STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155104	A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE CENTER	**1201 W BUENA VISTA RD EVANSVILLE, IN 47710**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide adequate supervision to prevent falls with a major injury for 2 of 4 residents reviewed for falls. Residents D and F sustained falls that resulted in fractures. Interventions in place were not effective, and new interventions were not implemented to prevent future falls. (Resident D, Resident F) Findings include: 1. During an interview on 7/29/20 at 12:05 p.m., the DON indicated Resident D had a fall in the room that resulted in fracture. The fall was unwitnessed by staff. Resident D had X-rays done in the facility and was then sent out to the hospital to be evaluated and treated for [REDACTED]. [REDACTED]., [MEDICAL CONDITIONS] disease, abnormalities of gait/mobility, right [MEDICAL CONDITION], and compression fracture to L4. The Annual MDS (Minimum Data Set), dated 5/6/20, indicated Resident D was severely cognitively impaired. Resident D was independent with bed mobility, transfers, and toileting, and was occasionally incontinent of bowel and bladder. The care plans included, but were not limited to, I have difficulty expressing my wants and needs due to Alzheimer's. Initiated on 12/4/19, interventions last revised 12/6/19. Interventions included, but were not limited to, allow adequate time to express needs, asked questions that can be answered with yes/no responses, attempt to anticipate wants/needs. I am an Amber (GEMS classification system of stages of dementia). I am caught in a moment of time. I am all about sensations. I like to explore. Initiated on 12/4/19, last revised 5/27/20. Interventions included, but were not limited to, no safety awareness, adjust and make safer environment to explore. I have an impaired cognitive function and impaired thought process related to Alzheimer's dementia. Initiated on 5/5/18, last revised 8/9/18. Interventions included, but were not limited to, often times forgets safety instructions and leaves his walker sitting or does not bring it at all. I have impaired visual function related to visual field deficit. Initiated on 7/10/20. Interventions included, but were not limited to, ensure the resident is wearing glasses which are free from scratches and in good repair, identify/record factors affecting visual function, including physiological, environmental, and choice. I am at risk for falls and fall related injuries due to: history of falls with and without injury, up ad lib with rolling walker, medication use, impaired safety awareness due to dementia, incontinence of bladder, comorbidities, [MEDICAL CONDITION]/psoriatic arthritis, Alzheimer's dementia, impaired vision due to presence of cataract, impaired balance, often walks away without using walker. Initiated on 5/5/18, last revised on 7/29/20. Interventions included, but were not limited to, bed in lowest position (added 7/21/20), non-skid socks on while in bed (7/29/20), instruct on use of call light, encourage naps or rest periods, ensure frequently used items are within reach: call system, glasses, light cord, water, phone, tissues. I have an ADL (activities of daily living) self care performance deficit related to dementia. Initiated on 5/5/18, last revised on 7/10/20. Interventions included, but were not limited to, encourage me to used call bell for assistance (2/25/20), up with assist x 2 with rolling walker (7/10/20), transferring assistance 6/12/19. The resident has a [MEDICAL CONDITION] related to a fall. Initiated 7/10/20. Interventions included, but were not limited to, anticipate and meet needs, ensure call light is within reach and respond promptly, follow MD orders for weight bearing status, PT/OT evaluation and treatment as ordered, monitor/evaluate/provide with/monitor use of adaptive devices as needed: fracture pain, gait belt, abduction pillow, walker, wheelchair, elevated toilet seat. A Self-Determination of Care form, dated 10/24/18, was provided by the DON (Director of Nursing) on 7/30/20 at 10:30 a.m. It indicated the POA (Power of Attorney) had requested the order: Resident up ad lib in room only with walker, not be administered. Requested the order be changed to: Up ad lib in facility with walker. Risk noted: fall that may cause injury, no injury, or death. The form was signed by the POA, facility representative, and the physician. The Care Plans lacked the new intervention of reevaluating the resident's up ad lib status waiver with the family. During an interview with the DON on 7/30/20 at 11:10 a.m., she indicated the waiver had not been reviewed since 2018, and the resident physical functioning and mental status had declined since the waiver was signed. A walker should have been in use at the time of his fall. Hospital records indicated, An x-ray of the pelvis and right hip, dated 7/3/20, indicated, possible subtle fracture involving the right intertrochanteric hip, correlate with CT. A CT pelvis without contrast, dated 7/4/20, indicated, Comminuted intertrochanteric fracture of right hip, with moderate chronic [MEDICAL CONDITION] joint space narrowing. A Hip 2 or 3 views with pelvis unilateral, dated 7/5/20, Internal fixation right [MEDICAL CONDITION] with anatomic alignment. Progress notes indicated, 6/11/20 at 1:53 a.m.- Resident has had slight weight loss and is noted to be sleeping more and eating less the last few weeks. MD family updated and requested medication review. 6/15/20 at 12:09 p.m.- Medication review requested due to increased drowsiness and decrease in appetite. Suggested to change time of [MEDICATION NAME] (antidepressant) and change up [MEDICATION NAME] (medication used to treat Alzheimer's) or lower dose. Requested [MEDICATION NAME] be discontinued as resident has advanced dementia. No new orders at this time. 7/3/20 6:29 p.m.- Fall note: Called to room after QMA walked past room and saw resident lying on floor. Upon questioning resident was unable to recall what he was doing or what had happened. He was laughing as we entered the room. He was assessed for any skin injury. ROM (range of motion) done to all extremities. Pain was noted with palpations and with ROM as well as of R (right) hip/pelvic area. He would not allow full ROM of right hip. Brought up to a sitting position with assist x 2 persons. Assisted to a standing position, which he would not put weight on right foot. He was grabbing at his right buttock and saying it hurts back here. He external rotation, shortening or lengthening was noted. Neurological checks within normal limits. No wt was placed on right leg. Upon sitting in his chair he began to move R leg at the knee region and stated his leg did indeed hurt on that side. He attempted to push himself up in his chair but was unable to move himself with his right leg. Had one tennis shoe on floor. One tennis shoe on, jacket half on. Previous interventions in place. Immediate intervention: assisted off of floor into chair, call light attached to chair, asked for return demonstration of use of call light. Both shoes placed on feet and walker placed within reach. Notified son, DON, MD. Stat X-ray of right hip and pelvis. New intervention: discuss up ad lib status with family. Would like for therapy to see for possible decline in ambulation. Walker was on other side of room. 7/4/20 at 1130 a.m.- Vital signs: 118/78, 68, 20, 98.2 96% on room air. X-ray results from 7/3 of pelvis and right hip. Showing possible subtle fracture of right intertrochanteric hip. Results reported to MD. New orders to send resident to emergency room for evaluation and treatment. Resident and POA notified. Ambulance service notified for pick up. Transferred to emergency room at 11:00 a.m. via ambulance. 7/4/20 at 4:21 p.m.- Call placed to hospital for update on resident. Informed he had been admitted to the ortho unit with a [DIAGNOSES REDACTED]. 7/6/20 at 10:04 a.m.- IDT meeting held to discuss 7/3 fall. Resident was up walking in his room, with one shoe on and one shoe off. He had his jacket half off and half on, assuming he was attempting to take it off. He fell between beds in room. Walker was no where near him, call light was not on. He is up ad lib per signed waiver of family. He is not cognitive enough to explain what he was doing or to remember to use the call light usually. He had complaints of immediate pain and had x-rays ordered. He was transferred the next day after results were received to hospital for further work up. All parties were notified of fall. Will adjust interventions upon

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) return from hospital due to change of condition related to this. 7/7/20 at 5:45 p.m.- Resident returned from hospital via ambulance on a stretcher. admitted with [DIAGNOSES REDACTED]. Resident is alert, drowsy, and usual confused cognition. Skin assessed. Three separate incision points to right upper thigh. 1st is 4.3 cm (centimeters) long with 7 staples, 2nd is 3.5 cm long with 6 staples, and bottom is 3.0 cm long with 6 staples. Resident can not answer questions, does grimace when dressing was being removed and new one placed. Call light lying on chest. During an interview on 7/30/20 at 11:10 a.m., the DON and Administrator indicated Resident D should have been using a walker when ambulating in his room, and it was not near him at the time of the fall. The new intervention of reassessing his ad lib status had not been added to his care plan since his readmission, and his functionality had decreased since his up ad lib waiver was signed in 2018. No staff was in the room at the time of the fall. 2. During an interview on 7/29/20 at 12:05 p.m., the DON indicated Resident F had a fall in the room that resulted in fractures. The fall was unwitnessed by staff. Resident F had X-rays done in the facility and was then sent out to the hospital to be evaluated and treated for [REDACTED]. The Quarterly MDS, dated [DATE], indicated Resident F was cognitively intact. Resident F required extensive assistance x 1 with toileting and bed mobility, and required extensive assistance x 2 with transfers. Resident F was on a toileting program and was frequently incontinent of bowel/bladder. The care plans indicated, but were not limited to, I have pain/discomfort related to low back pain, [MEDICAL CONDITION] bilateral lower extremities, [DIAGNOSES REDACTED]- neck and shoulder. Initiated on 3/29/28, revised 5/22/20. Interventions included, but were not limited to, monitor for increased risk for falls, monitor for altered mental status, dizziness, sedation. I have an ADL self care deficit related to weakness, low back pain, decreased activity intolerance. Initiated on 4/27/28, revised 5/22/20. Interventions included, but were not limited to, encourage the resident to use the call bell for assistance, encourage resident to sleep in the bed, assist him to the bathroom prior to going to bed, evaluate/address toileting needs, make sure non-skid socks/shoes are not worn down to prevent falling, silent alarm in recliner/wheelchair and bed, ensure frequently used items are within reach: call system, glasses, light cord, water phone, tissues, fall prevention measures, assist with changing pad or brief,self. Assist with transfers on/off commode, cue or assist to bathroom upon rising before lunch/supper and at bedtime. Assist at night and as needed. I have had an actual fall and am at risk for fall with injury related to weakness, leg [MEDICAL CONDITION], use of assistive device to aid in balance and forgetfulness, use of narcotic pain medication, antianxiety, and antidepressant medication. Initiated on 4/27/18, revised 2/13/20. Interventions included, but were not limited to, ambulate with 1 assist, assist to recliner once returned to room from activity or meals, encourage to sleep in the bed assist to bathroom prior to going to bed, ensure that shoes are on once up in recliner for the day, is on toileting program, keep oxygen concentrator in the middle of the room with shorter tubing, make sure non-skid socks/shoes are not worn to prevent falling, silent alarm to bed, recliner, wheelchair. Ensure wearing appropriate footwear when ambulating or mobilizing in wheelchair, ensure frequently used items are within reach, remind resident to use call light for assistance before transferring. Requires nursing intervention to improve self-performance in toileting. Initiated on 4/3/18, revised 5/22/20. Interventions included, but were not limited to, requires assistance with changing pad or brief, cleaning self, assist with transfer on/off commode, toileting program-cue and/or assist resident to bathroom upon rising, before lunch/supper, and bedtime. Assist at night when awake and as needed. Requires restorative nursing program to minimize decline or maintain physical abilities for ambulation. Initiated 5/4/18, revised 5/22/20. Interventions included, but were not limited to, assistive device rolling walker, keep assistive device within reach of resident, lock wheels of wheelchair, physical assistance of one person for gait and balance and management of oxygen. Another for wheelchair management to follow behind, remind resident to keep assistive devices close to body, remind resident to use handrails/grab bars, use gait belt, verbal cues to stand up straight, drop arm beside commode for safe toilet transfers, use assist x 2, encourage the resident to use the call bell for assistance, up with assist x 1 with rolling walker for bed to wheelchair, recommend he always exit and enter the bed using his left side which is stronger. A fall assessment, dated 4/22/20, noted a score of 12, moderate fall risk. A chest and C-spine x-ray, completed in the facility, dated 5/7/20, indicated no acute cardiopulmonary disease. Hospital records indicated, A MRI of the [MEDICATION NAME] spine, dated 5/13/20, indicated acute T2 compression fracture, subacute to chronic T4 compression fracture, chronic T11 compression fracture. Chronic T12 compression fracture with prior vertebroplasty. No focal disc protrusion or significant canal stenosis at any level. Progress notes indicated, 5/5/20 at 8:45 p.m.- Fall note: Resident was on toilet having a BM (bowel movement), attempted to ambulate self back to chair, fell in open floor. fell down walking from bathroom. No witnesses. Vital signs: 154/58, 57, 16, 100% on 2L of O2, 98.5, pain 9/10. 2 skin tears. Chest hurting. Pupils equal and reactive. Alert to person and place. No fluid on floor, no clutter, no fall mat, footwear on at time of fall. Oxygen not on at time of fall. Call light was not on. Prior fall interventions in place. Up x 3 staff to chair. Notified son, MD, administrator, no new orders. New interventions: stay in bathroom with resident at all times. Was using walker as instructed. 5/6/20 at 4:43 p.m.- IDT meeting regarding fall on 5/5/20 after getting up unassisted from commode. New intervention: for staff to stay in room with him while in bathroom. Resident F's care plans indicated he should have been ambulated with one assist. The care plan lacked an effective interventions to prevent the fall on 5/5/20. The new intervention for staff to stay in the bathroom with the resident at all times was not added to the care plans until after the fall on 5/5/20. 5/7/20 at 2:33 p.m.- Skin tears to left arm from fall have steristrips in place, no signs of infection noted. Resident having chest and back pain since fall. X-rays ordered. 5/8/20 at 12:16 a.m.- X-ray result faxed to MD, no fracture or acute cardiopulmonary disease. 5/13/20 at 10:28 a.m. Late entry- Staff assessment completed. Resident requested to be sent to the hospital on [DATE] due to severe chest and back pain. Resident continues to be alert and oriented. He is able to make wants/needs known. 5/13/20 at 10:57 a.m.- Resident stated he wanted to go to the emergency room this morning. Severe back and chest pain. MD was called at 9:50 a.m. and gave order to transfer to hospital. Family was notified at 9:52 a.m., ambulance service was called at 10:35 a.m., ambulance left facility at 11:02 a.m. 5/15/20 at 2:55 p.m.- Resident arrived at 2:55 p.m. Resident is alert and oriented. Up with assist. Lung sounds clear, vital signs taken. Bowel sounds present. Communicates clearly and appropriately. Skin checked. 5/15/20 at 8:23 p.m.- Skilled assessment: clinical condition requiring skilled services: compression fracture of spine. Vital signs within normal limits, BP slightly elevated. Cardiac assessment-circulation, cap refill, [MEDICAL CONDITION], pedal pulses, cap refill within normal limits. Trace [MEDICAL CONDITION] to bilateral lower extremities, pedal pulses present. Lungs are diminished, no shortness of breath, no coughing noted. Bowel sounds active x 4, mixed continence, pupils equal and reactive, generalized weakness noted, resident requires extensive assistance x 2 with transfers, alert x 3, follows commands well. Extensive 2 person assist with gait belt. Denies pain, Safety awareness poor-fair. During an interview on 7/30/20 at 1:05 p.m., the DON (Director of Nursing) indicated the facility averaged approximately 37 falls per month, and this was on track with the amount of falls they had last year. She acknowledged this sounded like a lot of falls, and there were several major injuries, but they were discussed daily in morning meeting, and new interventions were added after each fall. She acknowledged the interventions added were not always effective, and some interventions were not appropriate for the root causes of the falls. During an interview on 7/30/20 at 1:26 p.m., the DON indicated she remembered the shift when Resident F fell and that she was the nurse on duty. She recalled a CNA being in the room with Resident F and they assisted him to the restroom, but was unable to provide this documentation. It was not listed in the fall note or any of the fall documentation. During a review of the current policy, Falls Prevention, revised 12/18, provided by the DON on 7/30/20 at 12:53 p.m., indicated, To ensure that residents are safe and that appropriate preventative measures are initiated to minimize injuries related to falls .fall meeting with IDT held to review each fall. During a review of the current policy, Interdisciplinary Care Plans, dated 11/21/16, provided by the DON on 7/30/20 at 12:53 p.m., indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan .for each resident that includes measurable objectives and interventions to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident .prevent declines in the resident's functional status and/or functional levels .the care plan is reviewed with each quarterly MDS assessment .or more frequently if resident's condition changes. Assessments are made and revisions of the care plan are completed as necessary to maintain a current profile of the resident .A weekly high risk meeting will be held to discuss with the IDT scheduled MDS assessments with care plans for potential changes and also other high risk residents for potential significant changes to include, but not limited to falls . This Federal tag relates to Complaints IN 298 and IN 882. 3.1-45(a)