| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **155029** | A. BUILDING _____ B. WING _____ | **08/04/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **COMMUNITY NURSING AND REHABILITATION CENTER** | **5600 E 16TH ST INDIANAPOLIS, IN 46218** |

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) |
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| F 0689<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to ensure a resident's wheel chair was in safe, operational condition for 1 of 3 residents reviewed for accidents. (Resident B) Findings include: The clinical record for Resident B was reviewed on 8/4/20 at 11:20 a.m. The [DIAGNOSES REDACTED]. The 4/1/20 fall risk assessment indicated the resident was at a moderate fall risk. The 11/11/19 at risk for fall care plan, revised 7/29/20, indicated an approach was to provide maintenance to her wheel chair, effective 5/18/20. The 7/25/20 Significant Change MDS (Minimum Data Set) assessment indicated she was cognitively intact. An observation of Resident B was made on 8/4/20 at 12:20 p.m. She was lying in bed. Her right leg was amputated above her knee. An interview with Resident B was conducted on 8/4/20 at 12:44 p.m. She indicated on 5/13/20, she was coming out of the therapy room with PTA (Physical Therapy Assistant) 3, when PTA 3 asked one of the maintenance staff about fixing the loose left brake on her wheel chair, because it was dangerous and did not lock. No one ever came to fix her wheel chair. She inquired again with maintenance about getting her wheel chair fixed the afternoon of 5/15/20, but no one ever came. Then later that evening, on 5/15/20, when she was getting back into her wheel chair after using the bedside commode, she put her hand on the left armrest to secure it, but when she went to sit down, the wheel chair pulled out from under her, and she landed on both hands and her right side where her leg was amputated. She stated, I hollered so loud. The CNA (Certified Nursing Assistant) on duty came into the room with the nurse and assisted her back into her wheel chair. The TD (Therapy Director) came to fix her wheel chair the following Monday, 5/18/20. The TD repaired the wheel chair to the extent it would lock, but the brake was still loose. Afterwards, MA (Maintenance Assistant) 4 came and fixed it again by replacing the old brake with a new one. She was sore for at least 2 weeks, mostly where she had the amputation, but she also had a bruise on her right hand. No one informed her to ask for assistance when transferring into her wheel chair, not to use her wheel chair, or to do anything differently while waiting for her wheel chair to be fixed. She always transferred herself off of the commode. Sometimes, staff would hold her walker bar when transferring onto the commode, but never off the commode. An interview was conducted with PTA 3 on 8/4/20 at 11:55 a.m. He indicated he worked with Resident B on standing, walking, and transfers a couple of months ago before and after her amputation. He worked with her 3 times weekly after her amputation. She didn't need much assistance with transferring after her amputation. He would only hold onto her walker. She could transfer herself on and off the bedside commode and wheel chair. She would use the walker to pivot over and get into the wheel chair. The 5/15/20, 11:45 p.m., fall event, completed 5/16/20, indicated Resident B had an unwitnessed fall while transferring herself. She was standing with her walker and trying to get back into her wheel chair and fell on her bottom. It read, What intervention (s) was put into place to prevent another fall .since w/c (wheel chair) isn't working properly, res (resident) is to use call light when needing to transfer so proper care will be taken. The maintenance repairs binder was reviewed with the ED (Executive Director) and DOM (Director of Maintenance) on 8/4/20 at 12:00 p.m. It indicated a work order was placed on 5/13/20 by PTA 3 for Resident B's left wheel chair brake needing fixed. It was signed off as completed by MA 4 on 5/15/20. The 5/18/20, 3:51 p.m. progress note, written by the TD, read, .inspecting pt's (patient's) WC for flaw in application of brakes to WC wheels. R (right) brake locks adequately. L (left) brake tension adjusted too tightly and making it excessively hard to apply brake without warping of mechanism. OT (occupational therapist) loosening tension of L brake and brake applies effectively, preventing rotation of wheel. Bilateral brakes now in good working order. An interview was conducted with the TD on 8/4/20 at 12:00 p.m. She indicated she inspected and repaired Resident B's wheel chair brake on 5/18/20 after her 5/15/20 fall. She found the brake was difficult to apply, and if the brake was not locked, it could have contributed to her fall. An interview was conducted with MA 4 on 8/4/20 at 1:54 p.m. He indicated he repaired Resident B's wheel chair the week after her 5/15/20 fall. He stated, I replaced the old brake with a new brake and it was cool after that. You could pull the lever, but the lever itself was loose and prevented it from locking and won't grip the tires. I did not fix it on Friday (5/15/20, as indicated on the work order.) That date must be wrong. An interview was conducted with UM (Unit Manager) 2 on 8/4/20 at 1:40 p.m. She indicated she was not at the facility when Resident B fell , but Resident B informed her afterwards that her wheel chair didn't lock, so she informed the Maintenance Director that her brake wasn't working. The 5/18/20, 2:34 p.m. IDT (Interdisciplinary Team) note read, IDT met to review fall that occurred on 5/15/20 at 11:45pm. Prior to fall resident was standing with walker and trying to get back into w/c. Resident was found sitting on the floor, no socks, no shoes, top half dressed. No complaints of pain or difficulty moving extremities or injuries noted at time of fall. However the following day resident complained of pain to right wrist, right hip left shoulder Root cause: residents w/c slid out from behind her, upon assessment of w/c the left brakes would not lock. Immediate intervention: Res is to use call light when needing to transfer so proper care will be taken. Current interventions: Call light in reach, nonskid footwear, personal items in reach, therapy screen. IDT interventions: provide maintenance to residents w/c. Care plan and profile updated. IDT present: ED, DNS (Director of Nursing Services,) UM. The Fall Management Program policy was provided by the DNS on 8/4/20 at 11:57 a.m. It read, It is the policy of (name of facility) to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related to falls Facilities must implement comprehensive, resident-centered fall prevention plans for each resident at risk for falls or with a history of falls. This Federal tag relates to Complaint IN 226. 3.1-45(2) |

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.