STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLAND TERRACE OF CARMEL	689 PRO MED LANE CARMEL, IN 46032

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00425179 and IN00425290. Complaint IN00425179-State deficiencies related to the allegations are cited at R0052. Complaint IN00425290-State deficiencies related to the allegations are cited at R0052 Survey date: January 16, 2024 Facility number: 013510 Residential Census: 77 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on January 25, 2024.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to ensure a cognitively impaired resident who required staff assistance with mobility and assistive devices, received adequate supervision and assistance to prevent falls and failed to ensure staff notified the physician of a need to alter treatment significantly for 1 of 3 residents	R 0052	Please reference the enclosed “plan of correction” for the survey conducted January 16th, 2024. Respectfully, preparation and/or execution of this plan does not constitute admission by the provider of true facts alleged or	02/12/2024

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

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	reviewed for neglect. (Resident B) This deficient practice resulted in Resident B experiencing an unwitnessed fall with unrelieved pain for three days. Resident B sustained three fractures of the right rib cage and a right side hemothorax (a collection of blood in the cavity between the lungs and underneath the chest wall) which required hospitalization. Resident B died within 14 days of the fall. Finding includes: A document, titled "Intake Information," dated 1/2/24, indicated an anonymous complainant alleged, on 12/24/23, an aide at the facility, in the Memory Care unit, was assisting Resident B from a sitting to a standing position with a walker when the aide walked away from the resident to do something on her phone and the resident fell onto the wooden arm of her couch. There was a video recording of the fall. The resident cried out in pain, from 12/25/23 to 12/28/23, when a family member called 911 to have the resident taken to the Emergency Room to be evaluated and treated. Resident B was admitted to the hospital for fractures of the 6th, 7th and 8th rib, a moderate pleural effusion, and a Urinary Tract Infection (UTI). A family member had talked to the Care Team Manager approximately two weeks prior to the resident's fall regarding staffs' phone use and the lack of care given to residents. The record for Resident B was reviewed on 1/16/24 at 2:55 p.m. Diagnoses included, but were not limited to, Lewy Body dementia, dysphagia following nontraumatic intracerebral hemorrhage, urinary tract infections, major depressive disorder, and generalized edema. A service plan, dated 4/7/23, included, but was		conclusion set forth in the statement of deficiencies. The following plan of correction is in regard to complaints IN00425179 and IN00425290 resulting in citation R0052, Resident Rights -Offense; neglect. This plan of correction is prepared and executed because it is required by the Indiana State Department of Health. **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** For resident B it could be implied that the unwitnessed fall resulted in rib fractures, which was reported to the Indiana State Department of Health. There is no evidence that this fall could have been avoided, as with all falls. Resident B was immediately assessed after the fall by the nurse. Caregiver providing care to Resident B was educated on the fall protocol policy and mobility assistance policy prior to this survey being conducted. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** On January 16th a report was generated identifying all residents that require assistance with mobility and assistive devices. Any further residents with potential to be affected were	

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	not limited to, the following: the resident required assistance with mobility and assistive devices. She required assistance for toileting activity, to and from the toilet, to negotiate clothing after toileting and check and change at night. She required assistance with getting in and out of her recliner, which she slept in, use of her assistive devices, and with transferring. A service plan, dated 4/7/23, indicated the resident was at risk for falls and would be encouraged to call for help when needed. A fall follow-up nursing progress note, dated 12/24/23 at 10:21 a.m., indicated the nurse was called into the resident's room due to a fall. Resident B was found sitting on the floor next to her recliner. She appeared anxious and was yelling out. Two persons assisted her into her wheelchair. She was assessed and complained of pain. Hospice and family was notified. There was no documentation the physician was notified at the time of the fall. A nursing progress note, dated 12/25/23 at 9:15 a.m., indicated Resident B was yelling out. She expressed pain in the left shoulder and back. She was yelling out during check and change, so it required a three-person assistance for care. Pain medication was administered as ordered. Temperature was 99.1. There was no documentation the physician was notified of the resident was yelling out and expressing pain. A nursing progress note, dated 12/25/23 at 1:14 p.m., indicated the resident was expressing pain verbally and non-verbally. She had an elevated blood pressure and temperature. She received pain medication and non-medical interventions to lower her temperature. There was no		reviewed and distributed to all clinical staff. Caregiver on duty was educated on mobility assistance policy prior to this survey being conducted. **What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur and how it will be monitored:** This facility utilizes service plans to document task completions and level of assistance being provided i.e. mobility assistance. A service plan tool will be implemented in binders, at each nurses station with each residents service plan. This binder will be reviewed by clinical staff daily, per shift. Further, all data will be gathered for a Quality Assurance and Improvement Program reviewed monthly with the executive director and health and wellness director to discuss interventions for incidents to improve outcomes. -Training all clinical staff on Communities fall protocol policy -Training all clinical staff on resident rights/neglect policy -Implement binders that include each residents service plan, indicating if resident is a fall risk, needs assistance with mobility and assistive devices; to be reviewed by clinical staff prior to each shift; training all clinical staff on purpose of implemented binders	

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	documentation the physician was notified of the resident expressing pain, her elevated blood pressure or temperature. A nursing progress note, dated 12/25/23 at 10:24 p.m., indicated the resident was complaining of pain. The family allowed Morphine (a narcotic) to be administered. The pharmacy was called to send the Morphine. They indicated a new script was needed. Hospice was called to send a new script to the pharmacy. Tylenol was given as needed for the pain. A nursing progress note, dated 12/25/23 at 10:34 p.m., indicated the resident required a three person assist with changing her bed and adjusting her in bed. She was unable to tolerate extending limbs or turning side-to-side without expressing pain.There was no documentation the physician was notified of the resident expressing pain, being unable to tolerate extending her limbs or turning side-to-side without expressing pain. A nursing progress note, dated 12/26/23 at 8:42 a.m., indicated the resident was lying in bed mumbling while rubbing her right hand in repetitive motions against her chest. She had a fixed glare on the ceiling. Tramadol (non-narcotic pain medication) was given at 7:55 a.m., for pain. There was no documentation the physician was notified the resident had a fixed glare on the ceiling and was rubbing her right hand in repetitive motions against her chest. A nursing progress note, dated 12/27/23 at 10:33 p.m., indicated the resident's family member requested her as needed Morphine, Tramadol and Ativan (medication used to treat anxiety) to be held due to the resident had perked up and she was constipated. The nurse voiced concerns		-The facility will use the Notice of Change Alert form for change in condition as well (sample attached). The facility will monitor these forms for 90 days for compliance. This form will trigger an assessment by a licensed nurse to determine if the level of assistance should be increased or decreased, as well as documentation that the physician was notified of change in condition. The Health and Wellness Director and Executive Director will also monitor/audit each incident report to ensure the physician was notified of incident and change in condition. **What date will the corrective actions be put into place?** The completion date for the training is February 12th, 2024. The completion date for service plan binders is February 20th, 2024. **IDR Request:** The intent of this IDR is to show that the facility followed company policies and the caregiver present during the fall followed protocol according to the residents service plan. The facility is requesting a face to face/video conference for this IDR.	

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	regarding the resident's pain level and explained she would be able to have stool softeners or laxatives if needed. A nursing progress note, dated 12/28/23 at 11:49 a.m., indicated the resident's family member indicated she had called 911 for the resident to be taken to the hospital and she needed her paperwork and all her medications. She was not willing to tell the staff why she called 911. A nursing progress note, dated 12/28/23 at 12:30 p.m., indicated the family member was concerned the resident had a temperature. Her temperature was taken and was 98.1. Then she asked for Tramadol and Lorazepam to be given together. An hour later she requested the Morphine be given and the resident was resting when the Morphine was given as requested. A nursing progress note, dated 12/28/23 at 1:01 p.m., indicated the Emergency Medical Service arrived to pick up the resident. The family member indicated the resident would not be returning to the facility when discharged from the hospital. A nursing progress note, dated 12/28/23 at 5:42 p.m., indicated a nurse was notified by the resident's family member, she had multiple broken ribs and a UTI. She would be admitted into the hospital. A hospital trauma consult note, dated 12/28/23 at 5:08 p.m., indicated the resident was admitted to the hospital after falling into a wooden frame striking her right chest wall on the frame. She had a large right hemothorax (a collection of blood in the cavity between the lungs and underneath the chest wall), but the trauma physician did not recommend placing a chest tube (a tube placed in			

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	the cavity between the lungs and underneath the chest wall to allow blood, fluids, pus or air in the lung to drain out to reinflate the lung properly) in her lung to drain the hemothorax due to the goal of making the resident comfortable and limiting painful procedures. She had fractured her sixth, seventh and eighth ribs. His goal was pain control. He recommended incentive spirometry and flutter (breathing exercises to keep her lungs inflated and prevent pneumonia), but it was likely the resident would not be able to do these two breathing exercises due to her dementia. He did not want to recommend any further imaging of her chest because her treatment would not change with the number of rib fractures she had. She also had a UTI which was being treated with an antibiotic (a medication used to treat infections.) A document, titled "Verbal Coaching Documentation," dated 12/26/23, indicated HHA 1 was given verbal coaching, on 12/26/23, due to a resident had a fall in her room. She assisted the resident to a standing position with her walker, and was disposing of a soiled pad in the recliner when the resident lost her balance and fell to the floor. The actions/solutions included, but were not limited to, HHA 1 was removed from the schedule while management investigated the incident. Team member's comments indicated HHA 1 indicated she assisted the resident to stand with a walker. Resident B lost her balance with HHA 1 was disposing of a soiled pad and fell. During a phone interview, on 1/16/24 at 1:15 p.m., Home Health Aide (HHA) 1 indicated she was providing care to Resident B, on 12/24/23, when she fell. She had gotten her up prior to breakfast that day and her pants and chux pad were "soaked." She was standing with her walker and			

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	HHA 1 told the resident to go to the bathroom. The resident started walking to the bathroom. HHA 1 was walking ahead of her to throw the "soaked" chux pad in the trash. HHA 1's daughter kept calling her on her cell phone, so she took her phone out of her pocket to silence the phone, which was when the resident fell. HHA 1 was walking ahead of the resident, so by the time she turned around, Resident B was already on the floor. She threw the phone, wet chux, and went to assist the resident. The resident usually had a caregiver who got her up and ready for the day, but he did not show up that day. She did not know how steady the resident was on her feet when she first got up out of bed of a morning. During the day, she usually told her to get up out of her chair and walk to the bathroom and she did it without any problems. If she would do it all over again, she would walk behind the resident instead of in front of her to the bathroom, and she would have let her phone ring instead of silencing it. During an interview, on 1/16/24 at 2:04 p.m., QMA 2 indicated the resident had a private caregiver who came to get her up and ready for the day every Monday through Friday and every other weekend at 8:00 a.m., to approximately 9:30 p.m. She walked with a walker, and she was a one to two person assist to get her up depending on her mood. Typically, the staff members would walk behind her for her safety, but the staff member may have to walk beside her, so she knew where to go because she could not remember at times where the bathroom was located. During an interview, on 1/16/24 at 2:11 p.m., QMA 3 indicated he walked with Resident B behind her or to the side of her with a gait belt because she lost her balance frequently especially when she first started to walk after standing up. QMA 3			

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	typically stood her up out of the recliner, but she was still unsteady on her feet, at first, when standing up from the recliner. During an interview, on 1/16/24 at 4:40 p.m., the Director of Nursing (DON) and Executive Director (ED) were in attendance. The DON indicated she observed the video of Resident B falling on 12/24/23. On the video, HHA 1 was walking "too far ahead" of the resident to have caught her or to assisted her to the floor. She would have expected HHA 1 to walk behind the resident. HHA 1 did reach into her pocket and take her cell phone out and do something to her phone, while walking ahead of the resident, when Resident B fell. A current policy, titled "Falls Management," dated May 22, 2023, provided by the Executive Director on 1/16/24 at 12:52 p.m., indicated "Definitions: Fall: The failure to maintain an appropriate lying, sitting, or standing position, resulting in an individual's abrupt, undesired relocation to a lower level...If the Community nurse is not immediately available, notify the nurse on call. The nurse on call will ask the caregiver to observe the resident for: i. Signs of pain, such as facial expression, verbalizing or crying...If any of the above signs are present or upon being cleared to move the resident the resident requires more than minimal assistance to get up: i. The nurse will instruct team members to not move the resident (but provide reassurances and comfort to the extent possible) and to call hospice if resident is receiving hospice support or, if not receiving hospice services, 911. ii. A team ember is to remain with the resident until hospice advises on follow-up or emergency services arrive...." An Indiana Department of Health policy and			

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	procedure, titled "Long-Term Care Abuse and Incident Reporting Policy," dated 12/06/2022, indicated " ...Neglect: Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect means: a. An act or omission that places a resident in a situation that may endanger the resident's life or health b. Abandoning or cruelly confining the resident c. Depriving the resident of necessary support, including food, clothing, shelter, and medical care d. Depriving the resident of education as required by statute ...." This State tag relates to Complaints IN00425179 and IN00425290.			