STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155688	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Freelandville Community Home	310 W Carlisle Street Freelandville, IN 47535

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38770 Based on interview and record review, the facility failed to ensure detailed reporting of incidents for 2 of 3 facility incident reports reviewed. (Resident 2, Resident 137) Finding includes: 1. On 12/4/24 at 11:20 A.M., facility incident reports were reviewed. An incident that involved Resident 2, dated 3/8/24, indicated the resident was using the bathroom in her room and slid off of the toilet. The resident was assessed, sent to the emergency room , and admitted with a right femoral fracture. A follow-up added 3/14/24 indicated Resident 2 had been confused the morning of the fall, and was found on the floor along with a toilet seat riser. The reason for the riser sliding off was undetermined. The report indicated Resident 2 had a history of fidgeting with things, and was anxious due to getting a new roommate. On 12/4/24 at 11:32 A.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease and anxiety. The most recent Annual MDS (Minimum Data Set) Assessment, dated 9/13/24, indicated a severe cognitive impairment and substantial to maximum assistance required with toileting. An incident note, dated 3/8/24, indicated Resident 2 had fallen off of the toilet due to an unsecured high-rise toilet seat. On 12/4/24 at 2:00 P.M., Licensed Practical Nurse (LPN) 5 indicated she was at the facility on 3/8/24 when Resident 2 had fallen in the bathroom, and the fall occurred due to the toilet seat riser sliding off of the toilet. She indicated the roommate (who was no longer at the facility) was a larger person, and could have possibly shifted it loose prior to Resident 2 using it, causing it to slide off. 46416 (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. An Indiana Department of Health (IDOH) incident report, dated 8/29/24, indicated Certified Nurse Aide (CNA) 20 was involved when a resident had fallen during a transfer, was transferred to the hospital, and the hospital nurse reported to the facility Resident 137 had a right femur fracture. Follow up was added on 9/5/24 indicating Investigation complete. Care plans reviewed and updated. Resident is a Hospice patient and will not be evaluated by therapies. The facility has educated all CNAs on the importance of reviewing the Kardex in the EHR [electronic health record] and to review the plan of care. All residents with similar needs were reviewed and care plans and Kardex were updated as applicable. All staff re-educated for skills competencies in transfers and participated in return demonstration. Resident has returned from the hospital and continues with Hospice services with no change from prior level of functioning. On 12/4/24 at 1:28 P.M., Resident 137's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease and history of a stroke. The most recent Significant Change MDS (Minimum Data Set) Assessment prior to the fall, dated 8/1/24, indicated Resident 137's cognition was unable to be assessed, had impairment of both lower extremities, used a mechanical lift, and required the extensive assist of 2 staff for bed mobility and transfers, and was totally dependent on 2 staff for toileting. A Health Status Note, dated 8/29/24, indicated res [resident] fall [sic] during transfer. Signs of pain present. Notified MD [Medical Doctor], son, hospice, and DON [Director of Nursing] aware [sic]. Bed hold police [sic] sent, report called to [Name of Hospital]. Res sent via ambulance. On 12/4/24 at 3:30 P.M., hospital records from the hospitalization that occurred from 8/29/24 to 9/3/24 were reviewed. A Discharge Summary, dated 9/3/24, indicated Resident 137 presented to the emergency department via EMS (Emergency Medical Services) on 8/29/24 after a fall from a mechanical lift at the long term care facility where she resided. Upon exam, the resident's right leg was shortened with external rotation. An x-ray of the right femur demonstrated an acute fracture of the mid femoral diaphysis (a break in the middle of the femur bone). An orthopedic surgeon was contacted and the resident was admitted . On 8/30/24, the resident underwent a right femur retrograde intramedullary nail fixation (surgically inserting a metal rod (nail) into the hollow center of the femur bone where it is then secured with screws to stabilize the fractured bone and promote healing). The resident was discharged back to the facility on [DATE]. On 12/5/24 at 11:59 A.M., CNA 20's employee file was reviewed and indicated CNA 20 was hired on 7/15/24 as a CNA. At that time, she was currently certified through the Tennessee Nursing Board, issued 4/16/24, and working on getting her certification in Indiana within the 120 day window allowed. On 7/15/24, CNA 20 signed a document that indicated she had read the job description of a CNA, understood the qualifications, duties, and performance requirements. A facility Nurse's Aide Checklist for Orientation form, dated 7/15/24, lacked a skills competency for using mechanical lifts. An Employee Warning Notice and Disciplinary Action Report, dated 8/29/24 and 9/30/24, and signed by the Administrator and the employee indicated CNA 20 was suspended pending investigation from an incident on 8/29/24 where she operated a mechanical lift without a second person, resulting in a resident's fall during transfer. After CNA 20 was educated on the use of a mechanical lift, she proceeded to transfer another resident with the lift pad placed improperly underneath them. Due to the policy violation and failure to follow instructions, she was placed on leave of absence until she obtained her certification through Indiana. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/5/24 at 11:45 A.M., the Administrator indicated CNA 20 transferred Resident 137 alone and did not have the base of the lift all the way out which caused it to tip over and the resident to fall landing on the floor. The Administrator was here at the time of the fall and followed the nurse into Resident 137's room. Upon entry, the Administrator observed the resident laying on the floor in the lift pad and the lift was tipped over. During an investigation, CNA 20 indicated she was trained on using mechanical lifts in Tennessee but wasn't told to have 2 people to assist in transfer when using them. CNA 20 was trained initially at the facility during orientation to have 2 people when a mechanical lift was used, but she didn't ask for help with the transfer of Resident 137. The lift was not used after the incident so maintenance could determine it was not faulty equipment. It was found to be in good working condition but was ultimately replaced with a new one that had more safety features. The Administrator indicated when she sent the reportable to IDOH, she reported fall during a transfer because that was what happened. On 12/6/24 at 1:33 P.M., a current non dated Unusual Occurrence Reporting Policy, was provided by the Administrator and indicated . A written report detailing the incident and actions taken by the facility after the event shall be sent or delivered to the state agency . 3.1-28(c)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 46882 Based on interview and record review, the facility failed to ensure an accurate Minimum Data Set (MDS) Assessment was completed for 2 of 5 residents reviewed for unnecessary medications and 2 of 2 residents listed on the facility matrix as using restraints. The MDS indicated 2 residents used bed rails as restraints when they didn't, one resident received a hypoglycemic and was not coded, and one resident had a diagnosis of dementia that was not listed in the MDS. (Resident 19, Resident 29, Resident 15, Resident 8) Findings include: 1. On 12/5/24 at 10:10 A.M., Resident 19's clinical records were reviewed. Diagnoses included, but were not limited to personal history of traumatic brain injury, functional quadriplegia, and acquired absence of left leg above knee. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 10/8/24, indicated resident was unable to complete the cognitive test, was dependent on staff for bed mobility and transfers, was NPO (nothing by mouth) with a feeding tube, and bed rails were used as a restraint daily. The current physician orders lacked an order and a care plan for a restraint. During an interview on 12/6/24 at 8:11 A.M., LPN (Licensed Practical Nurse) 3 indicated the bed rails were not used for a restraint since Resident 19 was unable to move by himself. 2. On 12/6/24 at 10:59 A.M., Resident 29's clinical records were reviewed. Diagnoses included, but were not limited to cerebral infarction, anxiety disorder, and attention concentration deficit following cerebrovascular disease. The most recent Annual MDS Assessment, dated 9/16/24, indicated Resident 29 had moderate cognitive impairment, needed partial/moderate assistance for bed mobility and transfers, set up or clean up assistance for eating, supervision/touching assistance for toilet use, and bed rails were used as a restraint daily. The clinical record lacked current Physician Orders for a restraint. The clinical record lacked a care plan for restraints. During an interview on 12/6/24 at 8:11 A.M., LPN 3 indicated Resident 29 used bed rails for bed mobility. The bed rails were not a restraint. They didn't have any restraints in the building. During an interview on 12/6/24 at 11:19 A.M., MDS Coordinator indicated she had been taught if the clinical records indicated bed rails were in use, it had to be marked on the MDS as a restraint. She indicated she used the RAI (Resident Assessment Instrument) manual, and if the rails met the criteria of restraint, she marked Restraint on the MDS assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Chapter 3, page P-1 indicated the definition of Physical Restraints was Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. Chapter 3, page P-6 indicated Bed rails used with residents who are immobile. If the resident is immobile and cannot voluntarily get out of bed because of a physical limitation or because proper assistive devices were not present, the bed rails do not meet the definition of a physical restraint. 38770 3. On 12/5/24 at 2:03 P.M., Resident 8's clinical record was reviewed. Diagnosis included, but were not limited to, dementia (dated 9/1/23). The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 10/18/24, indicated a severe cognitive impairment, and substantial to maximal assistance with toileting, transferring, bathing, and bed mobility. The MDS indicated Resident 8 did not have dementia. Resident 8 lacked current Physician Orders for any medications related to dementia. A current care plan, dated 11/19/24, indicated a diagnosis of dementia with severely impaired cognition. A current care plan, dated 11/10/23, indicated impaired decision making due to a diagnosis of dementia. On 12/6/24 at 11:26 A.M., the MDS Coordinator indicated in order for a diagnosis to be coded on the MDS Assessment, something had to be done with that diagnosis in the previous 7 day look back period. She indicated she would run the Medication Administration Record (MAR) for information related to medications given and what diagnosis they were given for in order to mark diagnosis on the MDS Assessments. On 12/9/24 at 10:20 A.M., Licensed Practical Nurse (LPN) 3 indicated Resident 8's care for dementia was an every day activity that was not documented, such as encouraging to participate in activities, redirection, giving snacks, toileting, and offering to take naps. On 12/9/24 at 11:25 A.M., the Director of Nursing (DON) indicated Resident 8's daughters did not want the resident taking any medications to manage her dementia, and would rather manage symptoms in non-medicinal ways. 45933 4. On 12/5/24 at 10:34 A.M., Resident 15's clinical record was reviewed. Diagnoses included, but were not limited to, heart failure and diabetes mellitus. The most recent Admission MDS (Minimum Data Set) Assessment, dated 9/4/24 indicated Resident 15 was cognitively intact. The MDS indicated Resident 15 did not receive a hypoglycemic medication. Current Physician Orders included, but were not limited to: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Basaglar (hypoglycemic) KwikPen Subcutaneous Solution Pen-injector 100 units per milliliter (Insulin Glargine). Inject 10 unit subcutaneously in the morning for diabetes mellitus, dated 08/30/2024 HumaLOG (hypoglycemic) KwikPen Subcutaneous Solution Pen-injector 100 units per milliliter (Insulin Lispro). Inject 7 units subcutaneously in the evening for diabetes mellitus, dated 8/30/24. Resident 15's MAR (Medication Administration Record) for August and September 2024 indicated Basaglar and Humalog were administered during the assessment period for the 9/4/24 MDS. During an interview on 12/6/24 at 11:29 A.M., the MDS Coordinator indicated she does not code insulin as a hypoglycemic medication. During an interview on 12/6/24 at 11:29 A.M., the MDS Coordinator indicated she used the RAI manual as the policy.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45933 Based on observation, interview and record review, the facility failed to develop a care plan for 2 of 5 residents reviewed for Unnecessary Medications. Residents were administered a diuretic, insulin, anticoagulant, opioid, and antiplatelet medication and did not have a care plan related to the medication. (Resident 14, Resident 15) Findings include: 1. On 12/5/24 at 10:34 A.M., Resident 15's clinical record was reviewed. Diagnoses included, but were not limited to, heart failure, atrial fibrillation, end stage renal disease, and diabetes mellitus. The most recent Admission MDS (Minimum Data Set) Assessment, dated 9/4/24 indicated Resident 15 was cognitively intact. The MDS indicated Resident 15 received an anticoagulant, insulin, diuretic, opioid, and antiplatelet medication. Resident 15's current Physician's Orders included, but was not limited to: Apixaban oral tablet 2.5 mg (milligrams) (anticoagulant), give 1 tablet by mouth two times a day related to atrial fibrillation, dated 9/11/24 Aspirin 81 mg (antiplatelet) by mouth at bedtime, dated 10/2/24. Basaglar KwikPen Subcutaneous Solution Pen-injector 100 units per milliliter (Insulin Glargine). Inject 10 units subcutaneously one time a day for diabetes mellitus, dated 11/10/24. Furosemide 40 mg (diuretic) one time a day every Tuesday, Thursday, Saturday, and Sunday for heart failure, dated 9/12/24. Oxycodone HCL (hydrochloride) 5 mg (opioid) 1 tablet every 4 hours as needed for pain, dated 8/29/24. Tramadol HCL 50 mg (opioid) 1 tablet by mouth two times a day for left knee pain, dated 9/11/24. Resident 15's clinical record lacked a care plan for antiplatelets, insulin, and opioids. 46416 2. On 12/4/24 at 1:16 P.M., Resident 14's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease and heart failure. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 10/15/24, indicated Resident 14's cognition was moderately impaired and a substantial/maximum assist for toileting, bathing, transfers, and receiving a diuretic medication. Current Physician's Orders included, but were not limited to, the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	furosemide (Lasix) oral tablet (diuretic), Give 20 mg by mouth one time a day related to heart failure, dated 9/11/24 The clinical record lacked a care plan for the use of a diuretic. During an interview on 12/6/24 at 10:44 A.M., the Director of Nursing (DON) indicated the MDS Coordinator was responsible for putting care plans into the clinical record, but the DON does it as well. She indicated if the resident was being treated with a medication, a diuretic, insulin, anticoagulant, opioid, and antiplatelet, it should be in the resident's care plans. On 12/6/24 at 1:15 P.M., a current Comprehensive Care Plans Policy, dated March 2022, was provided by the DON, and indicated . A comprehensive, person-centered care plan includes services need to meet the resident's physical, psychosocial, and functional needs is developed . The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The comprehensive, person-centered care plan is developed within seven [7] days of the completion of the required MDS [Minimum Data Set] Assessment . Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change . 3.1-35(a)

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F 0689 Level of Harm - 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** 46416 Based on interview and record review, the facility failed to ensure adequate assistance was provided during a mechanical lift transfer and ensure staff used the equipment in accordance with facility policy for a resident who required extensive assistance of two staff and mechanical lift for transfers (Resident 137). The facility failed to ensure adequate supervision was provided in the bathroom for a cognitively impaired resident at risk of experiencing falls and failed to ensure a toilet seat was properly attached to the toilet for a resident (Resident 2). The facility failed to ensure new interventions were immediately implemented after a fall for Resident 137 and Resident 2 to prevent further falls for 2 of 3 residents reviewed for falls. This deficient practice resulted in Resident 137 sustaining a right femur fracture and Resident 2 sustaining a right hip fracture that required surgical repair. (Resident 137, Resident 2) Findings include: 1. An Indiana Department of Health (IDOH) incident report, dated 8/29/24, indicated Certified Nurse Aide (CNA) 20 was involved when a resident had fallen during a transfer, was transferred to the hospital, and the hospital nurse reported to the facility Resident 137 had a right femur fracture. On 12/4/24 at 1:28 P.M., Resident 137's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease and history of a stroke. The most recent Quarterly Fall Risk Assessment, dated 3/7/24, indicated Resident 137 was a high risk to fall. The clinical record lacked documentation of a Fall Risk Assessment being done between 3/8/24 and 8/29/24. The most recent Significant Change MDS (Minimum Data Set) assessment prior to the fall, dated 8/1/24, indicated Resident 137's cognition was unable to be assessed, had impairment of both lower extremities, used a mechanical lift, and required an extensive assist of two staff for bed mobility and transfers, and was totally dependent on two staff for toileting. A Physician's Order Summary, dated August 2024, did not include information to indicate staff should use a mechanical lift for transfers. A plan of care for falls, revised 8/5/24, included, but was not limited to, interventions to use a mechanical lift for transfers and to perform fall risk assessments quarterly and as needed. The plan did not include documentation to determine the number of staff required for the mechanical lift transfer. A Health Status Note, dated 8/29/24, indicated the resident fell during a transfer, signs of pain were present, and the resident was transferred to the hospital. The note did not include documentation to determine the specific details of the fall, the number of staff present at the time of the fall, and any new interventions to prevent further falls were immediately implemented. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The progress notes, fall assessments, and care plans dated 8/29/24 through 9/3/24, did not include documentation of the specific details about the fall or to show immediate interventions were implemented to prevent further falls. On 12/4/24 at 2:08 P.M., the Administrator provided an incident report for the fall on 8/29/24 but indicated it was a facility document only and not part of the clinical record. At that time, she indicated the details about the fall would be documented in progress notes, assessments, and care plans. An internal fall investigation summary tool, dated 8/29/24, provided by the DON indicated the mechanical lift transfer of Resident 137, on 8/29/24, was performed without the extensive assistance of two staff, the mechanical lift was used improperly, and no new interventions were immediately implemented to prevent further falls for Resident 137. During an interview on 12/5/24 at 9:46 A.M., the Director of Nursing (DON) indicated no additional documentation could be provided regarding the resident's fall on 8/29/24. On 12/4/24 at 3:30 P.M., the hospital discharge record, dated 9/3/24, indicated Resident 137 fell from a mechanical lift at the long-term care facility, sustained an acute fracture of mid-femoral diaphysis (a break in the middle of the femur bone) that required surgical repair, and was admitted to the hospital on 8/29/24. The record indicated that the resident was discharged back to the facility on [DATE]. On 12/5/24 at 11:59 A.M., the employee file of CNA 20 indicated mechanical lift skills competency was not completed. The CNA was suspended from duty for performing a mechanical lift transfer without a second staff person present. Education was provided and the CNA was terminated for continued noncompliance of facility policy. During an interview, on 12/5/24 at 11:05 A.M., Licensed Practical Nurse (LPN) 25 indicated she was Resident 137's nurse, on 8/29/24, when the fall occurred. LPN 25 was called to Resident 137's room and upon entering the room, the resident was observed on the floor, a handful of staff were standing in the room, and the mechanical lift was in the room, but she was unsure what position it was in at that time. LPN 25 indicated CNA 20 used the mechanical lift incorrectly and by herself instead of having two staff to do the transfer. LPN 25 indicated she did an assessment of Resident 137, and other than the resident appearing to have pain, there were no outward signs of injury. LPN 25 was not sure if the fall information should have been documented anywhere other than in the progress notes of the clinical record or how often fall risk assessments were completed on residents. LPN 25 indicated her head-to-toe assessment findings should have been documented in an assessment at the time of the fall but was unable to obtain these findings from the clinical record. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview, on 12/5/24 at 11:45 A.M., the Administrator indicated CNA 20 transferred Resident 137 alone and did not have the base of the lift all the way out which caused it to tip over and the resident to fall landing on the floor. The Administrator was here at the time of the fall and followed the nurse into Resident 137's room. Upon entry, the Administrator observed the resident laying on the floor in the lift pad and the lift was tipped over. The Administrator indicated CNA 20 was trained in another state where two staff were not required to perform a mechanical lift transfer. At that time, the Administrator indicated CNA 20 should have been trained on the mechanical lift policy and procedures during initial facility orientation but supporting documentation could not be provided to show the training occurred. The Administrator indicated CNA didn't use the lift correctly or ask for help with using the lift for the transfer of Resident 137 when the 8/29/24 fall occurred. 2. On 12/4/24 at 11:32 A.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease and anxiety. The most recent Annual MDS (Minimum Data Set) assessment, dated 9/13/24, indicated severe cognitive impairment, substantial to maximum assistance required with toileting hygiene and independent with toilet transfers. Resident 2 was at risk for falls, and falls risk assessments were completed on 3/10/23, 3/13/24, and 3/16/24. Current physician orders as of 12/4/24 included, but were not limited to: bed alarm while in bed, dated 5/27/24. No physician orders related to falls interventions were in place prior to 5/27/24. A risk for falls care plan, dated 5/31/23, included the following interventions: if fall occurs, initiate frequent neuro and bleeding evaluations per facility protocol and alert provider, initiate fall risk precautions, properly identify resident to indicate a fall risk to caregivers, review medications for drugs that increase the risk of falls, and utilize devices as appropriate to ensure safety, all dated 5/31/23. A current high risk for falls care plan, dated 4/16/24, indicated, but was not limited to, the following interventions: Anticipate needs, call light within reach and encouragement to use it, appropriate footwear while ambulating or using wheelchair, follow facility fall protocol, and participation in activities that minimize potential for falls, all dated 4/16/24. A current actual fall with the injury care plan, dated 4/16/24, indicated, but was not limited to, the following interventions: check range of motion and increased pain, swelling and bruising every shift until resolved, continue interventions for the at-risk plan, monitor, document and report pain, bruising, change in mental status, confusion, sleepiness, inability to maintain posture, or agitation, all dated 4/16/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155688	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Freelandville Community Home	310 W Carlisle Street Freelandville, IN 47535

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(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 - Actual harm Residents Affected - Few	From March 2024 through May 2024, Resident 2 experienced the following falls: Fall 1 An incident note, dated 3/8/24 at 12:40 P.M., indicated Resident 2 had slid off the commode in her room due to a high-rise toilet seat that had been placed on the toilet and was not secured. The resident slid off the toilet with the riser and was found sitting on her bottom on the floor by a Certified Nurse Aide (CNA) who was passing trays. The resident hit the right side of her buttock/hip. The note indicated a full assessment had been completed, although the clinical record lacked the assessment A Health Status Note, dated 3/8/24 at 6:25 P.M., indicated Resident 2 was taken to the emergency room via ambulance. A Health Status Note, dated 3/8/24 at 8:18 P.M., indicated Resident 2 was admitted for a fracture of the right hip. A Health Status Note, dated 3/13/24 at 1:53 P.M., indicated Resident 2 returned to the facility from the hospital, and was transferred to bed with assistance of one staff. A Health Status Note, dated 3/14/24 at 12:32 P.M., indicated Resident 2 had returned to the facility the previous day after an acute hospitalization related to a right hip fracture being surgically repaired. The falls care plan, dated 3/8/24, did not include documentation to indicate interventions were immediately implemented to prevent further falls. During an interview, on 12/6/24 at 11:44 A.M., the Director of Nursing (DON) indicated no documentation could be provided to show interventions to prevent further falls were immediately implemented after Fall 1 and should have been added to the plan of care. The progress notes, assessments, and plans of care, dated from 3/13/24 through 3/16/24 at 9:45 a.m., did not include documentation to indicate new interventions to prevent falls were implemented. Fall 2 A Health Status note, dated 3/16/24, indicated Resident 2 was found in her room on the floor on her back at approximately 10:00 A.M. The note indicated two nurses assessed the resident, although the assessment could not be located in the clinical record. The note indicated the bed would be placed in the lowest position and mats placed on the floor, and resident was to be placed by the nurse's station while awake Fall 3 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A Health Status note, dated 5/26/24 at 12:05 A.M., indicated Resident 2 was found sitting on the mat in front of her bed. Neuro checks initiated and vital signs checked. The resident's son requested a bed alarm and was initiated as a new intervention. The progress note indicated that an assessment was completed but was not found in the progress notes or assessments portion of the clinical record. On 12/5/24 at 9:45 A.M., the Director of Nursing indicated all falls information was either in progress notes or assessments. Review of the progress notes and assessments from 5/26/24 through 12/4/24 lacked a falls assessment following the fall on 5/26/24 On 12/4/24 at 2:00 P.M., Licensed Practical Nurse (LPN) 5 indicated she was here at the time of Resident 2's fall on 3/8/24 (Fall 1). She indicated Resident 2 fell off of the toilet due to the seat riser coming loose and sliding off when the resident tried to sit on it. She indicated Resident 2 had a new roommate at that time (no longer in the facility) that was a larger person and possibly shifted the seat riser loose prior to Resident 2 using it. She indicated it was the kind of riser that clicked into place and that the risers were no longer used in the facility for any resident. On 12/5/24 at 1:26 P.M., the Maintenance Supervisor indicated there were two types of toilet seat risers at the facility while in use. They were either screwed on or bolted to the actual toilet bowl. He indicated they were checked periodically, but there were no scheduled checks for them that he was aware of. He indicated all risers had been removed from the residents' bathrooms and were no longer physically in the building. On 12/6/24 at 10:22 A.M., Resident 2 was observed lying in a low bed on a bed alarm. A fall mat was observed on the floor by the bed. On 12/6/24 at 10:31 A.M., LPN 5 indicated she was unaware of any checks that were done for the toilet seat risers when the facility used them. She indicated if the nurses or housekeeping were to notice anything wrong with them, they were supposed to fill out a work order for maintenance. On 12/6/24 at 10:34 A.M., the Director of Nursing (DON) indicated the system that was in place at the time of Resident 2's falls was not conducive to nurse input or documentation. She indicated care plans should have been updated following each fall with a new intervention, but the process to do so had not been in place at the time of the falls. On 12/5/24 at 11:40 A.M., a Mechanical Lift Policy, revised July 2017, was provided by the Administrator and identified as the most current policy. The policy indicated, .At least two [2] nursing assistants are needed to safely move a resident with a mechanical lift . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/6/24 at 1:16 P.M., a Falls Policy, dated 9/2012, was provided by the DON and identified as the most current policy. The policy indicated If the individual continues to fall, the staff and physician will re-evaluate the situation and consider other possible reasons for the resident's falling . and will re-evaluate the continued relevance of current interventions . When a resident falls, the following information should be recorded in the resident's medical record . the condition in which the resident was found . assessment data, including vital signs and any obvious injuries . interventions, first aid, or treatment administered . Completion of a falls risk assessment . Appropriate interventions taken to prevent future falls . The staff will seek to identify environmental factors that may contribute to falling . 3.1-45(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 45933 Based on interview and record review, the facility failed to ensure services of an RN (Registered Nurse) were available at least 8 consecutive hours a day, 7 days a week for 2 of the 7 days reviewed. (November 28, 2024, November 29, 2024) Findings include: On 12/9/24 at 10:35 A.M., staffing was reviewed from 11/23/24 through 11/29/24. The facility lacked an RN in the building for 8 consecutive hours on 11/28/24 and 11/29/24. During an interview on 12/9/24 at 10:52 A.M., the Administrator indicated an RN was not in the building for 8 consecutive hours on 11/28/24 and 11/29/24, and she would expect an RN to be in the building for 8 consecutive hours a day. On 12/9/24 at 11:07 A.M., the Administrator provided a time card for RN 27 that indicated her recorded time at the facility was 3 hours and 47 minutes. On 12/9/24 at 11:07 A.M., a current Staffing, Sufficient and Competent Nursing policy, dated 2001, indicated, .A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week . 3.1-17(b)(3)