STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00424674 and IN00427546. Complaint IN00424674 -- No deficiencies related to the allegations are cited. Complaint IN00427546 -- Federal/State deficiencies related to the allegations are cited at F689 and F9999. Survey dates: February 13, 14, and 15, 2024 Facility number: 000135 Provider number: 155230 AIM number: 100266820 Census Bed Type: SNF/NF: 90 SNF: 5 Total: 95 Census Payor Type: Medicare: 7 Medicaid: 73 Other: 15 Total: 95 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 27, 2024.	F 0000	Dear Brenda Buroker, Attached is Rosebud Village's plan of correction for complaint survey completed on 2/15/24. Rosebud Village is requesting paper compliance for all deficiencies written in the 2567. Please accept the plan of correction as written. Thank you, Kari Alcorn, HFA Executive Director Rosebud Village	
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that -			

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

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	§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 interview and record review, the facility failed to ensure a fall from a mechanical lift did not occur during a transfer from the bed to the chair, resulting in cervical and thoracic fractures of the spine, for 1 of 3 residents reviewed for falls. (Resident B) The deficient practice was corrected on 1-10-24, prior to the start of the survey, and was therefore past noncompliance. The facility had completed assessments of the resident who had experienced a fall, conduct neurological checks, and audits related to fall events. Findings include: The clinical record of Resident B was reviewed on 2-13-24 at 5:40 p.m. His diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, depression, insomnia, aphasia and, nondisplaced fracture of the 7th cerebral vertebra and fracture of the 1st and 2nd thoracic vertebrae (neck area and upper spine area), sustained on 12-30-23. In an interview with CNA 3 on 2-13-24 at 4:26 p.m., she indicated she and CNA 4, were working on the secured memory care unit (MCU) and had entered Resident B's room to provide incontinence care, prior to getting him up from bed and into his chair. CNA 3 indicated she connected the hook of the sling to the mechanical lift of the bottom left hook and CNA 4 connected	F 0689	Received Past Non compliance.	02/15/2024

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	all the other hooks. Once they had the sling connected to the mechanical lift, they raised him up off the bed. "As [name of CNA 4] was starting to move him towards the [tradename of the chair], more of turning his body in the sling toward the [tradename of the chair], not really moving the actual mechanical lift and he was kind of between the bed and the chair, the hook on the top left, came undone. He literally did a flip in midair backwards and landed on his head. He let out some kind of a scream and I saw blood. I wouldn't call it a ton of blood, but some blood and I ran out to get the nurse at the desk on the unit while [name of CNA 4] stayed with him. It was [staff name], I think she is a QMA. The next thing I know a nurse and aide from A Hall came to help and check him out. The nurse was holding pressure to his head where he was bleeding. He got sent out to the hospital pretty quick. The EMS [emergency medical services] people were here pretty quick. I am [age under 18]...There seems to be some conflicting information as to if I'm allowed to help with the mechanical lifts or just not even touch them. So, that evening, I did hook up the one bottom hook. After I did that, I did tell [name of CNA 4] she should be the one to hook up the rest of the hooks on the mechanical and she did. From what I was told after this, we aren't allowed to operate the mechanical lifts until we are 18 now." Indicated she has worked at the facility for about 5 months. In an interview on 2-14-24 at 11:45 a.m., with CNA 4, she recalled Resident B's fall. She could not recall the exact date, but indicated the fall occurred at approximately 4:30 p.m. to 5:00 p.m., prior to dinner. She indicated Resident B's normal routine is to be assisted up into a chair for every meal and then returns to bed. She explained she and CNA 3 provided incontinence care prior to			

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	assisting him up via the mechanical lift. "I did all the mechanical lift operation because the other aide is [under 18]. If you are under 18, you can't operate the lifts, but you can be the helper. We got the sling hooked up to the lift like we normally would do. Then one of the upper hooks on the sling came undone...We had him between the bed and chair with the chair closer to the bathroom and he fell onto the floor near the dresser. He was about 4 to 5 feet in the air when it happened. He fell from sling. I cannot recall if he flipped in the air or fell straight to the ground. He usually makes a 'shhhew' noise and he immediately stopped. I don't remember him yelling after the fall, but he might have. I was pretty upset and traumatized by the whole thing. He doesn't really keep his eyes open most of the time and I don't remember him opening his eyes. Plus, he is pretty much non-verbal except for the 'shhew' sound he makes. When he landed on the floor, he was in the fetal position and bleeding from his head. The other aide immediately ran to get the QMA at the desk on the MCU and then the A Hall nurse came and checked him out. We left him in the same position he landed and didn't try to move him. Somebody, not sure who, got a washcloth to cover his head where it was bleeding and to put pressure on it. Don't know who called for an ambulance, but the EMT's were there pretty quick. They didn't move him until they were ready to put him on their cart and transport him to the hospital. I remember one of the EMT's did ask what happened and I remember we told them that he fell about 4 or 5 feet from the [mechanical lift] when we were in the middle of moving him from the bed to his chair. Feedback from hospital was he had some type of broken back and the place on his head did not get any stitches to his head. The laceration looked really bad at the beginning because he seemed to be bleeding a lot. It looked much better after they			

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	cleaned it up at the hospital. After all of this, I spoke with Administrator and Director of Nursing. I had to write out a statement and got training for the mechanical lift. I think they did do some type of inspection of the mechanical lifts and tried to do a re-enaction of what happened. I don't know what they found out about any problems with the [mechanical lifts]." She indicated she has been employed at the facility for less than a year. "Never happened to me before." In an interview on 2-14-24 at 10:40 a.m., with the Assistant Director of Nursing (ADON) and the Corporate Staff, they indicated they wished to clarify a statement of the policy and procedure related to mechanical lifts. They indicated for the statement of staff under 18 years of age, not being able to operate the mechanical lifts, staff under 18, may assist with the use of the mechanical lift, such as connecting the straps to the the lift, but cannot operate the machine itself. A document entitled, "Fall Reviews-Event 1-2-24," indicated on 12-30-23 at 5:00 p.m., Resident B had a fall from a mechanical lift while being transferred from his bed and into his chair while being assisted by two staff members. He did strike his head during the event and landed on his left side. Immediate care was provided of pressure held to a sustained laceration to his head, contacting emergency transport services and notification to the medical director and the family. Initial neurochecks indicated he were within normal limits for this resident. At the emergency room visit, a CT scan detected "moderate age-indeterminate compression of T3 [third thoracic vertebra]" and "nondisplaced fractures of the posterior transverse processes of the C7 [seventh cervical vertebra], T1 [first thoracic			

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	vertebra], T2 [second thoracic vertebra].' It indicated a notation from the emergency room physician stated, "He has a moderate size posterior scalp hematoma with superficial overlying abrasion not requiring repair. Have recommended gentle soap and water and triple antibiotic ointment. Family wanted to proceed with initial workup despite being on hospice...As patient is on hospice and they would like him to remain on hospice no specific spine follow-up is required and patient will use p.r.n. [as needed or desired] pain medications as needed to remain comfortable. Return instructions were discussed with family however patient is on hospice and lengthy conversation was had regarding need for return and respecting patient's hospice based wishes. Patient will return to the extended care facility at this time. Family comfortable with plan." It indicated the following day, hospice changed pain medication orders "from prn to Norco every 6 hours, plus every 4 hours as needed. "Hospice and family chose not to refer to therapy for eval [evaluation] or possible C [cervical] collar. Hospice/family would like neck pillow while up as tolerated for comfort only. Provided pillow, and resident is tolerating well." It indicated the facility's "immediate actions," included, but were not limited to, conducting staff interviews with staff involved in event, removing the mechanical lift used for Resident B from use, inspecting the mechanical lift for any obvious functional issues, conducting skills check offs of the mechanical lift with the two staff members involved in the event on the day of occurrence, conducting skills validation of mechanical lifts with all clinical staff, "including sling safety check and proper latching," Additional actions included			

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	an on-site inspection of all of the facility's mechanical lifts by the manufacturer on 1-9-24. No issues with malfunction were identified with the specific mechanical lift involved in the incident. In an interview with the Corporate Staff on 2-15-24 at 5:40 p.m., she indicated, "As far as the root cause analysis is concerned with the fall and the lift, we still cannot say exactly what happened. It could have been equipment failure or human error." On 2-15-24 at 2:20 p.m., the ADON provided a copy of a document entitled, "Fall Management Policy," with a revision date of August, 2022. This policy was indicated to be the current policy utilized by the facility. "It is the policy of American Senior Communities to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related to falls...Post Fall: Any resident experiencing a fall will be assessed immediately by the charge nurse for possible injuries and necessary treatment will be provided...A neurological assessment will be initiated on all residents with a suspected head injury based upon the fall. If the resident experienced an injury from the fall, contact facility DNS [Director of Nursing Services]/ED [Executive Director] per facility policy. The physician will be contacted immediately, if there are injuries, and orders will be obtained...The family will be notified immediately by the charge nurse of falls with injury...A fall event will be initiated as soon as the resident has been assessed and cared for. The report must be completed in full in order to identify possible root causes of the fall and provide immediate interventions. All falls will by discussed by the interdisciplinary team at the 1st IDT meeting after			

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	the fall to determine root cause and other possible interventions to prevent further falls." On 2-14-24 at 9:14 a.m., the ADON provided a copy of an undated document entitled, "Mechanical Lift/Hoyer Lift Safety," and it was identified as a training document. This document indicated, "I understand that all mechanical lifts...require the use of 2 trained people to operate safely...I understand that I must inspect the sling for any defects or wear and tear prior to applying the sling on a resident...I understand that if I am under the age of 18, I am not able to operate a mechanical lift but may be the second person assisting for safety." This Federal tag relates to Complaint IN00427546. 3.1-45(a)(1) 3.1-45(a)(2)			
F 9999 Bldg. 00	ADMINISTRATION AND MANAGEMENT (g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any: (D) major accidents.	F 9999	**F9999 Administration and Management** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** A detailed report of Resident B's fall including how the fall occurred and the root cause analysis for the fall is in his medical record. **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.**	03/10/2024

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	This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure a detailed reportable incident of a fall with a fracture was reported to the Indiana Department of Health (IDOH) Long Term Care (LTC) Division, with details of the fall occurring during a transfer with a mechanical lift, the resident falling at least 4 feet while being transferred and did not include an accurate root cause analysis (RCA) to explain why the fall with fracture occurred during a transfer from bed to chair for 1 of 3 residents reviewed for falls. (Resident B) Findings include: The facility emailed the IDOH-LTC Division a reportable incident, dated 12-30-23, regarding Resident B falling during a transfer with two staff members. The incident report indicated, "Resident was being transferred per plan of care when he had a fall." It indicated Resident B was assessed by nursing staff, neurological assessments were initiated and a physician order was received to send him to a local emergency room for further evaluation and treatment. It indicated Resident B sustained a scalp laceration, a scalp hematoma and fractures of moderate age-indeterminate compression of T3 [third thoracic vertebra] and nondisplaced fractures of the posterior transverse processes of the C7 [seventh cervical vertebra], T1 [first thoracic vertebra], T2 [second thoracic vertebra]. The report indicated preventative measures included, but were not limited to, "Investigation initiated to determine root cause. Resident's plan of care to be updated based on root cause. Interventions implemented based on root cause. Social services to follow up with resident for s/sx [signs and		All residents have the potential to be affected by the alleged deficient practice. All reportables for the last 3 months were reviewed by ED/Designee to ensure a root cause analysis was completed and interventions implemented based on the root cause. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.**—— ED/Designee will ensure that each reported incident will include details of the incident and root cause analysis. ED/Designee will review the policy for Long Term Care Incident Reporting. ED/Designee educated on the policy for Long Term Care Incident Reporting by regional vice president of operations. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.** Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director. Reportable File QAPI will be completed monthly x6, and quarterly x6 months. If Threshold of 90% is not met, an action plan will be developed to	

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	symptoms] of psychosocial distress." A follow-up report, dated 1-3-24, indicated, "1-3-2024 investigation completed with root cause analysis determining [the] resident fell during transfer. Full nursing assessment completed including initiating neuros. Scalp laceration noted. MD/Hospice notified, and resident sent to ER for further evaluation and treatment. Resident returned from ER, new orders in place for scalp laceration, pain management and neck pillow. Family declined therapy evaluation. Social Services to follow up as needed for s/sx of psychosocial distress." In an interview on 2-13-24 at 5:40 p.m., with the ADON, she indicated she is relatively new to management and did not send the reportable to IDOH regarding Resident B's fall. She indicated she thought the report was sent by the Executive Director, who is currently ill and not in the facility, and the Director of Nursing DON is currently on medical leave. She recalled hearing discussion about exactly what should be put in the reportable as the facility was not one hundred percent sure of the causes of the fall as it could have been machinery malfunction, human error or "just something that happened that we simply don't know why it happened." In an interview on 2-14-24 at 10:40 a.m., with the ADON and the Corporate Staff, a discussion was had concerning the reportable incident of Resident B's 12-30-23 fall fall and fracture. The Corporate Staff informed the ADON, "We need to paint the picture of what happened and try to explain the situation as best we can." In an interview on 2-15-24 at 5:40 p.m. with the Corporate Staff, she indicated, "As far as the root cause analysis is concerned with the fall and the lift, we still cannot say exactly what happened. It		ensure compliance. **By what date the systemic changes will be completed. Completion date: 3/10/24**	

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	could have been equipment failure or human error. We don't really know for sure. Should we have put that in the follow-up for the reportable?" On 2-15-24 at 2:20 p.m., the ADON provided a copy of a document entitled, "Long Term Care Incident Reporting Policy," revised on 6-7-22. This document was indicated to be currently utilized by the facility. " Purpose: To provide guidance on the type of incidents to be reported; the timeline for reporting; and the information to be included in the report...Types of incidents reportable under State rules only: Occurrence that directly threatens the welfare, safety or health of a resident...All fractures...Report Information: The Initial Report information should include the following...Brief description of event. Types of injury(s) sustained...The Follow Up Report information should include the following: Results of the investigation; Interventions implemented or corrective action taken; Method in which the facility will continue to monitor efficacy of plan/interventions..." This Federal tag relates to Complaint IN00427546. 3.1-13(g)(1)(D)			