STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155674	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER St Charles Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 3150 St Charles St Jasper, IN 47546	

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 - Minimal harm or potential for 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** 38770 Based on interview and record review, the facility failed to ensure each resident received adequate supervision and assistance to prevent accidents for 1 of 3 residents reviewed for falls. New interventions were not placed following falls to prevent further falls for a cognitively impaired resident. (Resident G) Finding includes: On 12/11/24 at 1:57 P.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, left tibia shaft fracture, osteoporosis, and Alzheimer's disease. Resident G was admitted to the facility on [DATE] and discharged [DATE]. The most recent Admission MDS (Minimum Data Set) Assessment, dated 8/15/24, indicated a severe cognitive impairment and no behaviors. Resident G was dependent on staff for toileting, bed mobility, transfers, and from sitting to standing. Resident G had experienced a fall with fracture that required surgical repair prior to admission. Physician orders included, but were not limited to: Activity: Two staff assist - Strict NWB (non-weight bearing) to left leg, dated 9/3/24. Sounding alarms to bed and chair at all times, and to check the function each shift three times a day, dated 9/9/24. Nurse to verify that bed and chair alarms functioning properly each shift, three times a day, dated 10/21/24. A falls care plan, dated 8/29/24, included the following interventions: Nurse to verify that alarm is functioning, dated 10/21/24. Not to be left in room in wheelchair unattended, dated 9/30/24. Sounding alarm to bed and chair, dated 9/10/24. (continued on next page)

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Mat beside bed, dated 9/10/24. Toileting schedule, dated 9/9/24. Encourage resident to assume standing position slowly, dated 8/29/24. Ensure the floor is free of liquids and foreign objects, dated 8/29/24. Keep call light in reach, dated 8/29/24. Keep personal and frequently used items within reach, dated 8/29/24. Provided non-skid footwear, dated 8/29/24. Staff to assist resident with transfers as needed, dated 8/29/24. Therapy evaluate and treat as needed, dated 8/29/24. An ADL (activities of daily living) care plan, dated 8/29/24, indicated Resident G required staff assistance to complete mobility functional tasks completely and safely. A hospital post-operative note, dated 8/9/24, indicated Resident G was admitted for surgical repair of a closed displaced comminuted fracture of shaft of left tibia From 9/8/24 through 10/19/24, Resident G experienced the following falls: Fall 1 A progress note, dated 9/8/24 at 4:30 P.M. indicated Resident G fell in her room at 4:00 P.M. after restlessly wheeling around hallway. The resident was observed on the floor in the entryway of the bathroom after attempting to transfer self to toilet. The note indicated the new intervention was to routinely toilet the resident. The falls care plan was updated on 9/9/24 to include an intervention of toileting schedule. The clinical record lacked documentation that the toileting schedule had been followed or implemented. On 12/12/24 at 10:53 A.M., the Director of Nursing (DON) indicated Resident G's toileting schedule had been started on 9/9/24, and the Certified Nurse Aides (CNA) would have followed their assignment sheet at that time for the toileting schedule, but would not necessarily document it. On 9/8/24, an x-ray was ordered for the left leg. A progress note dated 9/8/24 at 9:36 P.M. indicated a left fibular neck fracture. Results were communicated with the physician, who indicated he would like for the resident to be monitored overnight and for the orthopedic to be notified the following morning on how to proceed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident G's clinical record lacked documentation of the communication with the orthopedic physician on 9/9/24. On 12/12/24 at 10:53 A.M., DON indicated she was unable to find any documentation of the communication with the orthopedic physician. She indicated there were no new orders related to the x-ray findings, because it had shown an existing fracture that the resident was admitted with. At that time, she was unaware that the x-ray result had indicated a new fracture of the fibula. A progress note dated 9/11/24 indicated Resident G's fall on 9/8/24 was reviewed. Resident was non-weight bearing to the left lower extremity and transferred self from the wheelchair and fell to the floor. The note indicated an x-ray was completed with no new fractures. Per daughter's request, Resident G was to have sounding alarms to the wheelchair and bed at all times. An order for sounding alarms was initiated 9/9/24. A progress note, documented by Registered Nurse (RN) 3 on 9/13/24, indicated Resident G had been making several attempts to wheel herself to her room. RN 3 informed the resident that she could not stay in her room by herself because she would attempt to get up by herself and was strict non-weight bearing to the left lower extremity. Fall 2 A progress note dated 9/28/24 at 8:18 P.M. indicated the nurse was notified by the CNA of the resident attempting to self transfer to the toilet. The fall was not witnessed and the resident was found on the bathroom floor. An Interdisciplinary Team (IDT) note, dated 9/30/24, indicated the resident was toileted and assisted to bed after being found on the bathroom floor on 9/28/24. The note indicated a new intervention to not be left in the room in wheelchair unattended. The falls care plan was updated on 9/30/24 to include not to be left in room in wheelchair unattended. On 12/12/24 at 10:30 A.M., RN 3 indicated is was known by all staff that Resident G was not to get up by herself due to being non-weight bearing on her left leg, and would try to constantly. She indicated the resident had the behaviors of trying to get up on her own from the time she was admitted to the facility. She indicated all staff were actively supervising Resident G and trying to prevent her from getting up on her own well before an intervention was placed to do so. Fall 3 A progress note on 10/19/24 at 4:45 P.M. indicated Resident G was found by the door in her room. Fall was unwitnessed. The resident indicated she crawled to the door. At the time of the fall, the alarm did not sound. An IDT note dated 10/21/24 indicated following the fall on 10/19/24, the new intervention would be for the nurse to verify that alarm was functioning properly each shift. The falls care plan was updated on 10/21/24 to include an intervention for the nurse to verify that the alarm is functioning properly each shift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The order for alarms dated 9/9/24 indicated to check for functionality each shift. On 12/12/24 at 10:39 A.M., CNA 25 indicated all residents that were at risk of falling were toileting frequently. She indicated CNA assignment sheets were updated daily with mobility assistance indicated for each resident. On 12/12/24 at 10:57 A.M., Qualified Medication Aide (QMA) 21 indicated Resident G required a lot of supervision due to her wanting to get up and go home. She indicated the resident needed pretty much a 1:1 supervision, and at times staff would call her daughter to sit with her because they could not supervise her as she required. She indicated Resident G was very confused and believed she could get up on her own, and staff was aware from the time she was admitted that she needed constant supervision. On 12/12/24 at 10:30 A.M., RN 3 indicated Resident G was confused and attempted to get up on her own from day one. She indicated staff would try and keep her in the common area or by the nurses station as she had strict NWB orders to the left leg. On 12/12/24 at 11:34 A.M., the DON indicated she was unsure why the alarm was not sounding when Resident G fell on [DATE]. She indicated the facility did not typically use sounding alarms, but the resident's daughter was insistent on using them, so the facility complied. She indicated care plans should be revised and updated following each fall, and depending on the circumstances, a new intervention put into place. On 12/12/24 at 1:08 P.M., a current Fall Management policy, dated 12/31/23, was provided and indicated Any orders received from the physician should be noted and carried out . The resident care plan should be updated to reflect any new or change in interventions This citation relates to Complaint IN00447969 and Complaint IN00447994. 3.1-45(a)