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	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00428044. Complaint IN00428044 - State deficiencies related to the allegations are cited at R214. Survey date: February 13 and 14, 2024. Facility number: 015081 Residential Census: 68 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 20, 2024.	R 0000		
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on observation, interview and record review, the facility failed to develop interventions and update service plans related to falls for 3 of 3 residents reviewed for falls. (Residents B, Resident C, and Resident D) Findings include: 1. Resident B's clinical record was reviewed on 2/3/24 at 10:20 a.m. Diagnoses included dementia,	R 0214	What was done to correct: An audit will be completed for all falls within the last 6 months to ensure assessments and interventions are in place and care planned. How will recurrence be prevented:	06/04/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Searfeeair Sutherland	RCS	03/04/2024

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	hypertension, and bradycardia. Her medications included Eliquis (blood thinner) 2.5 mg (milligram) twice daily, hydrochlorothiazide (treat high blood pressure) 12.5 mg daily, metoprolol tartrate (treat high blood pressure) 50 mg twice daily, and trazodone (treat depression) 100 mg daily at bedtime. A Brief Interview for Mental Status (BIMS) assessment, dated 12/20/23, indicated she was moderately cognitively impaired. Her fall risk assessments, dated 12/15/23, 12/28/23, 1/3/24, 1/4/24, 1/29/24, 1/30/24, and 2/3/24, indicated she was at a high risk for falls. She had a service plan for falls (7/21/23). Her goal was to remain free from injury (revised 11/29/23). Her interventions included using a rolling walker (7/21/23) and reminded to call for assistance (7/21/23). Review of her nurses notes indicated the following: On 12/15/23 at 4:04 p.m., she was found sitting on the floor. She was in a hurry to get to bingo and stumbled on the floor. No injuries were noted. She was assisted to standing position by two staff members. Her clinical record lacked a new intervention to prevent further falls. On 12/28/23 at 4:44 a.m., she was found on the floor. She was lying on her side, by the bathroom. She had taken herself to the bathroom, she stated she got dizzy, and her legs gave out.		All falls will be discussed in morning meetings with the IDT. Proper interventions will be put into place. Fall assessments will be completed at the time of the fall and quarterly per policy. The DON or designee will ensure new interventions are added to the service plan and family is updated. The DON or designee will audit all incidents/falls twice weekly for 3 months then weekly for 3 months to ensure compliance. Falls will also be reviewed and monitored monthly thereafter indefinitely during quality assurance meetings. Person responsible: DON or designee Due Date: 06/04/2024	

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	Her clinical record lacked a new intervention to prevent further falls. On 1/3/24 at 6:30 a.m., she was found on the floor. Her vitals were obtained, range of motion was completed, and a neurological assessment was performed. She had no complaints of pain. Her clinical record lacked a new intervention to prevent further falls. On 1/4/23 at 3:51 a.m., she was found sitting on the floor beside her recliner. Staff assisted her off the floor. She denied any pain or injury. There was no change in her range of motion. Her clinical record lacked a new intervention to prevent further falls. On 1/29/24 at 1:20 p.m., she was found sitting on the floor. Her vital signs were obtained, neurological checks were performed and were within normal limits. Her clinical record lacked a new intervention to prevent further falls. On 1/30/24 at 7:55 a.m., she was found sitting on the floor in front of her television, with her walker next to her. She was assessed for injuries and her vital signs were obtained. Two staff members assisted her off the floor. She was incontinent of bladder. She had an abrasion from her left upper back to her lower back. Her clinical record lacked a new intervention to prevent further falls. On 2/3/24 at 1:32 p.m., she was found sitting on her buttocks in her bedroom. Her vital signs were			

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	obtained, neurological checks were performed and were within normal limits. She stated she hit her head and complained of her head hurting. She was sent to the emergency room for an evaluation. On 2/3/24 at 6:00 p.m., she was transferred to a local hospital. Her daughter indicated she had several fractures in her lower back and her finger. An emergency room note, dated 2/3/24, indicated she had multiple compression fractures of her thoracic spine at T2, T3, T6, T10, and T12, one being acute, some being acute to subacute. She had a fracture to her sacrum. Her lumbar spine showed a chronic compression fracture at L1. Her right L2 and L3 showed transverse process fractures. She had a non-displaced eleventh rib fracture and a fracture to her right fourth finger. Also, she had a questionable sternum fracture as well as pelvic fracture. The physician recommended she be transferred to a trauma center. During an interview with LPN 12, on 2/13/24 at 12:26 p.m., she indicated Resident B had increased falls. After she fell, the DON, the Administrator, and the family discussed new interventions, which were updated in her service plan. The CNAs were unable to access the service plans. The staff notified the CNAs of her falls through the shift reports. During an interview with QMA 13, on 2/13/24 at 12:39 p.m., she indicated she wasn't aware Resident B was a fall risk. She was able to access the resident's progress notes, service plans, and interventions. After a resident fell, the DON or the nurse updated their service plans. During an interview with CNA 14, on 2/13/24 at			

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	12:48 p.m., she indicated Resident B was incontinent a few days prior to her fall, on 2/3/24, which resulted in injuries requiring hospitalization. During an interview with CNA 15, on 2/13/24 at 1:08 p.m., she indicated the DON contacted the nurse, who then updated the service plans, either the QMA or nurse updated the staff regarding the new interventions after Resident B fell. During an interview with the DON, on 2/13/24 at 1:19 p.m., she indicated herself or the nurse updated the service plans after Resident B fell. During an interview with Resident B's representative, on 2/14/23 at 9:09 a.m., she indicated Resident B had fallen numerous times while at the facility before being moved to the memory care unit from assisted living. During an interview with LPN 16, on 2/14/23 at 10:00 a.m., she indicated she had fallen numerous times. She was unsure what interventions were put into place after she fell. The service plans were updated by the DON or the nurse. During an interview with the DON, on 2/14/23 at 11:28 a.m., she indicated there were no written documents showing any new interventions were placed after her falls.2. During a random observation, on 2/13/24 at 9:22 a.m., Resident C was in the bathroom. A CNA walked out of her bathroom and indicated to her to "hit" her button when she was ready. The CNA stood outside of her bathroom door. During the initial tour of the memory care unit, accompanied by the DON on 2/13/24 at 9:35 a.m., a CNA entered Resident C's room and asked her if she was done and closed the door to her room.			

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	On 2/14/24 at 12:55 p.m., Resident C was observed sitting in her wheelchair in the dining room by herself. She had a hard cast to her right arm/wrist. She indicated she didn't know what happened to her arm, but she was waiting to go to the doctor's office. Resident C's clinical record was reviewed on 2/13/24 at 10:30 a.m. Diagnoses included legal blindness, vitamin D deficiency, age-related osteoporosis without current pathological fracture and unspecified dementia, severe, with mood disturbance. Her medications included buspirone (treat anxiety) 7.5 mg every 12 hours, escitalopram oxalate (treat depression) 10 mg daily, furosemide (diuretic) 40 mg daily, and Eliquis 5 mg twice daily. A BIMS assessment, dated 2/6/24, indicated she was severely cognitively impaired. Her fall assessments, dated 11/14/23, 1/16/24, 2/6/24 and 2/8/24 indicated she was at a high risk for falls. A nurses note, dated 2/8/24 at 9:52 p.m., indicated a CNA found Resident C on the floor. She was observed on her right side, lying parallel with her bed, facing her bathroom. An immediate head-to-toe assessment was completed. Her wrist was swollen and slightly deformed. Her ribs and bony prominences palpated with no complaints of pain or discomfort as a result. Her vitals were obtained, and neurological checks were performed and within normal limits. A nurses note, dated 2/8/24 at 10:13 p.m., indicated she was transported to a local hospital			

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	via ambulance. A nurses note, dated 2/9/24 at 2:28 a.m. indicated she returned to the facility with a hard cast on her right arm and wrist with a sling, due to fracture to her right wrist. A nurse practitioner note, dated 2/9/24 at 12:32 p.m., indicated she had an unwitnessed fall and went to the emergency room and was found to have a right distal comminuted, displaced radial fracture. Her clinical record lacked a service plan or update related to her fall and fracture. During an interview with LPN 16, on 2/14/24 at 10:00 a.m., she indicated Resident C had never fallen since she been at the facility, and she very scared of falling. During an interview with CNA 17, on 2/14/24 at 10:23 a.m., she indicated Resident C did not normally have falls. She was legally blind and cautious about falling. During an anonymous interview, it was indicated this was Resident C's first fall. She was very cautious and scared to fall. 3. During the initial tour of the memory care unit, accompanied by the DON on 2/13/24 at 9:35 a.m., Resident D was standing just inside her apartment, with a sweater was lying on the floor behind her. Her walker was at the foot of her bed. The DON asked her to stay where she was and retrieved her walker for her. On 2/13/24 at 12:27 p.m., Resident D was assisted up out of her chair in the dining room by a CNA,			

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	and she ambulated down the hall towards her room with socks on her feet as she pushed her walker. The CNA entered Resident D's room and Resident D continued to walk past her room. The staff member called out to her and went back into her room and indicated she needed to clean her face. Resident D turned around and walked in the opposite direction past her room. The CNA exited the room and assisted Resident D to her room. On 2/13/24 at 12:34 p.m., she was in bed, with her walker located at the foot of her bed. On 2/14/24 at 12:57 p.m., she was lying sideways on her bed. Her legs, from the knee down, were hanging off the side of the bed, and her walker was located at the end of the bed. Resident D's clinical record was reviewed on 2/13/24 at 10:52 a.m. Diagnoses included unsteadiness on feet and dementia in other diseases classified elsewhere, moderate, with anxiety. Her orders included melatonin (promote sleep) 3 mg at bedtime, hydralazine (treat high blood pressure) 25 mg three times daily, sertraline (treat depression) 50 mg daily, amlodipine besylate (treat high blood pressure)10 mg daily, clonidine (treat high blood pressure) 0.1 mg every 12 hours, and lisinopril (treat high blood pressure) 10 mg daily. Her Brief Interview for Mental Status (BIMS) document indicated she was not able to complete the assessment due to cognition. Her fall assessments, dated 12/7/23, 12/18/23, 12/28/23, 12/31/23, 1/10/24, 1/18/23 and 2/10/24 indicated she was at a high risk for falls.			

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	She had a service plan for an acute fall with fracture to her right shoulder due to weakness, she ambulated with a fast gait, and she required frequent reminders to use her walker (revised 8/23/23). She had a service plan for falls (7/3/23). Her goal was she would be encouraged to call for assistance when needed (7/3/23). Her interventions included remind to call for assistance (7/3/23), rolling walker, proper footwear 8/23/23), at risk for falls due to fast gait, not using walker at times (8/23/23). frequent checks (8/25/23) and assure nonskid footwear (8/25/23). Her nurses notes indicated the following: On 11/13/23 at 12:04 p.m., she was found face down on the floor crying with her head in a cubby that had shelves, and the table next to the cubby was knocked out of the way. Her clinical record lacked a new intervention to prevent further falls. On 12/7/23 at 10:13 a.m., she was sitting on the floor in her apartment, her walker was nearby. She was unable to state why she was sitting on the floor. Her clinical record lacked a new intervention to prevent further falls. On 12/18/23 at 12:57 p.m., she was sitting on her buttocks outside of her bathroom. She was unable to describe what led up to the fall. Her clinical record lacked a new intervention to prevent further falls.			

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	On 12/28/23 at 7:01 p.m., she was crawling out in the hallway from her room. Her clinical record lacked a new intervention to prevent further falls. On 12/31/23 at 8:16 a.m., her son found her on the bathroom floor lying on her side. Her clinical record lacked a new intervention to prevent further falls. On 1/1/24 at 6:23 p.m., she was observed lying on her right side just outside her room, facing the dining room. When she was asked what happened, she replied she just got tired and wanted to lay down. Her clinical record lacked a new intervention to prevent further falls. On 1/10/24 at 2:12 p.m., yelling was heard from a room and found her sitting on the floor. She did not have her walker with her. Her clinical record lacked a new intervention to prevent further falls. On 1/18/24 at 3:34 a.m., she was walking in the hallway with her walker, but only using her left arm to push her walker. The CNA heard a noise and found her on her right side lying on the floor in the hallway. She sustained a large deep skin tear on her right forearm and seven small skin tears to her right arm. Her daughter was taking her to the emergency room for treatment. Her clinical record lacked a new intervention to prevent further falls.			

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	On 2/10/24 at 1:34 p.m., she was sitting in the doorway to her room and unable to describe what led to her fall. Her clinical record lacked a new intervention to prevent further falls. During an interview with QMA 13, on 2/13/24 at 12:39 p.m., she indicated Resident D had been at the facility for a long time and had always been a fall risk. She was always walking, she never stopped moving, and she forgot her walker. She would be sweating bullets and still she wouldn't sit down. Half of her falls were from her not having her walker. During an interview with LPN 16, on 2/14/24 at 10:00 a.m., she indicated Resident D constantly walked without her walker, and she was up and out of her room before they knew it. They redirected her to use her walker and told her not to forget it, plus they made sure she had shoes on. After a fall, she or the DON would put an intervention in service plan after every fall. During an interview with CNA 17, on 2/14/24 at 10:23 a.m., she indicated she needed to make sure Resident D had either grip socks on or shoes. She walked without her walker. She required a lot of care and needed constant supervision. The second and third shift didn't have enough staff and she didn't know how they kept an eye on residents who were at risk for falls. There were seven residents who were at risk for falls. Anonymous interviews were conducted during the survey. During an anonymous interview, it was indicated			

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	Resident D got up without her walker. She tripped on her blankets and was not fit for assisted living and needed to be in a long-term care facility. She needed to be assisted with meals most of the time and needed assistance with care. She normally walked with a walker when she didn't forget it. She shuffled her feet and tripped over her shoes. They received new interventions by text messaging, unless when they worked, it was told to them directly. A current facility policy, revised 10/15, titled "FALL PREVENTION AND FALL MANAGEMENT PROCEDURE," provided on the conference room table, on 2/14/24 at 10:40 a.m., indicated the following: "...PROCEDURE: The following process is designed to prevent a resident from falling and to ensure in the event of a fall an immediate intervention is implemented to prevent any further falls. Based on the admission assessment, change in condition assessments and annual assessments, the staff, Home Health Care Provider, Physical Therapist, and physician will identify interventions to prevent falls and implement the interventions appropriately. In the event of a fall, the facility will implement pertinent immediate interventions in an attempt to prevent subsequent falls...." This citation relates to Complaint IN00428044.			