STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155799	A. BUILDING 00 B. WING	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE MARION LLC	614 WEST 14TH STREET MARION, IN 46953

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00411202. Complaint IN00411202 - Federal/state deficiencies related to the allegations are cited at F677, F684 and F689. Survey dates: June 27 and 28, 2023. Facility number: 012809 Provider number: 155799 AIM number: 201136580 Census Bed Type: SNF/NF: 42 SNF: 5 Total: 47 Census Payor Type: Medicare: 5 Medicaid: 28 Other: 14 Total: 47 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 3, 2023.	F 0000		
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record	F 0677	Tag number: F 677	07/10/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tamera Shirels	ED	07/15/2023

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	review, the facility failed to ensure dependant residents received assistance with showering for 3 of 3 residents reviewed for ADL care (Resident B, D and E). Findings include: 1. Resident B's clinical record was reviewed on 6/27/23 at 9:55 a.m. Diagnoses included cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, vascular dementia without behavioral disturbance, aphasia following cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, contracture of right shoulder, right elbow, and right hand, and other abnormalities of gait and mobility. An admission MDS (Minimum Data Set), dated 5/17/23, indicated he was severely cognitively impaired. He required extensive assistance of two staff members for transfers, dressing, toilet use and personal hygiene. He had an impairment to one side of his upper and lower extremities. He had a current ADL (Activities of Daily Living) self-care performance care plan for deficits including bed mobility, eating, transfers, and toileting (1/15/23). His interventions included provide sponge bath when a full bath or shower cannot be tolerated (3/18/21) and he was totally dependent on staff to provide bath/shower twice weekly and as necessary (5/23/22). A review of his shower sheets and ADL tasks for bathing/showers on Tuesday and Fridays on day shift indicated he did not receive a bath or shower on the following days: 6/9/23, 6/13/23, 6/20/23 and 6/27/23.		I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident Shower List, with days and time they prefer showers, were reviewed and updated to ensure all residents and their preferences were on the schedule, II. 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 will be interviewed to ensure their preferences are being met. Any resident preferences not being met will be corrected. Updated preferences will be added to the resident shower list . III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All nursing staff will be educated on the shower policy including the resident's preferences. and the process for reporting potential violations of resident rights. The nursing staff will be educated on shower sheets and turning them in to the ADON daily. IV. 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; The ADON or designee will interview 15 residents weekly x 4 weeks then 5 residents weekly x 4 weeks	

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	2. Resident D's clinical record was reviewed on 6/27/23 at 1:19 p.m. Diagnoses included end stage renal disease, obesity, other abnormalities of gait and mobility, and unsteadiness on feet. An admission MDS, dated 6/8/23, indicated she was cognitively intact. She required extensive assistance of two staff members for transfers, dressing, toilet use and personal hygiene. She had a current ADL self-care performance deficit care plan related to congestive heart failure, end-stage renal disease with dependence on hemodialysis, unsteadiness on feet, obesity, and metabolic encephalopathy (6/6/23). Her interventions included assist with bathing two times weekly and as needed (6/6/23). A review of her shower sheets and ADL tasks for bathing/showers on Tuesday and Fridays on evening shift indicated she did not receive a bath or shower on the following days: 6/2/23, 6/6/23, 6/9/23, 6/16/23, 6/23/23 and 6/30/23. During an interview with Resident D on 6/28/23 at 9:59 a.m., she indicated she did not receive her showers per her preference. A few nights ago, they gave her a bed bath. She was not sure when her shower days were, but she thought she was supposed to get a shower this day. 3. Resident E's clinical record was reviewed on 6/28/23 at 9:02 a.m. Diagnoses included degenerative disease of nervous system, weakness and unspecified dementia, psychotic disturbance, mood disturbance, and anxiety. A significant change MDS, dated 4/21/23, indicated she was severely cognitively impaired. She required extensive assistance of one staff		and then 10 residents monthly to ensure showers are being done. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	member for transferring, dressing, toilet use and personal hygiene. She had an ADL self-care performance deficit care plan including bed mobility, eating, transfers, and toileting related to weakness, falls, hypertensive chronic kidney disease, hypertension, hypotension, diagnosis of dementia with behavioral disturbances, peripheral vascular disease, convulsions, degenerative disease of the nervous system, malnutrition, incontinence (11/22/22). Her goal was she would maintain her current level of function through the review date. Her interventions included follow her preference of receiving bed baths (3/22/22), she required substantial/maximal staff assistance with bed baths twice weekly and as necessary (11/22/22). She had a current care plan for her preference to receive bed baths instead of showers (3/22/22). Her interventions were allow to choose when to have bed bath per preference (3/22/22) and promote preferences of choice to have bed baths instead of showers (3/22/22). A review of her shower sheets and ADL tasks for bathing/showers on Tuesday and Saturdays on day shift, indicated she did not receive a bath or shower on the following days: 6/3/23, 6/6/23, 6/10/23 and 6/24/23. During an interview with CNA 25, on 6/28/23 at 9:47 a.m., she indicated when she gave showers she would document they were given on the shower sheets and chart them in the electronic health records. During an interview with CNA 19, on 6/28/23 at 3:23 p.m., she indicated shower sheets were to be completed and given to the nurse to sign for			

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	confirmation and they were also supposed to chart the showers in the electronic health record. A current facility policy, titled "Bathing - Shower and Tub Bath," revised on 1/31/18 and provided by the Administrator on 6/28/23 at 4:26 p.m., indicated the following: "...Policy: To ensure resident's cleanliness to maintain proper hygiene and dignity. Guidelines: A shower, tub bath or bed/sponge bath will be offered according to resident's preference two times per week or according to the resident's preferred frequency and as needed or requested...Document bathing task and assistance provided in the electronic record, including pertinent observations...." This Federal tag relates to complaint IN00411202. 3.1-38(a)(3)			
F 0684 SS=D 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 interview and record review the facility failed to monitor and provide interventions for residents with constipation for 2 of 3 residents reviewed for bowel movements (Resident B and C). Findings include:	F 0684	FTAG 684 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents on the bowel alert were assed by nurse and interventions were given	07/10/2023

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	1. Resident B's clinical record was reviewed on 6/27/23 at 9:55 a.m. Diagnoses included cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, vascular dementia, psychotic disturbance, aphasia following cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side and gastrostomy status. His orders included senna syrup (constipation) 10 ml (milliliter) twice daily. An admission MDS (Minimum Data Set), dated 5/17/23, indicated he was severely cognitively impaired. He required extensive assistance of two staff members for bed mobility, transfers, toilet use and personal hygiene. He had an impairment to one side of his upper and lower extremities. He was always incontinent of bowel. He had a current care plan for at risk for constipation related to impaired mobility (5/23/22). His goal was he would have a bowel movement at least every three days. His interventions included administer medications and bowel protocol as ordered (5/23/22), assist with fluid intake as needed (5/23/22), auscultate for bowel sounds (5/23/22), encourage fluids (5/23/22), and monitor medications that may cause constipation (5/23/22). His bowel and bladder elimination documentation indicated the following: On 6/16/23 at 12:41 p.m., he had a medium sized bowel movement. He did not have a bowel movement on 6/17/23, 6/18/23 and 6/19/23.		per doctor orders. II. 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; Nurses are monitoring bowel alerts every shift and will alert MD for those at 48 hours. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All nursing staff was educated on bowel protocol, including charting of bowels. IV. 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; DON/designee will review the bowel alert report daily, Monday-Friday in morning clinical meeting to ensure that interventions have been started on residents on the list. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated	

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	On 6/20/23 at 1:05 p.m., he had a small sized bowel movement. On 6/21/23, he did not have a bowel movement. There was no documentation for bowel movements on 6/22/23. On 6/23/23 he had a small sized bowel movement at 12:43 a.m. and 1:36 p.m. His name was not on the BM alert list from 6/1/23 through 6/28/23. His nurses notes indicated the following: On 6/17/23 at 11:51 a.m., he had a large amount of dark emesis. He was able to answer questions and shook head when asked if abdomen was hurting. The NP (Nurse Practitioner) was notified with new order to obtain a chest X-ray on 6/18/23. On 6/17/23 at 11:55 a.m., he complained of abdominal pain being worse. A new order to obtain a STAT (immediate) KUB (Kidney, Ureter and Bladder) X-ray. On 6/17/23 at 12:22 p.m., his daughter requested for him to be sent to the ER (Emergency Room). The NP was updated and a new order was received. The hospital was called for transport. On 6/17/23 at 12:30 p.m., he was transferred to a local hospital. On 6/17/23 at 5:06 p.m., he returned to the facility with an order to follow up with a gastroenterologist. On 6/17/23 at 5:15 p.m., he was to be kept upright			

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while eating and not to be reclined immediately after eating or drinking.

On 6/20/23 at 2:40 p.m., he had coffee ground emesis. The NP was notified with new orders for a chest X-ray.

A KUB supine image completed, on 6/21/23, indicated no acute intra-abdominal process, but he had constipation with large volume fecal material within the rectum, which may require disimpaction.

A NP note, dated 6/23/23 at 12:01 p.m., indicated he shook his head that his abdomen felt better. His abdomen appeared less distended. His assessment/plan was coffee ground emesis recurred, and there was a concern for aspiration. His hemoglobin dropped 2 gm (grams) compared to the ER labs. Orders were written for Protonix (gastroesophageal reflux) and Carafate (stomach ulcers). A KUB was obtained for constipation with findings of large retained stool. A suppository was given twice and an enema was given. His senna was increased, and he may need flushes or free water increased.

His MAR (Medication Administration Record) indicated the following:

Call and schedule a follow up appointment with the gastroenterologist on 6/19/23. On 6/19/23 the MAR indicated to see progress notes. There was no documentation in the nurses notes, on 6/19/23, of the gastroenterologist being contacted or a follow up visit scheduled.

A bisacodyl rectal suppository (laxative) 10 mg (milligram) was to be given on 6/21/23 for constipation. The MAR indicated it was not

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	given. A Fleet oil enema (mineral oil) (constipation) was to be given on 6/21/23 and 6/26/23 for constipation. The MAR indicated it was not given. Metoclopramide 10 mg (gastric motility) was ordered to be given one time on 6/21/23 for gastric motility. The MAR indicated it was not given. On 6/28/23 at 8:48 a.m., LPN 5 indicated he had called the gastroenterologist and left a message. He was waiting on a call back from them. Resident B received Senna daily. They received a notification on the electronic health record when a resident had not had a bowel movement for 48 hours. When he received notification, he would give an as needed medication to help the resident have a bowel movement. During an interview with LPN 17, on 6/28/23 at 11:03 a.m., she indicated a CNA found Resident B with dark colored vomit between 7:30 a.m. and 8:00 a.m. She immediately stopped his feeding. His daughter wanted him sent to the hospital. His bowel sounds were normal. Staff had reported he had a BM the day before. The hospital noted blood in his vomit, but it was nothing to worry about. She put an order in to leave the head of his bed elevated. An abdominal X-ray showed he was not impacted and the NP indicated to continue with what she had ordered (Fleet enema and suppository). During an interview with the DON, on 6/28/23 at 2:07 p.m., she indicated when a resident has constipation the nurse should follow the resident's orders. If they did not have orders, then the nurse should contact the physician and give			

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	what was ordered. The BM (Bowel Movement) alerts came up on the dashboard, the ADON put the residents name on a sticky note, and would give it to the nurse on the hall. The nurse should listen to the resident's bowel sounds if they were on the BM alert. 2. Resident C's clinical record was reviewed on 6/27/23 at 12:54 p.m. Diagnoses included other irritable bowel syndrome. Her orders included docusate sodium (constipation) 100 mg twice daily, hydrocodone-acetaminophen (pain reliever) 5-325 mg twice daily, bisacodyl 10 mg suppository every 24 hours as needed for constipation (6/27/23) and magnesium hydroxide (constipation) 30 ml every 24 hours as needed for constipation, if no results after 24 hours give 30 ml and continue natural laxative dose (6/27/23). A quarterly MDS, dated 6/19/23, indicated she was severely cognitively impaired. She required total assistance of one staff member for bed mobility. She required extensive assistance of two staff members for transfers. She required extensive assistance of one staff member for toileting and personal hygiene. She was always incontinent of bowel. She had a current care plan for at risk for constipation. Her goal was she would have a bowel movement at least every three days. Her interventions included administer meds and bowel protocol as ordered (7/26/22), assist with fluid intake as needed (7/26/22), auscultate for bowel sounds (7/26/22), encourage at least 50-75% of meal consumption (7/26/22), encourage mobility and exercise (7/26/22), and monitor medications that may cause constipation (7/26/22).			

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	Her bowel and bladder elimination documentation indicated the following: On 6/2/23 at 11:41 p.m., she had a small sized bowel movement. She did not have a bowel movement on 6/3/23, 6/4/23 or 6/5/23. She had a small bowel movement on 6/6/23 at 12:07 p.m. On 6/7/23 at 12:45 a.m., she had a medium sized bowel movement. She did not have a bowel movement on 6/8/23, 6/9/23, 6/10/23 or 6/11/23. On 6/12/23 at 6:30 p.m., she had a medium sized bowel movement. On 6/16/23 at 3:27 a.m., she had a medium sized bowel movement. She did not have a bowel movement on 6/17/23, 6/18/23 or 6/19/23. On 6/20/23 at 21:13 p.m. she had a small sized bowel movement. She did not have a bowel movement on 6/21/23 or 6/22/23. On 6/24/23 at 8:26 p.m., she had a large sized bowel movement. She did not have a bowel movement on 6/25/23, 6/26/23, 6/27/23.			

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	Her MAR indicated she received Milk of Magnesia (MOM) on 6/28/23 at 1:08 p.m. Her nurses notes lacked documentation related to the constipation or interventions. She was on the BM alert list indicating she had not had a BM in a 72 hour period on the following days: 6/2/23, 6/10/23, 6/11/23, 6/12/23, 6/19/23, 6/20/23 and 6/28/23. During an interview with Resident C's representative, on 6/27/23 at 2:23 p.m., he indicated Resident C had problems with having bowel movements. Sometimes they have to give her Milk of Magnesia and mix something together for her. She received a stool softener, but it didn't always help. Resident C indicated she was constipated a lot and felt they put a lot of cheese in her food at the facility. During an interview with LPN 13, on 6/27/23 at 2:46 p.m., she indicated if a resident does not have a bowel movement after two days, she was to give (MOM) and the third day a suppository or enema, whichever the resident had an order for. During an interview with LPN 7, on 6/27/23 at 3:01 p.m., she indicated they did different interventions for different residents. After two days of no bowel movement, the resident could receive prune juice, MOM, or a suppository. Everyone was different. She would document the as-needed medication that was given. The ADON would alert the nurses daily of residents who had not had a BM. She was not aware of Resident C having problems with constipation. During an interview with LPN 17, on 6/28/23 at 11:03 a.m., she indicated there was an alert for			

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	BMs on the dashboard of the electronic health records. Every morning the ADON gave her a list of residents who had not had a bowel movement. She would ask the resident if they had a BM if they were alert and oriented, assess their bowel sounds and administer an as needed medication, if available. Resident C was on the BM list today. She probably had problems with constipation. She liked to stay in bed, and it would help if she got up to sit on the toilet. During an interview with the DON, on 6/28/23 at 2:07 p.m., she indicated Resident C's representative had indicated her bowel pattern (having a BM every 3-4 days) was normal for her. During an interview with the ADON, on 6/28/23 at 2:54 p.m., she indicated she would review BMs every morning. She clicked on every person on the BM alert and if they had a BM she would clear them. For the residents who did not have a bowel movement, she would write their names down and provide the list to the nurse on each hall. The nurses were supposed to check with the CNAs to see if the resident had a BM that day, if not, they were to initiate something to help them have a BM. The nurses were to do an abdominal assessment. Resident C was a very poor eater. If they could talk her into getting up on the toilet, she would be able to have a BM. A current facility policy, titled "Bowel Elimination Protocol," revised on 5/31/19 and provided by the Administrator on 6/27/23 at 2:03 p.m., indicated the following: "...Guidelines...Residents who have had no documented BM for 48 hours will be observed for signs and symptoms of constipation which may include but is not limited to bowel sounds, abdominal distention, watery stool, nausea/vomiting, etc. and review of			

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	record...Residents who have had no BM for 72 hours will be considered for pharmacological intervention or increased non-pharmacological intervention. If resident continues to have no BM after additional intervention, notify MD for further instructions...." This Federal tag relates to complaint IN00411202. 3.1-37(a)			
F 0689 SS=D 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 observation, interview, and record review, the facility failed to transfer a resident per physician order for 1 of 3 residents reviewed for falls (Resident B) and the facility failed to implement safety interventions to prevent injuries for 1 of 3 residents reviewed for falls (Resident D). Findings include: 1. During an observation and interview with CNA 21, on 6/27/23 at 1:28 p.m., she was assisting Resident B back to his room by the CNA using the joy stick on the resident's motorized wheelchair. They entered Resident B's room and she shut the door. The resident's motorized chair was parked next to his bed. He was sitting on the side of his bed, and CNA 21 was leaning over and	F 0689	FTAG 689 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A fall risk assessment was done on each resident to ensure that proper transferring and to equipment required to transport them safely. II. 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; Each resident, after fall risk assessment is done, that requires assistance of 2 or more staff for transferring,	07/10/2023

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	assisting his legs into the bed. The motorized wheelchair was in the way of turning his legs into the bed, and the CNA moved the motorized chair back. She assisted the resident's legs and body to a laying position in his bed. There were no other staff members present in the room, nor did she use a gait belt, during the transfer. As she positioned him in bed, she indicated she tried to alternate him laying on his side while in bed and his family wanted him to rotate side to side. She raised the head of his bed and lowered the bed to the lowest position. She indicated some CNAs had to use to two people to transfer him, but she had never had any problems with transferring him. He helped her pivot by grabbing onto her waist, but sometimes it took two people to transfer him. It was okay to transfer him to bed by herself. Resident B's clinical record was reviewed on 6/27/23 at 9:55 a.m. Diagnoses included cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, vascular dementia, psychotic disturbance, mood disturbance and anxiety, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, contracture of right shoulder, right elbow, and right hand, other abnormalities of gait and mobility, and unsteadiness on feet and abnormal posture. His physician orders included pivot transfer with the assistance of two persons. He was to be up in electric wheelchair for every meal and then laid back down in bed following the meal (6/13/23) and a two person pivot transfer with gait belt per family request (6/12/23). An admission MDS (Minimum Data Set), dated 5/17/23, indicated he was severely cognitively impaired. He required extensive assistance of two		will have their care plans updated to include the type of transfer and the number of staff it takes to transfer that resident and the equipment that needs to be in place for transporting them safely. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All nursing staff were educated on transfers and transporting residents, different types and equipment that may need to be used. IV. 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; The DON/designee will randomly observe 15 staff members weekly to ensure all transfer and transportation of residents are being done as care planned. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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staff members for bed mobility, transfers, dressing, toilet use and personal hygiene. He had an impairment to one side of his upper and lower extremities. An assistive device was not indicated on the assessment.

A fall risk assessment, dated 5/13/23, indicated he was at risk for falls.

He had a current ADL (Activities of Daily Living) self-care performance care plan for deficits including bed mobility, eating, transfers, and toileting. His interventions included he required total staff assistance to move between surfaces as needed (3/8/21) and he required substantial/maximal to total staff assistance to turn and reposition in bed at least every two to three hours and as necessary (3/8/21).

During an interview with CNA 6, on 6/27/23 at 2:41 p.m., he indicated Resident B was a two-person assist for transfers. He was a one person extensive assist until you transferred him, then he needed the assistance of two persons.

During an interview with CNA 25, on 6/28/23 at 9:47 a.m., she indicated Resident B transferred and pivoted with a gait belt and two staff members.

2. Resident D's clinical record was reviewed on 6/27/23 at 1:19 p.m. Diagnoses included end stage renal disease, essential (primary) hypertension, obesity, acute on chronic systolic (congestive) heart failure, other abnormalities of gait and mobility, unsteadiness on feet, cerebral infarction, and unspecified symptoms and signs involving the nervous system.

Her orders included dycem (non-slip mat) to wheelchair seat for safety (6/28/23) and leg rest to

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wheelchair when up in chair for safety (6/27/23).

An admission MDS, dated 6/8/23, indicated she was cognitively intact. She required extensive assistance of two staff members for bed mobility and transfers. She required assistance of two staff members for locomotion off the unit. An assistive device was not indicated on the assessment.

She had a current care plan for risk for falls related to history of of falls, impaired mobility, unsteady gait, diabetes mellitus, fatigue and hypotension after dialysis, medication, incontinence, obesity, fatigue related to anemia and poor safety awareness (6/6/23). Her interventions included leg rest at all times when up in wheelchair (6/26/23) and dycem to her wheelchair seat (6/26/23).

Her nurses notes indicated the following:

On 6/15/23 at 5:15 p.m., she returned to the facility via facility transport when her wheelchair tipped over, causing her to hit her head and bump her right arm. She had a raised area to her right temple, with two skin tears to her right elbow measuring 4 cm (centimeters) length x 2.5 cm width and to her right wrist, measuring 2 cm length x 1.5 cm width. The areas were cleansed and steristrips were applied. She asked to go to the Emergency Department (ED)for evaluation and treatment, and an order was obtained to send her to the ED.

On 6/16/23 at 12:40 a.m., she returned to the facility with no new orders or paperwork.

A fall-initial occurrence note, dated 6/24/23 at 2:16 p.m., indicated she had a witnessed fall outside. On 6/24/23 at 1:00 p.m., the nurse was ready to load her onto the facility bus for dialysis. The

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	nurse pushed her approximately 10 feet, and she fell forward out of her wheelchair, hitting the pavement. She hit her head and had a cut to the bridge of her nose. Her right side eye had a bruise. She was alert and oriented, and remained awake the whole time. The assessment indicated she did not strike her head and neurological checks were not indicated. She was alert and oriented to time person, place and situation. No changes in range of motion from her normal baseline. Range of motion was within normal limits. A new injury was observed. Pressure was provided to the cut on her nose for bleeding. Her vital signs were assessed and all within normal range. She was sent to the ED for further evaluation. On 6/24/23 at 5:49 p.m., she returned from the hospital. She had a fracture nose. An ED provider report, dated 6/24/23, indicated she presented from nursing home for the evaluation of a fall out of her wheelchair during a transfer. Her only complaint was facial and right knee pain. An impression from a maxillofacial without contrast computed tomography (CT) scan indicated a probable nasal spine fracture. A fall IDT (Interdisciplinary Team) note, dated 6/27/23 at 5:36 p.m., indicated the nurse attempted to load Resident D onto the facility bus for a dialysis appointment. The nurse pushed her in her wheelchair approximately ten feet, she fell forward out of her chair hitting the pavement. She hit her head and had a cut to the bridge of her nose. Her right eye was bruised. She was alert, oriented and talking the whole time. Pressure was applied to the cut on her nose to stop the bleeding. Vital signs collected and within normal limits. Range of motion was within resident normal range. She was sent to the ER per physician for further evaluation			

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	and treatment. The root cause of the fall was weakness, fatigue, poor balance, and unsteady gait. She had decreased physical and lost torso control resulting in witnessed fall hitting head/face on pavement. Her intervention and care plan was updated; foot pedals to wheelchair at all times for transporting and dycem to her wheelchair seat was initiated. During an interview with LPN 5, on 6/27/23 at 1:58 p.m., he indicated he was about 10 feet away from the bus and Resident D fell forward. She did not have foot pedals on her wheelchair. She needed assistance with putting them on her wheelchair, but had not been putting them on lately. There were two other cars parked near the entrance to the facility, and he had to park away just out from the entrance to the porch. He was pushing her, and they were just talking and she went forward. He was unable to catch her. During an observation and interview with Resident D, on 6/28/23 at 9:35 a.m., she had purple bruising under both her eyes and scabbing to the bridge and between the bridge and tip of her nose. She had a dressing to her right arm at her elbow, and to her forearm near her wrist. She indicated she was in the van coming back to the facility from her dialysis appointment about a week and a half ago, when they went around a curve and she fell out of her wheelchair. She hit her head and cut up her arm. She couldn't remember whether or not she had her seatbelt on. They told her the floor strap came loose. Last Saturday, she was going to dialysis and LPN 5 was pushing her out to the bus when she fell on the ground and broke her nose. Her foot pedals were not on her wheelchair. She kept "harping" about wanting them put on her wheelchair, but the didn't put them on. Her legs were short and her foot got			

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	caught the pavement. During an interview with Bus Driver 3, on 6/28/23 at 11:28 a.m., he indicated he picked Resident D up from her appointment. She was the last appointment of the day, around 4:00 p.m. He had turned off of Highway 9 and there was a "jog" in the road, where you needed to turn right then left. Her wheelchair was strapped with the four point straps. When they turned the corner to the left and Resident D pushed all the way to the right, one of the four point straps malfunctioned. The wheelchair was kind of suspended to the right and one of the straps was extended. He pulled the bus to the side of the road and made sure she was alright. He took the strap off the wheelchair to get her in an upright position. Her head was against the wheelchair ramp. She was bleeding on her arm and she had a bump on her head. He had no problems before, and had been driving for a year for the facility. He thought the facility had ordered new straps. A current facility policy, titled "Transfers -Manual Gait Belt and Mechanical Lifts," revised on 1/19/18 and provided on the conference room table on 6/28/23 at 1:40 p.m., indicated the following: "...Guidelines...9. Use of gait belt for all physical assist transfers is mandatory...." A current facility policy, titled "Fall Prevention Program," revised on 11/21/17 and provided by the Administrator, on 6/28/23 at 4:26 p.m., indicated the following: "...The Fall Prevention Program includes the following components: Methods to identify risk factors...Use and implementation Fall/safety interventions may include but are not limited to...Transfer conveyances shall be used to transfer residents in accordance with the plan of care...Use and			

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	implementation of professional standards of practice...." This Federal tag relates to complaint IN00411202. 3.1-45(a)			