on 10/14/21. The immediate jeopardy was removed on 10/15/21, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. During the survey a confidential interview		for quality of care (Resident E and Resident B). - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **Resident E and Resident B no longer reside in the facility** - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken - **Residents who fall have the potential to be affected** - **Residents who have had a fall in the past 30 days were reviewed and assessed for change of condition, notification, and medical attention** - **Licensed nursing staff will receive education on assessments following a fall, notification of condition changes and emergency medical attention by the DNS/designee on or before 11/2/21** - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:	

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	indicated Resident E had been admitted to the facility for strengthening and rehabilitation after a recent hospital stay for an infection. He had only been at the facility a few days and was doing well, but he and his family were a "little nervous" about him getting in and out of bed because he was weak and unsteady on his feet. The family requested bed rails but had been told by the facility they could not put bed rails up because they would be considered a restraint. The family asked a second time about bed rails but was told they could only offer a "mobility" bar. On 9/18/21 the family was notified, Resident E had fallen that morning around 7:30 a.m., and bumped his head. Other than "some bruises," he was fine and had been put to bed and rested comfortably. The family arrived around 1:00 p.m. and were surprised at the extent of his injuries. They asked him what happened. Resident E said he tried to get out of bed to go to the bathroom. He had a large bandage on his forehead, and his face was black and blue, but at that time, Resident E was responsive. He got out of bed and went to the front of the facility to sit outside for the visit. During the family visit, Resident E complained of his head and neck hurting, but the family had been assured by the Assistant Director of Nursing Services (ADNS), they would be able to control his pain at the facility. They gave him Tylenol and ordered some cream to rub on his neck. The family was unsure about leaving him overnight and stayed until visiting hours were over. Throughout the day he seemed to get more and more "tired," and continued to complain of pain in his head and neck, but the ADNS continued to assure the family, the Medical Doctor (MD) was aware of his condition and would be in to see Resident E. The next morning, on 9/19/21, the family returned to visit Resident E around 11:00 a.m., and were shocked at his		**- Licensed nursing staff will receive education on assessments following a fall, notification of condition changes and emergency medical attention by the DNS/designee on or before 11/2/21** **- 2 nurses will respond to resident fall events to ensure appropriate assessment, notification and medical attention are provided** **- DNS or designee will be notified of resident falls** **IDT will review residents with falls the next business day to ensure proper assessments, notifications, medical attention, and interventions are completed** - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: - **To ensure compliance, the DNS/Designee is responsible for the completion of the Fall Management QAPI tool and Change of Condition QAPI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive**	

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	apparent decline. He no longer responded to questions, he kept holding his head, and moaned in pain, he would not eat or drink anything. The family insisted he be sent to the emergency room (ER) for pain control to keep him comfortable, but the ADNS insisted they should keep him in the facility, and he could get COVID if he went to the 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...."		**quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.**	

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	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			

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	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			

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	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			

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	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			

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	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			

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	incontinent care. When turned, resident did state, "ouch," when writer asked if something hurt, he stated, "just body aches..." During an interview, on 10/13/21 at 10:47 a.m., the Therapy Director indicated Resident E had participated in Physical Therapy and Occupational Therapy. He only attended 2 of the 3 sessions and missed his therapy sessions on 9/17/21 due to "medical complications." Resident E was alert and oriented. He was very friendly, polite and motivated to get stronger so he could discharge back home. On 10/13/21 at 10:00 a.m., Resident E's medical record was reviewed. A comprehensive nursing admission assessment, dated 9/13/21 at 6:09 p.m., 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 problems with his bowels and incontinence of the bowel, he had balance problems and was unsteady on his feet, he had weakness, reported no pain and had weakness. He had current diagnoses which included, but were not limited to, hypotension (low blood pressure), ankylosing hyperostosis (an ankylosis [abnormal immobility] of the vertebral column resulting from ligamentous ossification [hardening] without significant disc disease), and anemia. An admission Pain Assessment, dated 9/13/21 at 6:33 p.m., indicated a total score of 0 of 10 and no reported pain in the last 5 days. A second Pain Assessment, dated 9/17/21 at 2:52 a.m., indicated a total score of 0 of 10 and no reported pain in the last 5 days.			

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	An admission Fall Risk Assessment, dated 9/13/21 at 6:32 p.m., indicated Resident E was considered a high fall risk with a score of 17, where 13 or more points indicated a high fall risk. An admission Bowel Assessment, dated 9/14/21 at 9:34 a.m., had been opened, but not completed. All fields were left blank. A comprehensive care plan, initiated 9/14/21, indicated Resident E was at risk for falls. The intervention in place at that time was for him to wear non-skid socks. A CNA assignment sheet, dated 9/15/21, indicated Resident E needed assistance with bathing and ambulation as needed but did not indicate he was a high fall risk or list any fall interventions which should be in place. 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. Resident E's nursing progress notes were reviewed. There were no nursing progress notes which indicated Resident E reported any pain from the time of his admission on 9/13/21 at 5:07 p.m., until after his fall on 9/18/21. A "Hot Charting" event tool, dated 9/16/21 at 8:25 a.m., indicated Resident E had not had a bowel movement in 3 days. The physician had not been notified. A "Hot Charting" event tool, dated 9/17/21 at 8:23			

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	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			

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	and labs. The record lacked documentation a full skin check was completed on or after the fall event. The record lacked documentation a full pain assessment for the new injuries and neck pain sustained from the fall had been completed on or after the fall event. A nursing progress note, dated 9/18/21 at 7:23 p.m., indicated Resident E's family was reassured the facility would do everything possible to ensure the resident was comfortable and well taken care of...the NP gave a new order for BioFreeze for neck pain. A physician order, dated 9/18/21 at 2:00 p.m., prescribed BioFreeze (menthol 5% gel) to apply as needed to the back of the neck for pain and stiffness. Resident E's MAR (medication administration record) was reviewed. BioFreeze was not documented on the MAR as having been administered and there were no additional pain monitoring orders on the MAR. A nursing progress note, dated 9/19/21 at 4:50 a.m., indicated Resident E had received medication earlier that shift for a headache and had been using his call light appropriately. He asked to be repositioned several times due to inability to find a comfortable position. A "Nursing to Therapy Referral" event was opened on 9/19/21 at 11:58 a.m. The referral indicated Resident E was choking and sounded like he was gargling when he took a drink of water and when he took his medicine. Resident E also			

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	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.			

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	His blood pressure was 120/98, his respirations increased to 13 (per minute) and his oxygen saturation level rose to 98 with oxygen canula in place. His skin was noted to have multiple large, purple bruises, including on his back with tenderness. The Run Report narrative indicated "...dispatched 911 and responded immediately to an ECF [extended care facility] for a sick person...advised the facility had reported the [patient] was an elderly male with neck pain and trouble swallowing... presented as an alert and oriented 93 [year old white male] laying semi fowlers [laying on back, angled between 30 degrees and 45 degrees] in bed...family present. There were no staff members present and [EMS responder] went to locate the patient's nurse for report and collect paperwork. Patient had significant bruising noted to the face and arms. There was a large bandage on the patient's forehead over an abrasion. Patient had significant dark purple bruising and swelling around both eyes. Patient complained of severe neck pain and was holding the back of his neck. Family reported the patient fell sometime yesterday and he was not taken to the hospital. Family claimed the facility staff had told them the patient did not need to go to the hospital for his injuries yesterday. Family had pressed facility staff to send the patient to the hospital today when he began to complain of severe neck pain. Staff had previously administered acetaminophen for pain management without improvement. Patient was immediately placed in a cervical collar. Staff nurse came to the patient's room and reported he had fallen sometime yesterday and claimed she had no knowledge of any of the details pertaining to the fall and also claimed there was no documentation about the fall in the patient's chart. Staff did not report any assessment or vital signs. Staff nurse reported the patient had not been evaluated by a			

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	physician and had no knowledge of why the patient was not transported to the ED [emergency department] for evaluation of his injuries. Patient was noted to have bleeding skin tears on the right lower leg and some blood on his sheets. When questioned about these injuries, the staff nurse claimed they were old and from a previous fall despite EMS pointing out they were actively bleeding. The staff nurse commented she was a new employee and she did not typically care for this patient. Patient to cot via draw sheet with manual C-Spine precautions. Patient was secured in a semi fowlers position of comfort. Cot to ambulance without incident...Patient had extensive purple bruising primarily to the RUE [right upper extremities], face, and back. The extent of the bruising to the back was not investigated due to the patient's severe neck pain and limited room for maneuvering in the ambulance...EMS was unable to palpate or auscultate [examine a patient by listening to sounds] a BP. Patient had weak, irregular radial pulses. 12 Lead ECG [Electrocardiograms, sometimes referred to as ECGs, capture the electrical activity of the heart and transfer it to graphed paper] showed arrhythmia [a problem with the rate or rhythm of your heartbeat] ...he had an initial oxygen saturation of 98% but quickly experienced difficulty breathing and desaturation to 87%. Pt became tachypneic [rapid breathing] with subcostal retractions [when the belly pulls in beneath the rib cage]. Applied oxygen at 12 lpm [liters per minute]...Patient had a wristband with 'DNR' printed on it and ECF paperwork that said 'DNR'... Patient very clearly stated he did not want anything done and just wanted to die when it was his time...." A hospital report summary, dated 9/19/21, indicated Resident E arrived as a trauma 2, but			

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	was upgraded to a trauma 1 after a fall at ECF. His family reported they asked the facility to call EMS as they noted Resident E was not acting "right." He was brought to the ED with agonal breathing and O2 (oxygen) saturations in the 80s. His eyes were open spontaneously but he did not regard faces or respond to his name. Attempted to go to CT scanner for imaging, however patient did code in scanner, time of death at 2:06 p.m. Injuries noted on the patient upon arrival included, 1. Scalp bruising 2. Periorbital Ecchymosis (or "raccoon eye" was commonly seen in surgical emergency and results from accidental injuries to the base of the skull) 3. Significant Ecchymosis (Blood or bleeding under the skin due to trauma of any kind) of abdominal region and 4. Right hip Ecchymosis. Cause of death listed: fall, acute hypoxic respiratory failure, cardiac arrest. The postmortem CT scan indicated Resident E sustained a severe hyperextension teardrop-type fracture at the C4 with 3 column involvement, suggesting significant mechanism of injury in the setting of complete fracture through hyperostotic osteophyte and vertebral body.2. During an interview, on 10/11/21 at 9:50 a.m., Resident B's son and Power of Attorney (POA) indicated the facility did not call when his mother fell or when she died. He knew from the hospice nurse she fell about 4:00 a.m. and she was bleeding "all over the place." Paramedics were called to stop the bleeding. Her head wound was on her upper left forehead, across to the middle. It was pressure wrapped. Hospice indicated she would not come out of this, and it would lead to her passing. The Director of Nursing talked to him and indicated there was one person changing her brief, there should have been 2 staff members to change her brief, and she fell off the bed. His mother lay in her bed for a week in pain and she finally stopped breathing. Hospice provided a low dose of			

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	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			

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	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.			

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	Resident B's neurological assessment, on 10/4/21 at 10:55 a.m., LPN 17 charted Resident B's bilateral (both eyes) pupil size had changed from 3 mm to 2 mm. LPN 17's 1:00 p.m. neuro charting indication Resident B's consciousness was no longer oriented. The next neuro charting due at 8:00 p.m. was incomplete. It indicated the right pupil was 2 mm, with no measurement for the left pupil. A progress note, on 10/5/21 at 1:05 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 Resident B. A fall care plan, revised 10/6/21, indicated Resident B was at risk for falls due to decreased mobility and			

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	strength, osteoporosis, osteoarthritis, daily diuretic use, over age 80, decreased balance, needs assist with mobility, history of falls, use of high-risk medications, diagnosis of insomnia, utilizes glasses, incontinent, restless leg syndrome and receiving hospice services. New approaches, dated 10/5/21, were use 2 staff members to assist for bed mobility and incontinent 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 touch. Lungs sounds were diminished. On 10/6/21 at 11:55 a.m., Resident B's lung sounds were diminished. Resident B was not drinking any fluids. On 10/6/21 at 10:34 p.m., the resident was responsive to touch and voice. Lung sounds diminished. On 10/9/21 at 5:17 a.m., the resident had no signs or symptoms of shortness of breath, but wheezing was noted. On 10/9/21 at 1:52 p.m., the resident was not able to swallow anything.On 10/10/21 at 1:44 p.m., the resident was not able 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			

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	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 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.			

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	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			

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	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 and found the left side of the forehead had 8-10 steri-strips, and the wound was about 2 ½ 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			

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	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 didn't want you to send her out. The DNS indicated to the son the wound had stopped bleeding. On 10/5/21, the Hospice RN arrived at 9:06 a.m., she observed Resident B's head was still wrapped with gauze. The was no visible blood. The Aides were trying to give her water with a straw and the water would trickle right back out of her mouth. The resident did not eat anything. She was just staring straight ahead. She was in pain. Her pupils were not the same size,			

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	the left pupil was 5 mm (millimeters), and the right pupil was 2 mm. The Hospice RN called Resident B's son to give an update on her condition. She informed him Resident B was found with uneven pupils and no longer able to speak or swallow. She educated him the resident's neurological decline was consistent with head trauma and due to her decline, she was likely transitioning. Anew Hospice would be monitoring her daily. On 10/6/21, the Hospice LPN arrived. She indicated the steri-strips were gone and there was powder on the wound. On 10/8/21 at 11:15 a.m., the Hospice RN arrived. The son and his spouse were at Resident B's bedside. They asked about pain, Hospice RN responded the pain could be intra-cranial pressure. All the resident's limbs were contracted, including bilateral knees, shoulders, and elbows prior to the fall. Their discussion included x-rays and with the need to move the limbs to get x-rays, the family declined the x-rays. The Hospice RN indicated, after Resident B's fall, you would have needed the family's permission to give morphine. The first scheduled morphine dose was given on 10/5/21 as 0.25 mL (milliliters) every 6 hours. The Hospice RN believed the resident was in pain because she was moaning, increased vital signs, and body language. On 10/8/21, the morphine was			

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	increased in frequency to 0.25 mL every 4 hours. Resident B's pupils were back to the same size, but the right eye was drifting, and her mouth could no longer form words. The Hospice RN asked Resident B if she was in pain and her left eye wound blink several times. Her son indicated his mother was moaning when they changed her and turned her. On 10/13/21 at 4:15 p.m., Resident B's chart was reviewed. An area of nursing information, called Documentation Guidelines/Hot Charting, filled out by LPN 4 indicated there was a hematoma and laceration to the forehead. The Physician or NP (Nurse Practitioner)/PA (Physician's Assistant) was notified on 10/4/21 at 4:41 p.m. On 10/13/21 at 4:33 p.m., Hospice provided nursing notes regarding Resident B's care after her fall. The 10/4/21 documentation indicated the problem to be altered neurological status. "Level of Consciousness: Stupor/Semi-Coma ...Clinical Findings: Head wound from fall. Orientation to person, place and time: Severely impaired. Alertness: Severely impaired. Type of accident: Fall with injury. Circumstances surrounding the accident: Patient was being toileted in bed and was dropped off the side of the bed. Treatment received as result of accident: Minor treatment by caregiver. Type of injury: Bruises/contusions, cut/laceration. Narrative			

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	Notes: Resident in bed with eyes closed. Had a witnessed fall earlier this morning. Has a kerlix bandage dressing wrapped around her head, with a significant amount of sanguineous saturation. Hair on right side of head completely saturated, mainly due to positioning, wound is on left forehead. Patient is contracted and can't move on her own...[RN 17] indicated she was accidentally dropped off the side of the bed. Was unable to see the wound due to the amount of active bleeding. Counted 8-9 steri-strips in place on left forehead, which covered the wound and they were saturated with blood seeping out around the strips. The right forehead had significant swelling and bruising. The Hospice RN applied pressure for approximately 20 minutes to active bleed and was unable to get the wound clotted off. RN 17 and Hospice RN applied more gauze and kerlix. Patient was moaning and saying, 'please,' during care. Notified Hospice supervisor. Also, phoned patient's son to see if he wanted her sent to ER for treatment, possibly sutures, to stop the bleeding. He stated that he would like to have her sent out. By the time the paramedics arrived her dressing was saturated again. Once the paramedics arrived at her room, the facility DNS stopped them and stated that the son did not want her send out after all, due to the fact			

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	that they had the bleeding under control. She stated it was clotted off and slowing down. The Hospice RN called the son again and he clarified he wanted her to stay at the facility for now but if she continued to bleed uncontrollably then he wanted her sent out. 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 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			

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	from the fall. Patient without any intake since the fall. Patient pupils are unequal. Patient moaned out in pain when touched or moved. PRN pain medication was given by the facility nurse. Patient appeared to be transitioning. Unit manager indicated patient was saying yes and no to questions earlier but unable to at this time. On 10/7/21, the Hospice notes indicates the level of consciousness was unresponsive and pupils were unequal. Patient had a flat affect. Patient without any intake since the fall. Patient pupils were unequal. Patient moans out in pain when touched or moved. PRN pain medication given by the facility nurse. Urine output diminished with sluggish bowel sounds. On 10/8/21, the Hospice notes continued. Arrival time 11:15 a.m. Resident B's level of consciousness was stupor/semi-coma. Patient staring straight ahead with right eye drifting outward. Pupils appeared to be equal. Patient had pain upon touch or movement. Had no intake of food or water since 10/3/21. Orders received to increase frequency of morphine. During an 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			

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	pressure was applied to the wound. She looked for other areas of injury. Another aide came in, LPN 6 was still applying pressure to her head. The staff in the room grabbed the sheet, and hoisted her on her bed, Then, she was able to observe an abrasion to the resident's back. Someone went to get ice. LPN 6 indicated she did neuro checks (neurological assessment). After some time, the forehead wound stopped bleeding, but as with a head wound it continued to seep out more blood. She measured the wound size, applied steri-strips, and a dry dressing. All head wounds seep out more blood. When she came back that night for her next shift, Resident B had a different dressing. At first the resident was moaning, so she gave her PRN (as needed) morphine concentrate - immediate release solution (MSIR). It was effective for pain. The neuro checks started at 4:30 a.m. The new shift came in at 6:00 a.m. On 10/14/21 at 10:13 a.m., the DNS indicated it was the policy of the facility to notify the family or other responsible party. LPN 6 had stopped Resident B's bleeding forehead wound and it started bleeding again. We were able to stop it from bleeding again. The DNS indicated she believed the Hospice RN did not talk to the family before she called 911. During an interview, on 10/14/21 at 10:29 a.m., Resident B's son			

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	indicated he did agree to have his mother go to get stitches. The Hospice RN called him back and said the bleeding was under control. So, she was not sent out. He never actually spoke to the DNS. Within 24 hours of the fall, his mother was in transition, and the family decided to let her pass in comfort. He believed it was a wrongful death, she did not fall out of bed, she was dropped by the aide, and this started the transition to death. His mother was a two person assist for toileting, and only one person did the check and change resulting in her being dropped to the floor. Her forehead wound was about the size of 2 golf balls. He saw the DNS around 3:00-4:00 p.m., on the same day as the fall. He asked the DNS "you aren't going to tell me she just fell. He indicated the DNS told him, 'No, we messed up. We messed up.'"During an interview, on 10/14/21 at 11:20 a.m., the DNS indicated another Hospice staff person was at the facility. She was the Hospice Supervisor. She had worked at this facility for years, and still saw residents there. The Hospice Supervisor talked to the son and told him the bleeding was under control. She was in a different part of the building and came over when the EMS services arrived. The DNS told the Hospice RN the facility staff had gotten the bleeding under control again. The DNS indicated the Hospice RN thought Resident			

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	B needed stitches, 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 indicated the forehead wound was approximately 5 cm long. During an interview, on 10/14/21 at 1:27 p.m., the ADNS indicated the steri-strips were removed because they were no longer effective because they were saturated with blood. They were not adhering to her skin anymore. The collagen was not a physician's order, it was a nursing measure. The hospice doctor was called by the on-call service.During an interview, on 10/14 21 at 11:54 a.m., the Hospice Clinical Director indicated their afterhours on-call services indicated the first call from the facility was from LPN 6 at 6:17 a.m. and a second call from LPN 6 was at 7:08 a.m. The Hospice Clinical Director indicated the afterhours on-call service did not notify the physician. On 10/14/21 at 2:54 p.m., the Hospice Supervisor emailed the over-night information to the 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 from LPN 6 at Brownsburg Meadows regarding Resident B. Resident with a fall that morning at 4:20 a.m., fell out of bed. Three cm laceration to left forehead,			

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	pressure and ice applied, bandaged. Neuro checks were within normal limits, PRN pain medications were given. Abrasion to center of her back. The resident was comfortable and sleeping. The family had not yet been called. Hospice Supervisor indicated she updated Resident B's son, he expressed understanding. The facility was okay with a visit later this morning. The second call was at 7:09 a.m., the call received was again from LPN 6 at Brownsburg Meadows regarding Resident B with vitals: Respirations 24, Pulse 110, Oxygen saturation at 86% on room air, with oxygen applied via nasal cannula was 96%. Ativan was given.A current policy, titled "Fall Management Program," dated 11/2017, was provided by the DNS on 10/12/21 at 2:26 p.m. A review of the document indicated "...to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related to falls...The resident specific care requirement will be communicated to the assigned caregiver utilizing resident profile or CNA assignment sheet...If the resident experience an injury from the fall, contact facility DNS/ED (Executive Director) per facility policy. The physician will be contacted immediately, if there are injuries, and orders will be obtained...The family will be notified immediately by the charge nurse of falls with			

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	injury...."A current policy, titled "Resident Change of Condition Policy," dated 11/2018, was provided by the ADNS on 10/12/21 at 10:38 a.m. A review of the document indicated "...all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place ...All nursing actions, physician contacts, and resident assessment information will be documented in the medical record...Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communication to the physician...The responsible party will be notified that there has been a change in the resident's condition and what steps are being taken...All symptoms and unusual signs will be documented in the medical record and communicated to the attending physician promptly...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 residents' condition is noted...Document resident change of condition and response in the medical record. Documentation will include time and family/physician response...."The immediate jeopardy that began on 9/18/21 was removed on 10/15/21 when the facility provided			

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	immediate in-service education for all licensed nursing staff on, 1. Assessing residents for changes in condition, 2. Fall prevention and fall program management policy and procedure, and 3. A new facility-wide practice of requiring all resident who use a low air loss mattress must be assisted by two staff for bed mobility was implemented. The noncompliance remained at the lower scope and severity level of, actual harm with the potential for more than minimal harm that is not immediate jeopardy.This Federal tag relates to Complaints IN00364839 and IN00364490.3.1-37(a)			
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure Resident B had adequate staff present to prevent her from rolling off her bed, hitting her head, notifying the family at the time of the fall, notifying the physician with a change of condition resulting in altered mental status, pain, change of condition and death for 1 of 3 residents reviewed for accidents (Resident B).	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 facility	11/02/2021

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	Finding includes: During an interview, on 10/11/21 at 9:50 a.m., Resident B's son and Power of Attorney (POA) indicated the facility did not call when his mother fell or when she died. He knew from the hospice nurse she fell about 4:00 a.m. and she was bleeding "all over the place." Paramedics were called to stop the bleeding. Her head wound was on her upper left forehead, across to the middle. It was pressure wrapped. Hospice indicated she would not come out of this, and it would lead to her passing. The Director of Nursing talked to him and indicated there was one person changing her brief, there should have been 2 staff members to change her brief, and she fell off the bed. His mother lay in her bed for a week in pain and she finally stopped breathing. Hospice provided a low dose of 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		information and therefore misrepresents the care and services administered by the provider to its residents. Based on interview and record review, the facility failed to ensure Resident B had adequate staff present to prevent her from rolling off her bed, hitting her head, notifying the family at the time of the fall, notifying the physician with a change of condition resulting in altered mental status, pain, change of condition and death for 1 of 3 residents reviewed for accidents (Resident B). What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice - **Resident B no longer resides at the facility** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: - **Residents who require staff assistance with bed mobility have the potential to be affected** - **Residents who require staff assistance with bed mobility were reviewed for appropriate interventions including level of staff assistance; care plans and**	

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	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 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		**resident profiles were reviewed and/or updated to reflect current bed mobility interventions** **- Nursing staff will receive education on providing assistance for bed mobility following the care plan/ profiles, including obtaining/waiting for additional staff member(s) when 2 or more staff are needed for bed mobility and safe use of specialty mattresses per manufacturer guidelines by the DNS/designee on or before 11/2/21** **- Licensed nursing staff will receive education on assessments following a fall, notification of condition changes and emergency medical attention by the DNS/designee on or before 11/2/21** - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **- Nursing staff will receive education on providing assistance for bed mobility following the care plan/ profiles, including obtaining/waiting for additional staff member(s) when 2 or more staff are needed for bed**	

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	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. Resident B's neurological assessment, on 10/4/21 at 10:55 a.m., LPN 17 charted Resident B's bilateral (both eyes) pupil size had changed from 3 mm to 2 mm. LPN 17's 1:00 p.m. neuro charting indication Resident B's consciousness was no longer oriented. The next neuro charting due at 8:00 p.m. was incomplete. It indicated the right pupil was 2 mm, with no measurement for the left pupil. A progress note, on 10/5/21 at 1:05 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.		**mobility and safe use of specialty mattresses per manufacturers' guidelines by the DNS/designee on or before 11/2/21** **- Licensed nursing staff will receive education on assessments following a fall, notification of condition changes and emergency medical attention by the DNS/designee on or before 11/2/21** **- Charge nurses will communicate with nursing staff on their units each shift about residents who need 2 or more staff to assist with bed mobility using the resident profile interventions and will make observational rounds during their shift to ensure compliance** **- Nurse managers will make daily observational rounds to ensure staff are providing the appropriate level of assistance for bed mobility per resident profile interventions and that residents on a low air-loss mattress are being assisted by 2 staff** **- Staff observed not following resident profile interventions will receive immediate education regarding following profile interventions. Continued non-compliance will result in further education and/or disciplinary action.**	

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	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 Resident B. A fall care plan, revised 10/6/21, indicated Resident B was at risk for falls due to decreased mobility and strength, osteoporosis, osteoarthritis, daily diuretic use, over age 80, decreased balance, needs assist with mobility, history of falls, use of high-risk medications, diagnosis of insomnia, utilizes glasses, incontinent, restless leg syndrome and receiving hospice services. New approaches, dated 10/5/21, were use 2 staff members to assist for bed mobility and incontinent 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 touch. Lungs sounds were diminished. On 10/6/21 at 11:55 a.m., Resident B's lung sounds were diminished. Resident B was not drinking any fluids. On 10/6/21 at 10:34 p.m., the resident was responsive to touch and voice. Lung sounds diminished. On 10/9/21 at 5:17 a.m., the resident had no signs or symptoms of shortness of breath, but wheezing was noted. On 10/9/21 at 1:52 p.m., the resident was not able to swallow anything. On 10/10/21 at 1:44 p.m., the resident was not able		- how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **To ensure compliance, the DNS/Designee is responsible for the completion of the Fall Management QAPI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.**	

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	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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	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			

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	and found the left side of the forehead had 8-10 steri-strips, and the wound was about 2 ½ 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			

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	didn't want you to send her out. The DNS indicated to the son the wound had stopped bleeding. On 10/5/21, the Hospice RN arrived at 9:06 a.m., she observed Resident B's head was still wrapped with gauze. The was no visible blood. The Aides were trying to give her water with a straw and the water would trickle right back out of her mouth. The resident did not eat anything. She was just staring straight ahead. She was in pain. Her pupils were not the same size, the left pupil was 5 mm (millimeters), and the right pupil was 2 mm. The Hospice RN called Resident B's son to give an update on her condition. She informed him Resident B was found with uneven pupils and no longer able to speak or swallow. She educated him the resident's neurological decline was consistent with head trauma and due to her decline, she was likely transitioning. Anew Hospice would be monitoring her daily. On 10/6/21, the Hospice LPN arrived. She indicated the steri-strips were gone and there was powder on the wound. On 10/8/21 at 11:15 a.m., the Hospice RN arrived. The son and his spouse were at Resident B's bedside. They asked about pain, Hospice RN responded the pain could be intra-cranial pressure. All the resident's limbs were contracted, including bilateral knees, shoulders, and elbows prior to the fall. Their discussion included x-rays and with the need to move the limbs to get x-rays, the family declined the x-rays. The Hospice RN indicated, after Resident B's fall, you would have needed the family's permission to give morphine. The first scheduled morphine dose was given on 10/5/21 as 0.25 mL (milliliters) every 6 hours. The Hospice RN believed the resident was in pain because she was moaning, increased vital signs, and body language. On 10/8/21, the morphine was increased in frequency to 0.25 mL every 4 hours. Resident B's pupils were back to the same size, but the right eye was drifting, and her mouth could no longer			

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	form words. The Hospice RN asked Resident B if she was in pain and her left eye wound blink several times. Her son indicated his mother was moaning when they changed her and turned her. On 10/13/21 at 4:15 p.m., Resident B's chart was reviewed. An area of nursing information, called Documentation Guidelines/Hot Charting, filled out by LPN 4 indicated there was a hematoma and laceration to the forehead. The Physician or NP (Nurse Practitioner)/PA (Physician's Assistant) was notified on 10/4/21 at 4:41 p.m. On 10/13/21 at 4:33 p.m., Hospice provided nursing notes regarding Resident B's care after her fall. The 10/4/21 documentation indicated the problem to be altered neurological status. "Level of Consciousness: Stupor/Semi-Coma ...Clinical Findings: Head wound from fall. Orientation to person, place and time: Severely impaired. Alertness: Severely impaired. Type of accident: Fall with injury. Circumstances surrounding the accident: Patient was being toileted in bed and was dropped off the side of the bed. Treatment received as result of accident: Minor treatment by caregiver. Type of injury: Bruises/contusions, cut/laceration. Narrative Notes: Resident in bed with eyes closed. Had a witnessed fall earlier this morning. Has a kerlix bandage dressing wrapped around her head, with a significant amount of sanguineous saturation. Hair on right side of head completely saturated, mainly due to positioning, wound is on left forehead. Patient is contracted and can't move on her own...[RN 17] indicated she was accidentally dropped off the side of the bed. Was unable to see the wound due to the amount of active bleeding. Counted 8-9 steri-strips in place on left forehead, which covered the wound and they were saturated with blood seeping out around the strips. The right forehead had			

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	significant swelling and bruising. The Hospice RN applied pressure for approximately 20 minutes to active bleed and was unable to get the wound clotted off. RN 17 and Hospice RN applied more gauze and kerlix. Patient was moaning and saying, 'please,' during care. Notified Hospice supervisor. Also, phoned patient's son to see if he wanted her sent to ER for treatment, possibly sutures, to stop the bleeding. He stated that he would like to have her sent out. By the time the paramedics arrived her dressing was saturated again. Once the paramedics arrived at her room, the facility DNS stopped them and stated that the son did not want her send out after all, due to the fact that they had the bleeding under control. She stated it was clotted off and slowing down. The Hospice RN called the son again and he clarified he wanted her to stay at the facility for now but if she continued to bleed uncontrollably then he wanted her sent out. 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 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.			

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	On 10/6/21, the Hospice notes indicated the level of consciousness was unresponsive with pupils unequal. Forehead swollen and bruised from trauma wound from the fall. Patient without any intake since the fall. Patient pupils are unequal. Patient moaned out in pain when touched or moved. PRN pain medication was given by the facility nurse. Patient appeared to be transitioning. Unit manager indicated patient was saying yes and no to questions earlier but unable to at this time. On 10/7/21, the Hospice notes indicates the level of consciousness was unresponsive and pupils were unequal. Patient had a flat affect. Patient without any intake since the fall. Patient pupils were unequal. Patient moans out in pain when touched or moved. PRN pain medication given by the facility nurse. Urine output diminished with sluggish bowel sounds. On 10/8/21, the Hospice notes continued. Arrival time 11:15 a.m. Resident B's level of consciousness was stupor/semi-coma. Patient staring straight ahead with right eye drifting outward. Pupils appeared to be equal. Patient had pain upon touch or movement. Had no intake of food or water since 10/3/21. Orders received to increase frequency of morphine. During an 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 pressure was applied to the wound. She looked for other areas of injury. Another aide came in, LPN 6 was still applying			

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	pressure to her head. The staff in the room grabbed the sheet, and hoisted her on her bed, Then, she was able to observe an abrasion to the resident's back. Someone went to get ice. LPN 6 indicated she did neuro checks (neurological assessment). After some time, the forehead wound stopped bleeding, but as with a head wound it continued to seep out more blood. She measured the wound size, applied steri-strips, and a dry dressing. All head wounds seep out more blood. When she came back that night for her next shift, Resident B had a different dressing. At first the resident was moaning, so she gave her PRN (as needed) morphine concentrate - immediate release solution (MSIR). It was effective for pain. The neuro checks started at 4:30 a.m. The new shift came in at 6:00 a.m. On 10/14/21 at 10:13 a.m., the DNS indicated it was the policy of the facility to notify the family or other responsible party. LPN 6 had stopped Resident B's bleeding forehead wound and it started bleeding again. We were able to stop it from bleeding again. The DNS indicated she believed the Hospice RN did not talk to the family before she called 911. During an interview, on 10/14/21 at 10:29 a.m., Resident B's son indicated he did agree to have his mother go to get stitches. The Hospice RN called him back and said the bleeding was under control. So, she was not sent out. He never actually spoke to the DNS. Within 24 hours of the fall, his mother was in transition, and the family decided to let her pass in comfort. He believed it was a wrongful death, she did not fall out of bed, she was dropped by the aide, and this started the transition to death. His mother was a two person assist for toileting, and only one person did the check and change resulting in her being dropped			

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	to the floor. Her forehead wound was about the size of 2 golf balls. He saw the DNS around 3:00-4:00 p.m., on the same day as the fall. He asked the DNS "you aren't going to tell me she just fell. He indicated the DNS told him, 'No, we messed up. We messed up.'" During an interview, on 10/14/21 at 11:20 a.m., the DNS indicated another Hospice staff person was at the facility. She was the Hospice Supervisor. She had worked at this facility for years, and still saw residents there. The Hospice Supervisor talked to the son and told him the bleeding was under control. She was in a different part of the building and came over when the EMS services arrived. The DNS told the Hospice RN the facility staff had gotten the bleeding under control again. The DNS indicated the Hospice RN thought Resident B needed stitches, 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 indicated the forehead wound was approximately 5 cm long. During an interview, on 10/14/21 at 1:27 p.m., the ADNS indicated the steri-strips were removed because they were no longer effective because they were saturated with blood. They were not adhering to her skin anymore. The collagen was not a physician's order, it was a nursing measure. The hospice doctor was called by the on-call service. During an interview, on 10/14 21 at 11:54 a.m., the Hospice Clinical Director indicated their afterhours on-call services indicated the first call from the facility was from LPN 6 at 6:17 a.m. and a second call from LPN 6 was at 7:08 a.m. The Hospice Clinical Director indicated the afterhours on-call service did not notify the physician.			

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	155761	A. BUILDING 00 B. WING	10/15/2021

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	On 10/14/21 at 2:54 p.m., the Hospice Supervisor emailed the over-night information to the 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 from LPN 6 at Brownsburg Meadows regarding Resident B. Resident with a fall that morning at 4:20 a.m., fell out of bed. Three cm laceration to left forehead, pressure and ice applied, bandaged. Neuro checks were within normal limits, PRN pain medications were given. Abrasion to center of her back. The resident was comfortable and sleeping. The family had not yet been called. Hospice Supervisor indicated she updated Resident B's son, he expressed understanding. The facility was okay with a visit later this morning. The second call was at 7:09 a.m., the call received was again from LPN 6 at Brownsburg Meadows regarding Resident B with vitals: Respirations 24, Pulse 110, Oxygen saturation at 86% on room air, with oxygen applied via nasal cannula was 96%. Ativan was given. A current policy, titled "Fall Management Program," dated 11/2017, was provided by the DNS on 10/12/21 at 2:26 p.m. A review of the document indicated "...to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related to falls...The resident specific care requirement will be communicated to the assigned caregiver utilizing resident profile or CNA assignment sheet...If the resident experience an injury from the fall, contact facility DNS/ED (Executive Director) per facility policy. The physician will be contacted immediately, if there are injuries, and orders will be obtained...The family will be notified immediately by the charge			

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	nurse of falls with injury...." A current policy, titled "Resident Change of Condition Policy," dated 11/2018, was provided by the ADNS on 10/12/21 at 10:38 a.m. A review of the document indicated "...all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place ...All nursing actions, physician contacts, and resident assessment information will be documented in the medical record...Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communication to the physician...The responsible party will be notified that there has been a change in the resident's condition and what steps are being taken...All symptoms and unusual signs will be documented in the medical record and communicated to the attending physician promptly...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 residents' condition is noted...Document resident change of condition and response in the medical record. Documentation will include time and family/physician response...." This Federal tag relates to Complaints IN00364839 and IN00364490. 3.1-45(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and			

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	assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on interview and record review, the facility failed to ensure a resident's incontinent bowel program and plan of care was followed to prevent the potential for elimination complications for 1 of 5 residents reviewed for quality of care (Resident E). Finding includes:	F 0690	Based on interview and record review, the facility failed to ensure a resident's incontinent bowel program and plan of care was followed to prevent the potential for elimination complications for 1 of 5 residents reviewed for quality of care (Resident E).	11/02/2021

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	During the survey a confidential interview indicated Resident E had been admitted to the facility for strengthening and rehabilitation after a recent hospital stay for an infection. He had only been at the facility a few days and was doing well, but he and his family were a "little nervous" about him getting in and out of bed because he was weak and unsteady on his feet. On 9/18/21 the family was notified, Resident E had fallen that morning around 7:30 a.m., and bumped his head. Other than "some bruises," he was fine and had been put to bed and rested comfortably. The family arrived around 1:00 p.m. and were surprised at the extent of his injuries. They asked him what happened. Resident E said he tried to get out of bed to go to the bathroom. 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. After the nurses finished their assessments, she and another CNA got Resident E up into bed to clean him up. He had been incontinent of a small bowel movement (BM).		- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice - **Resident E no longer resides in the facility** - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken - **All residents have the potential to be affected** - **The BM record for the past 7 days for all residents will be reviewed and bowel program followed for residents without a BM 3 days or more** - **Nursing staff will be educated by the DNS/designee on the bowel management program on or before 11/2/21** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: - **Nursing staff will be educated by the DNS/designee on the bowel management program on or before 11/2/21** - **Charge nurses will review the facility bowel report for their assigned residents each shift and follow the bowel program for residents without a BM for 3 days or more** - **The facility bowel report**	

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	On 10/13/21 at 10:00 a.m., Resident E's medical record was reviewed. A comprehensive nursing admission assessment, dated 9/13/21 at 6:09 p.m., 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 problems with his bowels and incontinence of the bowel, he had balance problems and was unsteady on his feet, he had weakness, reported no pain and had weakness. He had current diagnoses which included, but were not limited to, hypotension (low blood pressure), ankylosing hyperostosis (an ankylosis [abnormal immobility] of the vertebral column resulting from ligamentous ossification [hardening] without significant disc disease) and anemia. An admission Bowel Assessment, dated 9/14/21 at 9:34 a.m., had been opened, but not completed. All fields were left blank. A CNA assignment sheet, dated 9/15/21, indicated Resident E needed assistance with bathing and ambulation as needed but did not indicate he was a high fall risk or list any fall interventions which 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		**will be reviewed during the IDT clinical meeting to ensure compliance with the bowel management program** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; **To ensure compliance, the DNS/Designee is responsible for the completion of the Bowel Management QAPI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.**	

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	movement in 3 days. The physician had not been notified. A "Hot Charting" event tool, dated 9/17/21 at 8:23 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. 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. On 10/13/21 at 3:54 p.m., the ADNS provided a copy of current facility policy, titled "Bowel Elimination," dated 1/2015. The policy indicated, "...It is the policy of [name of the facility's management company] to ensure that each resident maintains a safe and healthy bowel elimination pattern. Each resident and/or responsible party will be interviewed during the admission assessment about his/her usual bowel history...A bowel assessment will be completed during the nursing admission assessment to include bowel sounds, abdominal distention, firmness, and date of last bowel movement. Bowel assessments will be completed based upon each resident's specific plan of care and documented in the EMR (electronic medical record). Bowel movements will be recorded on the facility EMR and/or recorded daily by direct care staff. A resident bowel report will be completed by the assigned charge nurse of resident who have not			

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	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)			