

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2024
NAME OF PROVIDER OR SUPPLIER Salem Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Connie Ave Salem, IN 47167	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>38239</p> <p>Based on interview and record review, the facility failed to follow procedures, adequately supervise, and ensure a resident's safety while on an outing related to a resident falling and rolling into a lake (Resident B) for 1 of 3 residents reviewed for accident hazards.</p> <p>Findings include:</p> <p>During a telephone interview on 12/03/24 at 11:39 A.M., Certified Nurse Aide (CNA) 3 indicated she worked in the Activities Department and she and Bus Driver (BD) 4 took seven residents from the Memory Care Unit on the facility bus for an outing in October. They drove to a local donut shop and then went to a local lake/park area. They arrived at the lake, got the residents off the bus, and sat them down at some picnic tables. There were residents that were in wheelchairs and residents that were able to walk without assistive devices. While the other residents were sitting at the tables, CNA 3 and BD 4 were walking with Resident B near the water, about 10 feet away from the residents at the table. CNA 3 asked BD 4 to watch Resident B while she walked back towards the other residents. A couple minutes later, BD 4 yelled Help! CNA 3 looked back and saw Resident B in the lake sitting in the water. CNA 3 jumped into the lake. The water was only a couple of feet deep. CNA 3 eased Resident B towards the shore but she couldn't get him out of the water, so she stayed in with him. Someone called 911 and the police and an ambulance came to the park. CNA 3 and a police officer were able to get the resident out of the water. They wrapped a blanket around the resident. The resident refused to go in the ambulance but was assessed by the Emergency Medical Technician (EMT) and was not injured. CNA 3 called the facility and the EMT spoke with Resident B's nurse. CNA 3 was told to bring the residents back, so they loaded everyone up and went back to the facility. CNA 3 indicated she thought BD 4 would watch the resident. CNA 3 turned her back on the resident at the time of him entering the lake.</p> <p>During an interview on 12/03/24 at 11:51 A.M., the Director of Nursing (DON) indicated she was not sure how the incident occurred, and she was not at the facility when it happened. They were just supposed to just go on a bus trip to the bakery and get donuts and take a drive around the lake. She thought BD 4 and CNA 3 took it upon themselves to decide to stop and get the residents off the bus. CNA 3 received disciplinary action for the incident.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 12/03/24 at 11:59 A.M., CNA 3 indicated before they left for the outing, she told the Memory Care Unit Coordinator she was going to take the residents off the bus. The Unit Coordinator said okay and if she had any problems give her a call. CNA 3 realized after talking with the DON that she shouldn't have had that many residents on the outing. She was thankful that Resident B was okay.</p> <p>During an interview on 12/03/24 at 11:11 A.M., RN 2 indicated Resident B exhibited a lot of behaviors. The resident had been physically and verbally aggressive, and in the past had cursed and slapped at staff and refused care. The resident had recently declined and was using a wheelchair now, but back in October he was up walking without any assistive devices. He wandered a lot; He used to do laps around the unit but was really unsteady.</p> <p>The clinical record for Resident B was reviewed on 12/03/24 at 12:30 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 08/23/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, non-Alzheimer's dementia and anxiety.</p> <p>During an interview on 12/03/24 at 1:09 P.M., the Administrator indicated CNA 3 and BD 4 were just supposed to take the residents on a bus ride. They were instructed to contact the Memory Care Unit Coordinator if the stopped anywhere. They did not call the Memory Care Unit Coordinator when they stopped the bus at the park/lake.</p> <p>A document, titled Employee Communication Form was provided by the Administrator on 12/03/24 at 1:13 P. M. The form indicated CNA 3 violated the Activity Outing Policy on 10/08/24 when she was instructed not to take the residents off the bus unless she contacted the Memory Care Unit Coordinator first so that the Unit Coordinator could drive to the location to be present for supervision. The bus stopped at a local lake and there was an occurrence with a resident falling and rolling into the lake. The employee not only put that resident in a situation where there was inadequate supervision and assistance, but the other six residents that were on the outing as well.</p> <p>An undated document signed by BD 4 was provided by the Administrator on 12/03/24 at 1:40 P.M. The document indicated BD 4 was walking with Resident B on an outing at the lake. She turned away from the resident and looked towards CNA 3 to be sure the CNA was with the other residents. BD 4 turned back around to walk with Resident B and realized the resident was getting ready to fall. The resident fell to the ground and started rolling towards the water. BD 4 ran towards him, and they both got to the edge of the shallow water. BD 4 called out for help while she held on to the resident so he wouldn't panic. With help, they got the resident's hips out of the water and onto the bank of the lake and called 911. The police and an ambulance came. An EMT assessed the resident and said he looked okay. She got a wheelchair off the bus, assisted the resident into the wheelchair, and covered him with a blanket. They loaded all the residents onto the bus and returned to the facility.</p> <p>The current, undated facility policy, titled Outing Checklist was provided by the Administrator on 12/03/24 at 1:13 P.M. The policy indicated, .Supervision always required on an outing .No resident should be left unattended .</p> <p>The current facility policy, titled Activity Outing Policy, dated 07/15, was provided by the Administrator on 12/03/24 at 1:13 P.M. The policy indicated, .it is the policy .to offer both enjoyment and safety during outings coordinated by the facility .Residents will be supervised during the outing at all times .</p> <p>(continued on next page)</p>		

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