STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155118	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Lagrange Skilled Nursing Facility, The	787 N Detroit St Lagrange, IN 46761

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45794 Based on interview and record review, the facility failed to ensure an advance directive (code status) was accurate for 1 of 7 residents reviewed (Resident 4). Findings include: Resident 4's record was reviewed on [DATE] at 10:09 AM. Diagnoses included chronic obstructive pulmonary disease, (emphysema) unspecified dementia, schizoaffective disorder and bipolar disorder. Resident 4's Quarterly Minimum Data Set, (MDS) dated [DATE], indicated their Brief Interview for Mental Status (BIMS) score was 15 (no cognitive deficit). The MDS indicated Resident 4 required substantial to maximum assistance for activities of daily living. Resident 4's Care Plan, dated [DATE], indicated their code status was Do Not Resuscitate (DNR). A physician order, revision date [DATE], indicated DNR status had been discontinued. A Cardiopulmonary Resuscitation (CPR) Status Form, signed by Resident 4's representative on [DATE] indicated the resident's code status was to have CPR initiated. Resident 4's physician signed the form on [DATE]. In an interview on [DATE] at 12:01 PM, the DON indicated they were not aware of Resident 4's CPR code status. The DON indicated resident code status should be the same throughout each document in the resident's record. A current undated facility policy, provided by the Regional Nurse Consultant on [DATE] at 11:51 AM, indicated each resident's choice of advance directive would be honored and incorporated into their plan of care. The policy indicated advance directive choices would be reviewed annually and as needed. 3XXX,d+[DATE](d)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45794 Based on interview and record review, the facility failed to ensure family notification of an episode of resident-to-resident contact for 1 of 2 residents reviewed (Resident 63). Findings include: Resident 63's record was reviewed on 9/30/24 at 1:13 PM. Diagnoses included dementia with mood disturbance, Parkinson's Disease, major depressive disorder, anxiety disorder and visual hallucinations. Resident 63's Quarterly Minimum Data Set (MDS), dated [DATE], indicated the resident's Brief Interview for Mental Status (BIMS) score was 3 (severe cognitive impairment). The MDS indicated Resident 63 required substantial to maximal assistance to roll left and right, to move from a lying to a sitting position and to move from a sitting to a standing position. Resident 63's Care Plan, dated 12/8/23, indicated the resident did not participate in many activities. The Care Plan Indicated Resident 63 mostly sat in the background and watched others. The target goal was for the resident to participate in activities of interest at least 2 times a week through 12/9/24. Interventions included the determination that religious beliefs and religious activities were important to Resident 63. A Behavior Charting note, dated 9/18/24 at 5:19 PM, indicated Resident 63 kissed another resident (Resident 49) on the lips in the dining room. Separation of the residents was effective. Resident 63's progress notes, dated 9/18/24 through 9/30/24, did not indicate the resident's family representative had been made aware of the resident kissing another resident. The progress notes did not indicate the episode had been reported to the family or the resident's physician. In an interview, on 10/1/24 at 1:36 PM, The Social Service Director (SSD) indicated the kiss between Resident 63 and Resident 49 was a brief peck on the lips. The SSD indicated the incident was not reportable as both the residents had a diagnosis of dementia. The SSD indicated the kiss was not sexual. The SSD indicated Resident 63 was a willing participant. The SSD indicated although Resident 49 currently displayed sexual behaviors the kiss was friendly. The SSD indicated Resident 49's sexual behaviors had improved with medication and was now easily redirected. The SSD indicated they were not aware of further information related to the kissing episode as they were not at work that day. The SSD indicated the Administrator may have further information in their office. In an interview, on 10/1/24 at 2:05 PM, the Administrator indicated they had not been made aware of Resident 63 and Resident 49 kissing and did not believe they had any further information related to family and/or physician notification of the incident. A current policy titled, Guidelines for Incidents/Accidents/Falls dated 6/30/23, provided by the Registered Nurse (RN) 27 on 9/27/24 at 11:51 AM, indicated the facility would ensure any incident/accident/fall that met reporting criteria would be identified and reported accurately and timely to appropriate persons and agencies which included follow-up reporting. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-5(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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46756 Based on observation, interview, and record review the facility failed to ensure contents of a urinary catheter bag were not visible from the hallway for 1 of 2 residents reviewed (Resident 44). Findings include: During an observation, on 9/25/24 at 9:42 AM, Resident 44 was lying in bed in a semi-reclined position with a catheter bag attached to the bedframe and facing the door. Resident 44's door was open, his bag was in plain sight and visible from the hallway. The bag was about half full of yellow liquid. During an observation on 9/26/24 at 6:44 PM, Resident 44 was lying in bed with a catheter bag attached to the bedframe and facing the door with about 200 milliliters of yellow liquid in the bag. The bag was in plain sight from the hallway. During an observation, on 9/27/24 at 2:50 PM, Resident 44 was lying in bed with a catheter bag attached to the bedframe and facing the hallway about two-thirds full of yellow liquid. During an interview, on 9/27/24 at 2:50 PM, Licensed Practical Nurse (LPN) 25 indicated catheter bags should be emptied at the end of the traditional day shift, around 2:00 PM. She indicated catheter bags should be anchored on the other side of the bed so it would not be visible from the hallway, protecting resident privacy. She indicated a privacy cover should be in place on the bag to keep urine from being visible to the casual observer. Resident 44's record was reviewed on 9/27/24 at 3:19 PM. Diagnoses included benign prostatic hyperplasia with lower urinary tract symptoms, retention of urine, and neuromuscular dysfunction of the bladder. Resident 44's current quarterly Minimum Data Set (MDS), dated [DATE], indicated their Basic Interview for Mental Status (BIMS) score was 7 (cognitively impaired). The MDS indicated the resident used an indwelling urinary catheter. Resident 44's current care plan titled Catheter indicated the resident had a problem of requiring the use of an indwelling catheter, with a goal date of 11/19/24. Interventions included ensuring a dignity bag was in place. In an interview, on 9/27/24 at 3:11 PM, Regional Nurse Consultant 27 indicated the catheter bag containing urine should have been covered and its contents should not be visible from the hallway. A current policy titled Catheters, undated, provided by Regional Nurse Consultant 27 on 9/27/24 at 3:20 PM, did not address providing privacy by covering the catheter bag to prevent visibility of the contents by casual observers. No other policies pertaining to maintaining privacy for a resident requiring an indwelling catheter were available for review. 3.1-3(p)(2)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45794 Based on interview and record review, the facility failed to prevent abuse for 1 of 2 residents reviewed (Resident 41). Findings include: An Indiana State Department of Health Survey Report System Incident Number 189, dated 9/13/24 at 2:45 PM, indicated Resident 41's family member got loud with the resident during a visit at the facility. Immediate action taken was the removal of Resident 41's visitor from the facility. A preventative measure was the visitor not being permitted at the facility during the investigation. Follow up on 9/20/24 indicated on 9/13/24 a verbal altercation was overheard in Resident 41's room. The visitor was identified as Resident 41's Power of Attorney (POA). The visitor seemed intoxicated as evidenced by their appearance and smell. The visitor was asked to leave the facility immediately. Resident 41 voiced concern the visitor would return. Adult Protective Services recommended a visit restriction and a possible guardianship change. Resident 41's visitation was to be monitored for the next 30 days. Resident 41's Care Plan was reviewed and updated. Resident 41's record was reviewed on 9/27/24 at 3:00 PM. Diagnoses included systemic lupus erythema, adult failure to thrive, anxiety disorder, bipolar disorder, schizophrenia, cognitive communication deficit, obsessive compulsive disorder, depression, agoraphobia with panic disorder and posttraumatic stress disorder (PTSD). Resident 41's Quarterly Minimum Data Set, (MDS) dated [DATE], indicated their Brief Interview for Mental Status (BIMS) score was 6 (severe cognitive impairment). The MDS indicated Resident 41had a gastrointestinal (g tube) feeding tube. Resident 41's Care Plan, dated 5/22/24, indicated the resident had a history of trauma and Resident 41's triggers were still being determined. Resident 41 coped by speaking with their boyfriend (the visitor and POA who had been restricted from visitation). The target goal was for the resident to feel safe and comfortable through 11/22/24. Interventions included findings things of comfort and encouraging the resident to use them. Resident 41's Care Plan did not indicate Resident 41's visitation was to be monitored. The Care Plan did not indicate Resident's POA could not visit. The Care Plan did not indicate the facility had witnessed the abuse of Resident 41 on 9/13/24. A progress note, dated 9/13/24 at 4:11 PM, indicated Resident 41's boyfriend had been verbally abusive. The boyfriend was noted to use a loud voice and told Resident 41 they should stop crying and to get up and walk. Resident 41 had been crying and reported they were afraid of their boyfriend. The boyfriend left the facility after being asked to calm down. A progress note, dated 9/22/24 at 1:27 PM, indicated Resident 41's POA was observed sitting in a chair in the resident's room while the resident was in the dining room. Resident 41's POA left the facility when reminded they were not allowed to visit. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 41's Kardex (care plan summary for direct care staff) did not indicate the resident's visitation was to be monitored. The Kardex did not indicate the resident's POA was not permitted to visit. In an interview, on 10/1/24 at 11:40 AM, Qualified Medication Aide (QMA) 28 indicated they were not aware of Resident 41's visitation monitoring. QMA 28 indicated they did not work Resident 41's unit very often. QMA 28 indicated they were aware of Resident 41's boyfriend being nasty to the resident in the past. In an interview, on 10/1/24 at 1:36 PM, The Social Service Director (SSD) indicated Resident 41 had an extensive history of trauma that included multiple sexual assaults. The SSD indicated Resident 41's boyfriend had left Resident 41 unattended at home for an undetermined length of time. The SSD indicated Resident 41's boyfriend was their Power of Attorney. The SSD indicated the facility was aware of Resident 41's boyfriend's past abusive episodes at the facility. The SSD indicated the episode on 9/13/24 was the first time Resident 41 had asked for help. The SSD indicated they had provided copies of all Resident 41's documentation available. A current facility policy, dated 10/22/22, indicated the facility would identify residents with increased vulnerability for neglect, abuse or mistreatment. The facility would identify risk factors and incorporate the factors into the care plan to monitor and reevaluate. 3.1-27(a)(b)

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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** 45794 Based on interview and record review, the facility failed to ensure unusual incidents were reported to the appropriate agencies for 2 of 2 residents reviewed (Resident 63 and Resident 19). Findings include: 1. Resident 63's record was reviewed on 9/30/24 at 1:13 PM. Diagnoses included dementia with mood disturbance, Parkinson's Disease, major depressive disorder, anxiety disorder and visual hallucinations. Resident 63's Quarterly Minimum Data Set (MDS) dated [DATE], indicated the resident's Brief Interview for Mental Status (BIMS) score was 3 (severe cognitive impairment). The MDS indicated Resident 63 required substantial to maximal assistance to roll left and right, to move from lying to a sitting position and to move from a sitting to standing position. A Behavior Charting note, dated 9/18/24 at 5:19 PM, indicated Resident 63 kissed another resident (Resident 49) on the lips in the dining room. Separation of the residents was effective. Resident 63's progress notes, dated 9/18/24 through 9/30/24, did not indicate the resident's family representative had been made aware of the resident kissing another resident. The progress notes did not indicate the episode had been reported to the appropriate agencies. Resident 63's Care Plan, dated 12/8/23, indicated the resident did not participate in many activities. The Care Plan Indicated Resident 63 mostly sat in the background and watched others. The target goal was for the resident to participate in activities of interest at least 2 times a week through 12/9/24. Interventions included the determination that religious beliefs and religious activities were important to Resident 63. In an interview on 10/1/24 at 1:36 PM, The Social Service Director (SSD) indicated the kiss between Resident 63 and Resident 49 was a brief peck on the lips. The SSD indicated the incident was not reportable as both the residents had a diagnosis of dementia. The SSD indicated the kiss was not sexual. The SSD indicated Resident 63 was a willing participant. The SSD indicated although Resident 49 currently displayed sexual behaviors the kiss was friendly. The SSD indicated Resident 49's sexual behaviors had improved with medication and was now easily redirected. The SSD indicated they were not aware of further information related to the kissing episode as they were not at work that day. The SSD indicated the Administrator may have further information in their office. In an interview, on 10/1/24 at 2:05 PM, the Administrator indicated they were not aware of the kissing episode between Resident 63 and Resident 49 so had not reported it. 46156 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident 19's record was reviewed on 9/27/24 at 10:00 AM. Diagnoses included bipolar disorder, anxiety disorder, delusional disorders, complete traumatic amputation of right lower leg, idiopathic peripheral autonomic neuropathy, muscle weakness, and lack of coordination. Resident 19's current quarterly Minimum Data Set (MDS), dated [DATE], indicated her Basic Interview for Mental Status (BIMS) score was 8, moderate cognitive impairment. The MDS indicated for 7 to 11 days in a period of 14 days, she felt tired or had little energy, had trouble concentrating, poor appetite and was on an antidepressant. The MDS indicated she had lost weight of 5% in the last month or 10% in last 6 months and was not on Physician prescribed weight loss regimen. The MDS indicated the resident was impaired on 1 side of her lower extremity and used a wheelchair. The MDS indicated she required substantial/maximal assist with rolling left to right, transfers, and toileting. Resident 19's current care plan, initiated 2/12/24, indicated her care plan focus was high risk for elopement/wandering related to her bi-polar disorder. The goal of her focus area was the resident would not wander out of the facility or off the floor with a target date of 11/7/24. Interventions included wanderguard in placed initiated 6/10/24, assess/record/report to Medical Doctor (MD) risk factors for potential elopement initiated 2/12/24, and supervise closely and make regular compliance rounds whenever the resident was in her room initiated 2/12/24. A Care Plan Meeting progress note, dated 5/2/24 at 8:54 AM, indicated when Resident 19 wouo ld outside she was to be monitored. The note indicated the resident was not able to physically sign for herself anymore. The note indicated the facility was requesting the MD to evaluate Resident 19 to see if guardianship (a legal process that gives a person or entity the authority to make decisions for another person, called a ward, who is considered incompetent) was appropriate. A Progress note, dated 6/9/24 at 1:11 PM, indicated Resident 19 was found by activity personnel outside on the pavement of the parking lot lying on her right side. The resident told the staff a visitor let her out of the building. The resident indicated she fell from the sidewalk curb and reported hitting her head. Abrasions were found on the resident's left knee, redness found on her right elbow/shoulder, and swelling/discoloration on the right side of her forehead/temple. Resident 19 reported slight pain to her head and right hip immediately after the incident; ice was applied to the area. In an interview, on 10/2/24 at 1:42 PM, the Director of Nursing (DON) indicated Former Employee 45, working on the Assisted Living unit, was looking out the large main window in the Facility's Assisted living (located midway down the unit) and observed Resident 19 exit the building. The DON indicated Employee 45 went to find the Resident 19 (through half the corridor of the Assisted living, through the facility's lobby, through one set of doors, through anti-room, through second set of doors, and to the outside of the building). The DON indicated Former Employee 45 indicated before she could reach Resident 19 she fell out of her wheelchair outside the facility. The DON indicated the incident was reviewed and it was decided it was not an elopement (a resident who leaves a healthcare facility without authorization or supervision). In an interview, on 9/30/24 at 11:40 AM, the Administrator indicated Resident 19's elopement had not been reported to the proper agencies. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current policy titled, Guidelines for Incidents/Accidents/Falls dated 6/30/23, provided by the Registered Nurse (RN) 27 on 9/27/24 at 11:51 AM, indicated the facility would ensure any incident/accident/fall that met reporting criteria would be identified and reported accurately and timely to appropriate agencies which included follow-up reporting. 3.1-28(c)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46156 Based on observation, interview, and record review, the facility failed to ensure the elopement of a resident was investigated for 1 of 2 residents reviewed (Residents 19). Findings include: Resident 19's record was reviewed on 9/27/24 at 10:00 AM. Diagnoses included bipolar disorder, anxiety disorder, delusional disorders, complete traumatic amputation of right lower leg, idiopathic peripheral autonomic neuropathy, muscle weakness, and lack of coordination. Resident 19's current quarterly Minimum Data Set (MDS), dated [DATE], indicated her Basic Interview for Mental Status (BIMS) score was 8, moderate cognitive impairment. The MDS indicated for 7 to 11 days in a period of 14 days, she felt tired or had little energy, had trouble concentrating, poor appetite and was on an antidepressant. The MDS indicated she had lost weight of 5% in the last month or 10% in last 6 months and was not on Physician prescribed weight loss regimen. The MDS indicated the resident was impaired on 1 side of her lower extremity and used a wheelchair. The MDS indicated she required substantial/maximal assist with rolling left to right, transfers, and toileting. Resident 19's current care plan, initiated 2/12/24, indicated her care plan focus was high risk for elopement/wandering related to her bi-polar disorder. The goal of her focus area was the resident would not wander out of the facility or off the floor with a target date of 11/7/24. Interventions included a wanderguard was placed initiated 6/10/24, assess/record/report to Medical Doctor (MD) risk factors for potential elopement initiated 2/12/24, supervise closely and make regular compliance rounds whenever the resident was in her room initiated 2/12/24. A Care Plan Meeting progress note, dated 5/2/24 at 8:54 AM, indicated when Resident 19 would go outside she was to be monitored. The note indicated the resident was not able to physically sign for herself anymore. The note indicated the facility was requesting the MD to evaluate Resident 19 to see if guardianship (a legal process that gives a person or entity the authority to make decisions for another person, called a ward, who is considered incompetent) was appropriate. A Progress note, dated 6/9/24 at 1:11 PM, indicated Resident 19 was found outside by activity personnel on the pavement of the parking lot lying on her right side. The resident indicated a visitor her out of the building. The resident fell from the sidewalk curb and reported hitting her head. Abrasions were found on the resident's left knee, redness found on her right elbow/shoulder, swelling/discoloration on the right side of her forehead/temple. Resident 19 reported slight pain to her head and right hip immediately after the incident; ice was applied to the area. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview, on 10/2/24 at 1:42 PM, the Director of Nursing (DON) indicated Former Employee 45, working on the Assisted Living unit, was looking out the large main window in the Facility's Assisted living (located midway down the unit) and observed Resident 19 exit the building. The DON indicated Employee 45 went to find the Resident 19 (through half the corridor of the Assisted living, through the facility's lobby, through one set of doors, through anti-room, through second set of doors, and to the outside of the building). The DON indicated Former Employee 45 indicated before she could reach Resident 19 she fell out of her wheelchair outside the facility. The DON indicated the incident was reviewed and was decided it was not an elopement (a resident who leaves a healthcare facility without authorization or supervision) and was not investigated as an elopement. A current policy titled, Guidelines for Incidents/Accidents/Falls dated 6/30/23, provided by the Registered Nurse (RN) 27 on 9/27/24 at 11:51 AM indicated the facility would ensure any incident/accident/fall would be identified, reported accurately and timely to appropriate agencies, investigated, and resolved. 3.1-28(c)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 46756 Based on interview, and record review the facility failed to ensure showers were consistently offered for 1 of 6 residents reviewed (Resident 76). Findings include: During an interview, on 9/26/24 at 10:08 AM, Resident 48 indicated he was not getting showers on a regular basis. He indicated he was supposed to have a shower on Wednesdays and Saturdays at 3:00 pm. He indicated when staff did not show up to give him a shower, he would frequently go to the nurses' station to find out what was going on and was told they were short staffed. Resident 48's record was reviewed on 9/30/24 at 10:25 AM. Diagnoses included cerebral infarction due to thrombosis of right posterior cerebral artery, hemiplegia and hemiparesis following cerebral infarction affecting left, non-dominant side, and diabetes mellitus, type 2 without complications. Resident 48's current quarterly Minimum Data Set (MDS) indicated their Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact). The MDS indicated Resident 48 required moderate assistance with bathing and rejection of care was not exhibited. Resident 48's current care plan titled Preferences indicated Resident 48 expressed choices regarding his personal care was important to him, with a goal date of 10/4/24. Interventions included showering twice weekly around 3:00 PM. Resident 48's current care plan titled ADL (Activity of Daily Living) Self-Care Performance indicated the resident had a problem of a self-care deficit related to a cerebral infarction, with a goal date of 10/4/24. An intervention titled Personal Hygiene Routine indicated the resident prefered being shaved weekly and hands washed. Interventions did not include specifications on assistance provided for showering or any other hygiene. Progress notes, dated 8/6/24 at 6:11 PM, indicated Resident 48's skin was dry over his entire body and at high risk for skin breakdown. The notes indicated Nurse Practitioner (NP) 34 recommended Resident 34 receive good hygiene and skin care to prevent skin breakdown. An undated document titled Southwest Shower List indicated Resident 48 should receive showers on evening shift on Wednesdays and Saturdays. Shower/Skin Alteration Worksheets, dated September 2024, indicated Resident 48 received showers on 9/6/24, 9/11/24 and 9/25/24. A worksheet for 9/15/24 indicated Resident 48 refused his shower. No other showers or offerings of a shower were recorded between 9/11/24 and 9/25/24. A form titled I would like to know . provided by the Director of Nursing on 9/26/24 at 9:10 AM, indicated on 9/5/24, Resident 48 indicated he was concerned about missing showers. The Administrator's response noted on the form, dated 9/9/24, indicated Resident 48 received the first shower that week and had refused the second shower. He indicated the resident should receive showers on Wednesdays and Saturdays and he would review all shower schedules. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview, on 9/26/24 at 7:06 PM, Licensed Practical Nurse (LPN) 22 indicated evening shift showers were not being done consistently for the prior few months due to lack of staff to complete them. In an interview on, 10/1/24 at 10:16 AM, the Director of Nursing indicated she could not find any documentation of showers being provided or offered and refused between 9/11/24 and 9/25/24, except for a refusal recorded on a shower worksheet on 9/15/24. She indicated when staff were unable to provide a shower for a resident, it should be offered to the resident as soon as possible. She indicated habitual refusals would have been documented in a progress note and care planned. She indicated she was not aware of habitual refusals by Resident 48. A current policy titled Guidelines for Bathing, provided by the Administrator on 10/1/24 at 1:42 PM indicated bathing should occur to cleanse the skin and promote circulation. This citation is related to complaint IN00443976. 3.1-38(b)(3)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45794 Based on observation, interview and record review the facility failed to ensure supervision and maintain seizure precautions for 2 of 6 residents reviewed (Resident 32 and Resident 5). Findings include: During an observation, on 9/26/24 at 11:12 AM, upon entering the memory Care unit, a voice was heard calling for help. A staff member was observed entering the shower room. A voice was heard asking who the nurse was. The Director of Nursing (DON) wsa observed entering the shower room. On 9/26/24 at 11:55 AM, Resident 32 was observed leaving the unit on a gurney escorted by 2 paramedics. Resident 32 was covered with a blanket. In an interview, on 9/26/24 at 11:57 AM, Certified Nurse Aide (CNA) 30 indicated they had started working at the facility on 9/12/24 and they were being trained by CNA 35. CNA 30 indicated they entered the shower room after hearing the resident call for help. CNA 30 observed Resident 32 sitting on the floor in the shower with their right arm stuck in the handrail. CNA 30 indicated they were unable to remove Resident 32's arm from the handrail. CNA indicated Resident 32 had been in the shower room alone since 10:55 AM. CNA 30 indicated they were directed to place Resident 32 in the unsupervised by CNA 35. CNA 30 indicated they were not permitted to provide direct care to the residents until their training was complete but had been providing direct care due to a staffing shortage. CNA 30 indicated they were directed by CNA 35 to provide direct care due to low staffing. In an interview, on 9/26/24 at 12:05 PM, CNA 35 indicated Resident 32 was unsupervised in the shower room due to low staffing. CNA 35 indicated the unit had been short staffed for a few months. CNA 35 indicated the unit was often staffed with 1 CNA and 1 Qualified Medication Aide (QMA) (A CNA with medication training). CNA 35 indicated the unit QMA was on a break due to having stayed over from night shift. CNA 35 indicated the facility management was aware of the short staffing issues. CNA 35 indicated the corporate office would not allow the facility to use a staffing agency due to the cost. CNA 35 indicated CNAs in training were not supposed to provide resident care. CNA 35 indicated the Unit Manager had directed the CNA in training to provide direct care to residents due to low staffing. CNA 35 indicated the Unit Manager had directed the unsupervised shower of Resident 32. Resident 32's record was reviewed on 9/26/24 at 2:10 PM. Diagnoses included dementia, osteoarthritis, osteoporosis, and seizure disorder. Resident 32's Annual Minimum Data Set, (MDS) dated [DATE], indicated their Brief Interview for Mental Status (BIMS) score was 13 (no cognitive impairment). The MDS indicated the resident required partial to moderate assistance with showering or bathing. The MDS indicated the resident had 2 or more recent falls. Resident 32's Care Plan, dated 12/28/23, indicated the resident had a self-care deficit. The target goal was for the resident to participate in self-care with supervision through 9/17/24. Interventions included assisting the resident according to the resident's level of need and offering frequent rest breaks. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 32's Care Plan, dated 8/22/24, indicated the resident was at risk for falls. The target goal was to reduce risks to avoid significant injury from falls through 9/17/24. Interventions included increasing supervision and referring the resident to therapy. Resident 32's Care Plan, dated 9/7/24, indicated the resident required therapy due to decreased leg strength, impaired balance, decreased walking ability and a recent fall. The target goal was for the resident to receive therapy services through 9/17/24. Interventions included gait training, therapeutic exercise and neuromuscular re-education. Resident 32's Care Plan did not address their diagnosis of a seizure disorder. An Incident Description, dated 5/5/24 at 4:45 PM, indicated Resident 32 had a seizure while walking in the dining room. A Fall Risk Review, dated 5/6/24 at 12:50 PM, indicated Resident 32 had a fall risk of 10. The resident had normal gait and balance. An IDT note, dated 5/6/24 at 9:15 AM, indicated Resident 32 had a fall due to increased seizure activity. A new intervention was for the resident to be assisted by a staff member while walking until the resident was evaluated by a neurologist. An Incident Description, dated 7/9/24 at 6:30 PM, indicated Resident 32 had a seizure in their bathroom and had a laceration to their lip. An IDT note, dated 7/9/24 at 12:19 PM, indicated the resident had a fall due to seizure activity. A new intervention was to encourage the resident to call for assistance with toileting. A physician order, dated 5/16/24, indicated Resident 32 may have a camera in their room for safety due to a diagnosis of seizure disorder. Resident 32's physician orders did not indicate they were to have any other seizure or fall precautions. Resident 32's current Kardex, (care plan summary for CNAs), dated 9/26/24, indicated the resident had a camera in their room. The Kardex did not indicate the resident was at risk for falls. The Kardex did not indicate the resident had a seizure disorder or what interventions should be inplace to prevent falls. In an interview, on 9/30/24 at 2:50 PM, the DON indicated Resident 32 should not have been unsupervised in the shower room. The DON indicated Resident 32's Care Plan should have included interventions for seizure and fall precautions. The DON indicated seizure precautions and fall risk precautions should have been included on the resident's Kardex and omplemented from the care plan. An undated current facility policy, provided by the Regional Nurse Consultant on 9/27/24 at 11:51 AM, indicated residents were to never be left unattended in the shower room. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility policy, dated 6/20/23, provided by the Regional Nurse Consultant on 9/27/24 at 11:51 AM, indicated internal risk factors for falls included confusion, unstable joints, confusion, and weakness of the legs. The policy indicated external risk factors for falls included wet floors. The policy indicated the resident's Kardex would be updated as indicated. 46756 2) During an observation on 9/26/24 at 6:43 PM, a loud male voice was heard yelling for help. Resident 5 was lying on the floor on his right side next to a piano located across the hall from the dining room at the far end of the hall. Resident 5 was lying on his back turned slightly to the left on the floor with his feet near the piano positioned along the wall, his torso and head positioned toward the hallway. Licensed Practical Nurse (LPN) 22, LPN 25, and Registered Nurse (RN) 46 approached Resident 5 and asked him if he had any pain. Resident 5 indicated he had pain in his bottom. LPN 22, LPN 25, and RN 46 began to assist Resident 5 away from the piano bench, Resident 5 yelled out and complained of pain. Resident 5's current quarterly Minimum Data Set (MDS), dated [DATE], indicated their Basic Interview for Mental Status (BIMS) score was 4 (cognitively impaired). The MDS indicated the resident required moderate assistance to mobilize his wheelchair 50 feet with two turns and substantial assistance to mobilize his wheelchair 150 feet. Resident 5's current care plan, titled Pain indicated the resident had a problem of pain/discomfort, with a goal date of 11/5/24. Interventions included assess pain, notify physician as needed, acknowledge presence of pain and discomfort, listen to the resident's concerns, and document and report complaints and nonverbal signs of pain. Progress notes, dated 9/26/24 at 8:31 PM, indicated Resident 5 was heard yelling down the hall. He was found lying on the floor by the dining room with his head toward the dining room doors and feet toward the piano in lounge area. The notes indicated the resident was assessed for injuries with none found and assisted by 3 staff back into his chair. The resident was then assisted to the nurses' station for close monitoring. Vital signs and neurological checks were normal for the resident. The physician, family and Director of Nursing were notified. Progress notes, dated 9/27/24 at 1:49 PM, indicated two nurses attempted to assist Resident 5 to the toilet. When he stood while receiving the usual amount of assistance, he yelled out complaining of pain and indicated the pain was in his right hip. The physician was contacted with orders received to send to the emergency room for evaluation and treatment. Progress notes, dated 9/27/24 at 9:15 PM, indicated the nurse had received report from the hospital at about 5:00 PM and the resident was expected to return to the facility. The notes indicated the resident returned to the facility with new orders around 8:30 PM. No pain assessments were available for review. Emergency Department (ED) notes, dated 9/27/24 at 1:42 PM, indicated Resident 5 was brought into the ED with a complaint of right hip pain after a fall the previous evening. A hospital Xray report, dated 9/27/24 at 2:30 PM, indicated Resident 5 had a comminuted nondisplaced fracture of the right ischial tuberosity (part of the bone in the lower pelvis). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No progress notes or assessments related to pain interventions between 9/27/24 and 9/28/24 were available for review. Progress notes, dated 9/29/24 at 4:46 PM, indicated Resident 5 had a fractured pelvis. No pain assessments were available for review. A medication administration record (MAR), dated 9/29/24 at 2:52 PM, indicated Resident 5 received a one-time dose for oxycodone 5 mg, one tablet by mouth for pain. No pain assessment was available for review. Progress notes, dated 9/30/24 at 5:51 PM, indicated Resident 5 had increased pain and discomfort. New orders for oxycodone 5 mg, two tablets by mouth every four hours as needed for pain was received. Resident 5's record was reviewed on 10/1/24 at 11:15 AM. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, weakness, vascular dementia, and impulse disorder. In an interview, on 10/1/24 at 11:30 AM, LPN 47 indicated residents should be checked for injuries prior to moving when found on the floor. When a resident would report pain, the doctor would be notified, and his orders should be followed before moving the resident. A current policy titled Guidelines for Incidents/Accidents/Falls, dated 6/30/23, provided by Regional Nurse Consultant 27 on 9/30/24 at 2:25 PM, indicated upon the occurrence of a fall, a nurse should assess the resident for pain and notify the provider. The policy indicated documentation of the resident's physical and mental status should be completed at least every shift over the next 72 hours or until the condition improved. 3.1-37(a)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45794 Based on observation, interview and record review the facility failed to ensure adequate supervision to prevent resident elopement, falls and ensure safe smoking for 4 of 6 residents reviewed (Residents 32, Resident 19, Resident 64 and Resident 76). Findings include: 1. On 9/26/24 at 11:12 AM, a voice was heard calling for help. A staff member was observed entering the shower room. A voice was heard asking who the nurse was. The Director of Nursing (DON) entered the shower room. A voice was heard saying they were unable to stand the resident up. An overhead page was heard summoning the maintenance staff to the unit STAT (immediately). On 9/26/24 at 11:55 AM, Resident 32 was observed leaving the unit on a gurney escorted by 2 paramedics. Resident 32 was covered with a blanket. In an interview, on 9/26/24 at 11:57 AM, Certified Nurse Aide (CNA) 30 indicated they had started working at the facility on 9/12/24 and they were being trained by CNA 35. CNA 30 indicated they entered the shower room after hearing the resident call for help. CNA 30 observed Resident 32 sitting on the floor in the shower room with their right arm stuck in the handrail. CNA 30 indicated they were unable to remove Resident 32's arm from the handrail. CNA 30 indicated Resident 32 had been in the shower room alone since 10:55 AM. CNA 30 indicated they were directed by CNA 35 to place Resident 32 in the shower unsupervised. CNA 30 indicated they were not permitted to provide direct care to the residents until their training was complete but had been providing direct care due to a staffing shortage. CNA 30 indicated they were directed by CNA 35 to provide direct care due to low staffing. In an interview, on 9/26/24 at 12:05 PM, CNA 35 indicated Resident 32 was unsupervised in the shower room due to low staffing. CNA 35 indicated the unit had been short staffed for a few months. CNA 35 indicated the unit was often staffed with 1 CNA and 1 Qualified Medication Aide (QMA) (a CNA with medication training). CNA 35 indicated the unit QMA was on a break due to having stayed over from night shift. CNA 35 indicated the facility management was aware of the short staffing issues. CNA 35 indicated the corporate office would not allow the facility to use a staffing agency due to the cost. CNA 35 indicated CNAs in training were not supposed to provide resident care. CNA 35 indicated the Unit Manager had directed the CNA in training to provide direct care to residents due low staffing. CNA 35 indicated the Unit Manager had directed the unsupervised shower of Resident 32. In an interview, on 9/26/24 at 1:50 PM, the Maintenance Director (40) indicated they had been summoned to the shower room to remove a handrail. The Maintenance Director indicated they observed Resident 32 sitting on the floor with their right arm lodged in the handrail. The Maintenance Director indicated they left the unit to get a drill and upon their return, Resident 32's arm was no longer stuck in the handrail. Resident 32's record was reviewed on 9/26/24 at 2:10 PM. Diagnoses included dementia, osteoarthritis and seizure disorder. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 32's Annual Minimum Data Set (MDS), dated [DATE], indicated their Brief Interview for Mental Status (BIMS) score was 13 (no cognitive impairment). The MDS indicated the resident required partial to moderate assistance with showering or bathing. The MDS indicated the resident had 2 or more recent falls. The MDS indicated Resident 32 had diagnoses of arthritis, osteoporosis, dementia and seizure disorder. Resident 32's Care Plan, dated 12/28/23, indicated the resident had a self-care deficit. The target goal was for the resident to participate in self-care with supervision through 9/17/24. Interventions included assisting the resident according to the resident's level of need and offering frequent rest breaks. Resident 32's Care Plan, dated 8/22/24, indicated the resident was at risk for falls. The target goal was to reduce risks to avoid significant injury from falls through 9/17/24. Interventions included increasing supervision and referring the resident to therapy. Resident 32's Care Plan, dated 9/7/24, indicated the resident required therapy due to decreased leg strength, impaired balance, decreased walking ability and a recent fall. The target goal was for the resident to receive therapy services through 9/17/24. Interventions included gait training, therapeutic exercise and neuromuscular re-education. An Incident Description, dated 1/8/24 AT 7:00 am, indicated Resident 32 had impaired memory, decreased strength and endurance and had not been using their walker. A Fall Risk Review, dated 1/8/24 at 8:14 AM, indicated Resident 32 had a fall risk score of 12 (a fall risk score 10 or above is high risk). The review indicated Resident 32 required an assistive device to walk. An Interdisciplinary Team (IDT) note, dated 1/8/24 at 9:30 AM, indicated Resident 32 lost their balance and did not have their walker within reach. A new intervention was to place a reminder sign on the resident's walker. A Fall Risk Review dated 8/16/24 at 12:25 AM, indicated Resident 32 had a fall risk score of 9. The review indicated Resident 32 required the use of an assistive device to walk An Incident Description, dated 8/22/24 at 5:50 AM, indicated Resident 32 fell while getting clothes from their closet and had swelling above their right eye. A Fall Risk Review dated 8/22/24 at 7:10 AM, indicated Resident 32 had a fall risk score of 9. The review indicated Resident 32 had a balance problem while standing and walking. An IDT note, 8/22/24 at 9:54 AM, indicated Resident 32 had lost their balance and fell while getting clothes from their closet. A new intervention was to remain with the resident while choosing their clothes. An Incident Description, dated 9/5/24 at 7:30 PM, indicated Resident 32 fell while getting their pajamas. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Fall Risk Review, dated 9/5/24 at 8:00 PM, indicated Resident 32 had a fall risk score of 9. The review indicated Resident 32 had a normal gait, normal balance, required the use of an assistive device to walk. An IDT note, dated 9/6/24 at 9:42 AM, indicated Resident 32 fell while getting night clothes from their closet. A new intervention was for staff to lay out night clothes after supper each night. Resident 32's current Kardex, (care plan summary for CNAs), dated 9/26/24, indicated the resident's preference for bathing was to have a shower. The Kardex indicated Resident 32 required assistance with the application and removal of stockings and to lay out the resident's clothes after supper. The Kardex did not indicate the resident was at risk for falls. The Kardex did not indicate Resident 32 required assistance with walking. The Kardex did not indicate the resident had a seizure disorder. On 9/27/24 at 9:45 AM, purple and blue bruises were observed on Resident 32's right lower forearm. An arm sling was above the resident's elbow. Resident 32 indicated they had moved the sling out of the way. Resident 32 indicated they must have bumped their arm on the table. In an interview, on 9/30/24 at 2:50 PM, the DON indicated Resident 32 should not have been unsupervised in the shower room. The DON indicated Resident 32's Care Plan should have included interventions for fall precautions. The DON indicated fall risk precautions should have been included on the resident's Kardex. 46156 2. Resident 19's record was reviewed on 9/27/24 at 10:00 AM. Diagnoses included bipolar disorder, anxiety disorder, delusional disorders, complete traumatic amputation of right lower leg, idiopathic peripheral autonomic neuropathy, muscle weakness, and lack of coordination. Resident 19's current quarterly Minimum Data Set (MDS), dated [DATE], indicated her Basic Interview for Mental Status (BIMS) score was 8, moderate cognitive impairment. The MDS indicated for 7 to 11 days in a period of 14 days, she felt tired or had little energy, had trouble concentrating, poor appetite and was on an antidepressant. The MDS indicated the resident was impaired on 1 side of her lower extremity and used a wheelchair. The MDS indicated she required substantial/maximal assist with rolling left to right, transfers, and toileting. Resident 19's current care plan, initiated 2/12/24, indicated her care plan focus was high risk for elopement/wandering related to her bi-polar disorder. The goal of her focus area was the resident would not wander out of the facility or off the floor with a target date of 11/7/24. Interventions included Wanderguard placed initiated 6/10/24, assess/record/report to Medical Doctor (MD) risk factors for potential elopement initiated 2/12/24, and supervise closely and make regular compliance rounds whenever the resident was in her room initiated 2/12/24. Resident 19's quarterly MDS, dated [DATE], indicated their Basic Interview for Mental Status (BIMS) score was 15 (cognitive intactness). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Care Plan Meeting progress note, dated 5/2/24 at 8:54 AM, indicated when Resident 19 went outside she was to be monitored. The note indicated the resident was not able to physically sign for herself anymore. The note indicated the facility was requesting the MD to evaluate Resident 19 to see if guardianship (a legal process that gives a person or entity the authority to make decisions for another person, called a ward, who is considered incompetent) was appropriate. Resident 19's Elopement Risk Review, dated 5/7/24, indicated there were questions to complete; only one question was completed. The Elopement Risk total score was not determined due to the other questions being left blank; the Elopement Risk total score indicated not applicable (NA). Resident 19's MDS, dated [DATE], indicated her BIMS score was 9 (moderate cognitive impairment). A progress note, dated 6/9/24 at 1:11 PM, indicated Resident 19 was found by activity personnel outside on the pavement of the parking lot lying on her right side. The resident indicated a non-employee let her out of the building. The resident fell from the sidewalk curb and reported hitting her head. Abrasions were found on the resident's left knee, redness found on her right elbow/shoulder, and swelling/discoloration on the right side of her forehead/temple. Resident 19 reported slight pain to her head and right hip immediately after the incident; ice was applied to the area. A Fall Risk Assessment, dated 6/9/24 at 12:54 PM, indicated Resident 19's incident occurred in the morning. The assessment indicated the resident was wheelchair bound, had predisposing factors of mental status changes, impaired memory, depression, decreased safety awareness, and was non-compliant with safety instructions. The assessment indicated the resident was using an electric wheelchair outside without supervision. The resident did not inform nurses she was going outside, the resident did not sign out to go outside, and per the resident a visitor let the resident out of the facility to the outside. An Interdisciplinary Team (IDT) note, dated 6/10/24 at 9:42 AM, indicated the fall incident on 6/9/24 at 12:54 PM, root cause was due to the resident leaving the building without assistance. A Wanderguard was applied to resident. Resident 19's Elopement Risk Review, dated 8/19/24, indicated there were questions to complete, but only one question was completed. The Elopement Risk total score was not determined due to questions not completed. The Elopement Risk total score indicated NA. During an observation, on 9/25/24 at 9:05 AM, the facility was noted to have 3 sets of doors to get to the outside from the resident rooms where Resident 19 lived to the location Resident 19 was found on 6/9/24 on the ground outside. The first set of doors led from the Resident 19's home location in the facility, required a code to be entered into a security numerical code pad or an alarm would sound, had wooden double swing doors, and led to a lounge area. The second set of doors led from the lounge area, had a security numerical code pad (not on during day hours), metal double swing doors, and led to the anteroom (small room, that led into a larger more important room). The third set of doors allowed exit from the anteroom of the facility, required no code for entrance/exit, had metal double swing door, and led to the outside of the building to sidewalks and the front parking lot. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview, on 10/2/24 at 1:42 PM, the Director of Nursing (DON) indicated Former Employee 45, working on the Assisted Living unit, was looking out the large main window in the Facility's Assisted living (located midway down the unit) and observed Resident 19 exit the building. The DON indicated Employee 45 went to find Resident 19 (down half the corridor of the Assisted living, through the facility's lobby, through one set of doors, through the anteroom, through the second set of doors, and to the outside of the building). The DON indicated Former Employee 45 indicated before she could reach Resident 19 she fell out of her wheelchair outside the facility. The DON indicated the incident was reviewed and was decided it was not an elopement (a resident who leaves a healthcare facility without authorization or supervision) and was not investigated as an elopement. A current policy titled, Elopement and Missing Resident Prevention, reviewed 4/20/23, provided by the Registered Nurse (RN) 27 on 9/30/24 at 2:18 PM, indicated all residents would be provided adequate supervision to meet personal and nursing needs and be assessed for behaviors/conditions that put them at risk for elopement. The policy indicated all resident would be assessed for risk of elopement annually, quarterly, and with any significant change which included any attempt or actual elopement. Resident 19's record was reviewed on 9/27/24 at 10:00 AM. Diagnoses included bipolar disorder, anxiety disorder, delusional disorders, complete traumatic amputation of right lower leg, idiopathic peripheral autonomic neuropathy, muscle weakness, and lack of coordination. 46756 3) During an observation, on 9/26/24 at 9:05 AM, Resident 76 was observed seated on a bench, smoking a pipe in front of the building about 50 feet from the front door. During an interview, on 9/26/24 at 10:22 AM, Resident 76 indicated he was required to sign out at the nurses' station each time he goes out to smoke . He indicated he was supposed to turn in his smoking materials for staff to lock up, but he would occasionally keep them in his room when staff was not around or too busy. He indicated he did not have a way to lock the materials up in his room. Resident 76's record was reviewed on 9/26/24 at 10:28 AM. Diagnoses included diabetes mellitus type 2, acute systolic heart failure, and muscle weakness. Resident 76's current quarterly, Minimum Data Set (MDS), dated [DATE], indicated their Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact). A smoking assessment, dated 9/5/24, indicated a smoking apron was recommended for Resident 76, he was educated on its use, and he did not wish to use it. Resident 76's current care plan did not include identification of risk factors, gals, or interventions pertaining to Resident 76's smoking activities. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 9/30/24 at 1:34 PM, the Social Services Director (SSD) indicated upon admission, when a resident had a history of smoking, a smoking evaluation should be performed by therapy. The resident's ability to open and close the facility door and handle smoking materials appropriately would be assessed. The SSD indicated staff was aware of who smoked by common knowledge and by reading the Kardex. Residents must follow smoking assessment recommendations to be allowed to continue to smoke. She indicated a care plan should be in place to inform the staff of a resident's smoking status and any special instructions, such as signing out of the building to smoke, care of smoking materials and any devices needed to smoke safely. A current policy titled Smoking Policy, dated 6/10/23, provided by Regional Nurse Consultant 27 on 9/30/24 at 2:15 PM, indicated residents should be assessed for safe smoking behavior prior to smoking at the facility. The policy indicated education should be provided to the resident and staff based on the results of the smoking assessment. The policy indicated the care plan and certified nurse aide assignment sheets. 4) Resident 64's record was reviewed on 9/26/24 at 10:51 AM. Diagnoses included dementia, severe with other behavioral disturbances, delusional disorders, major depressive disorders, and muscle weakness. Resident 64's current quarterly Minimum Data Set (MDS), dated [DATE], indicated their Basic Interview for Mental Status (BIMS) score was 4 (cognitively impaired). The MDS indicated the resident required substantial assistance to move from sitting to standing positions and transferring in and out of a chair. A fall investigation, dated 8/27/24 at 1:21 PM, indicated Resident 64 slid down her wheelchair onto her calf cushion and tipped her wheelchair forward, causing her to change planes. The form indicated Resident 64 had impaired memory and decreased safety awareness. No additional care plan interventions were added on the document. A fall risk review, dated 8/27/24, indicated Resident 64 was at high risk for falls. A fall investigation, dated 9/17/24 at 2:15 AM, indicated Resident 64 was sleeping in a recliner in the lounge when the nurse heard a noise, checked on the resident and found her sitting on the floor in front of the recliner. A fall investigation, dated 9/17/24 at 9:20 PM, indicated Resident 64 was sitting in the recliner in the lounge with her feet up and scooted down to the foot of the recliner. The CNA on duty attempted to scoot the resident back in the chair but was alone on the hall with no one to assist her so she had to lower the resident to the floor. Resident 64's current care plan titled Fall Risk indicated the resident had a problem of being at risk of falls, with a goal date of 10/29/24. No new fall interventions were added after the 8/27/24 fall from the wheelchair. On 9/27/24 an intervention of raising the footrest while the resident was in the recliner was added. No additional interventions were added on 9/27/24. During an observation, on 9/26/24 at 7:01 PM, the recliners were observed located in a lounge located at the end of a short hallway across from the nurses' station. The recliners were not visible from the hallways where the residents on the southwest unit resided. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An as worked schedule for 9/17/24, confirmed by payroll records, indicated one CNA was assigned to the Southwest unit at the 9:20 PM when Resident 64 slid down to the end of the recliner in the lounge. In an interview on 10/1/24 at 10:22 AM, the Director of Nursing indicated she was aware that Resident 64 fell from the recliner twice in the same day. She indicated short staffing was a factor in the falls. A current policy titled Guidelines for Incidents/Accidents/Falls, dated 6/30/23, provided by Regional Nurse Consultant on 9/30/24 at 2:25 PM, indicated each fall should have a new care plan intervention added. 3.1-45(a)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45794 Based on observation, interview and record review, the facility failed to provide trauma informed care by identifying triggers to minimize re-traumatization for 1 of 2 residents reviewed (Resident 41). Findings include: Resident 41's record was reviewed on 9/27/24 at 3:00 PM. Diagnoses included systemic lupus erythema, adult failure to thrive, anxiety disorder, bipolar disorder, schizophrenia, cognitive communication deficit, obsessive compulsive disorder, depression, agoraphobia with panic disorder and posttraumatic stress disorder (PTSD). Resident 41's Quarterly Minimum Data Set, (MDS), dated [DATE], indicated their Brief Interview for Mental Status (BIMS) score was 6 (severe cognitive impairment). The MDS indicated Resident 41had a gastrointestinal (g tube) feeding tube. Resident 41's Care Plan, dated 5/20/24, indicated the resident had a diagnosis of PTSD. The target goal was for Resident 41 to be symptom free through 11/22/24. Interventions included sensitivity to the resident's feelings, encouragement of healthy coping strategies, open discussion, administration of psychoactive medications, observance and documentation of behaviors. The Care Plan did not indicate potential triggers for behaviors. The Care Plan did not indicate specific PTSD symptoms. Resident 41's Care Plan, dated 5/22/24, indicated the resident had a history of trauma. Resident 41's triggers were still being determined. Resident 41 coped by speaking with their boyfriend. The target goal was for the resident to feel safe and comfortable through 11/22/24. Interventions included findings things of comfort and encouraging the resident to use them. A Trauma Screening, dated 5/21/24, indicated Resident 41's trauma score was 4. The screening indicated the score was determined by the number of yes answers. The screening indicated a score of 5 or more was high risk for trauma related symptoms. A progress note, dated 5/28/24 at 9:40 AM, indicated Resident 41 had a history of tobacco use, alcohol use and elicit drug use. Resident 4 1 had been found in an unresponsive state at home by their boyfriend. Resident 41 had been covered with urine and stool for an unknown amount of time. A progress note, dated 9/13/24 at 4:11 PM, indicated Resident 41's boyfriend had been verbally abusive. The boyfriend was noted to use a loud voice and told Resident 41 they should stop crying and to get up and walk. Resident 41 had been crying and reported they were afraid of their boyfriend. The boyfriend left the facility after being asked to calm down. Adult Protective Services (APS) were notified. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 41's Kardex (care plan summary for direct care staff) did not indicate the resident had PTSD. The Kardex indicated Resident 41 would be symptom free through 11/22/24. Interventions included being sensitive to feelings, encouraging healthy coping mechanisms, acknowledgment by the resident of safety, open discussion by the resident, psychoactive medications and observation and documentation of behaviors. A progress note, dated 924/24 at 2:40 AM, indicated Resident 41 had been calling out for their boyfriend. A progress note, dated 9/20/24 at 2:42 PM, indicated Resident 41had been lying in bed yelling out. Resident 41 was calling for help and had stated he said I am going to lose my apartment if I don't go home and work. A progress note, dated 9/15/24 at 11:16 AM, indicated Resident 41 had been screaming and crying. Resident 41 kept referring to a traumatic event that had occurred on Friday. A new medication for panic disorder was ordered by the Psychiatric Nurse Practitioner. On 9/27/24 at 3:00 PM, Resident 41 was observed sitting in their wheelchair near the nurse station crying. Resident 41 indicated they did not have a car and asked to borrow a car or get a ride with someone to leave the facility. In an interview, on 10/1/24 at 11:40 AM, Qualified Medication Aide (QMA) 28 indicated they were not aware of Resident 41's visitation monitoring. QMA 28 indicated they did not work Resident 41's unit very often. QMA 28 indicated they were aware of Resident 41's boyfriend being nasty to the resident in the past. In an interview, on 10/1/24 at 1:36 PM, The Social Service Director (SSD) indicated Resident 41 had an extensive history of trauma that included multiple sexual assaults. The SSD indicated Resident 41's boyfriend had left Resident 41 unattended for an undetermined time. The SSD indicated they were not aware of any specific triggers or stressors. The SSD indicated the facility was aware of Resident 41's abusive episodes in the past. The SSD indicated Resident 41's boyfriend was the resident's Power of Attorney (POA). The SSD indicated the episode on 9/13/24 was the first time Resident 41 had asked for help. The SSD provided Resident 41's Adult Protective Services (APS) Case Manager contact information. The SSD indicated they had provided copies of all Resident 41's documentation. A current facility policy, dated 12/6/16, provided by the Regional Nurse Consultant on 9/30/24 at 9:30 AM, indicated all individuals should be treated as if they may have experienced trauma. The policy indicated trauma is primary to the development of addiction and mental health problems. The policy indicated the facility must ensure culturally competent, trauma informed care with professional standards of practice in order to eliminate or mitigate triggers that may cause re-traumatization.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 46756 Based on interviews and record review, the facility failed to ensure sufficient nursing staff to meet the anticipated and unanticipated needs for 82 of 82 residents residening in the facility receiving nursing services. Findings include: An Indiana Department of Health complaint intake, dated 9/10/24 at 8:14 PM, indicated on 9/10/24 one nurse, one QMA, and one CNA were scheduled in the building for the evening shift. The complaint indicated CNAs frequently work on a hall by themselves with over 30 residents to assist to bed. An as worked schedule form, verified by payroll records, dated 9/10/24, indicated one certified nurse aide worked between 6:30PM and 10:00 PM for a total of 89 residents. One QMA worked on the Southwest Unit with 38 residents, one LPN worked on the Northwest Unit with 22 residents, and one LPN worked on the dementia unit with 18 residents. An Indiana Department of Health complaint intake, dated 9/18/24 at 7:32 AM, indicated one CNA was present in the building to assist residents to get up and dressed for breakfast. She indicated 80 residents were in the building. An as worked schedule form, verified by payroll records, dated 9/18/24, indicated one CNA worked from 6:02 AM to 6:30 PM. No additional CNAs were on the schedule until 1:22 PM. An Indiana Department of Health complaint intake, dated 9/20/24 at 7:28 AM, indicated the dementia unit had been staffed with one staff member for 18 residents to provide all nursing and aide care. The complainant indicated they were unable to complete all needed services for the residents and feared risking injury to themselves or residents. An as worked schedule form, verified by payroll records, dated 9/20/24 indicated three certified nurse aide worked between 7:00 PM and 10:00 PM. The schedule indicated the CNA from the dementia unit had been pulled from the unit to help on the other units. An Indiana Department of Health complaint intake, dated 9/24/24 at 2:34 PM, indicated on 9/21/24 there were no aides during the first and second shifts for one hall, and on 9/22/24 there was one aide for 36 residents on one hall. On 9/22/24 evening shift there was one aide on one hall for the second and third shift and no aides on the other hall. An as worked schedule form, verified by payroll records, dated 9/21/24 indicated two CNAs were scheduled between 6:00 PM and 10:00 PM. One CNA was scheduled for the night shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An as worked schedule form, verified by payroll records, dated 9/22/24 indicated two CNAs were present from 6:00 AM to 6:00 PM, with an additional aide working 6:00 AM to 2:00 PM for the Southwest and Northwest units. No CNAs were scheduled on the dementia unit for the day, evening, or night shift. The dementia unit was staffed with an LPN for 15.53 hours and a QMA for 10.25 hours in the 24-hour period. The Center for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report for the facility's fiscal year third quarter of 2024 from April 1 - June 30 was reviewed. The PBJ triggered a one-star staff rating (the star rating system was 1-5 with nursing homes with 5 stars considered much above average quality and nursing homes with 1 star considered much below average quality). During an observation and interview, on 9/26/24 at 6:36 PM, the dementia unit halls and lounge were dimly lit. Qualified Medicine Aide (QMA) 21 indicated some of the residents who had been up for days without sleep had finally gone to sleep, so the staff tried to keep the unit darker and quiet to provide a good sleeping environment. 5 residents were seated in recliners in the resident lounge that was also dimly lit. QMA 21 indicated she and a nurse were working on the dementia unit that evening. She indicated the building had better staffing than usual that evening. She indicated most evenings she had to put her residents to bed quickly and then go out to the outer units and assist other halls with putting people to bed, leaving the unit unattended. She indicated staff started getting residents up between 6 and 6:30 in the morning, but since so many residents go to bed so early, they get up around 2:00 AM. She indicated the night shift has one staff member on the unit most of the time. See F689 for additional information on an accident occurring on the dementia unit involving an unattended resident falling in the shower while only one certified nurses' aide was present on the unit. In an interview, on 9/26/24 at 12:05 PM, CNA 35 indicated Resident 32 was unsupervised in the shower room due to low staffing. CNA 35 indicated the unit had been short staffed for a few months. CNA 35 indicated the unit was often staffed with 1 CNA and 1 Qualified Medication Aide (QMA) (a CNA with medication training). CNA 35 indicated the unit QMA was on a break due to having stayed over from night shift. CNA 35 indicated the facility management was aware of the short staffing issues. CNA 35 indicated the corporate office would not allow the facility to use a staffing agency due to the cost. CNA 35 indicated CNAs in training were not supposed to provide resident care. CNA 35 indicated the Unit Manager had directed the CNA in training to provide direct care to residents due low staffing. CNA 35 indicated the Unit Manager had directed the unsupervised shower of Resident 32. In an interview, on 9/26/24 at 1:50 PM, the Maintenance Director (40) indicated The Maintenance Director indicated many staff members had left the facility recently. The Maintenance Director indicated the staff members who remained were overworked and the new staff members didn't know what they were doing yet. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 9/26/24 at 6:43 PM, Licensed Practical Nurse (LPN) 25 and Registered Nurse (RN) 46 were each at separate medication carts placing pills in medication cups. LPN 22 was observed talking with a resident near the southwest lounge area across from the nurse's station. LPN 22 indicated she came on duty at 6:00 pm and had not been able to attend to shift report because the unit had been so busy. She indicated one CNA was on duty and 2 Basic Nurse Aides (BNA)s were on duty for the evening shift. She indicated this evening was better staffed than usual. She indicated she had come in on several shifts where no second shift CNAs were present, and she was responsible for all the needs of the 38 residents on the unit. She indicated she had called the scheduler for assistance, but did not receive a response. During an interview, on 9/26/24 at 6:49 PM, LPN 23 indicated she was working on the northwest unit with 2 CNAs. She indicated she normally worked with 1 CNA. She indicated nine residents on the unit required a full body sling lift, requiring two staff to perform the lift. She indicated when she assisted the CNA with the lift, there were no staff on the unit available to watch the residents on the unit who were at high risk for falls. She indicated one CNA on the unit was not enough to meet the anticipated and unanticipated needs of the resident on the unit. During an interview, on 9/26/24 at 6:58 PM, CNA 24 indicated he came in to work early at 4:00 PM to assist on an understaffed shift. He indicated staffing at the facility on second shift had been very bad in the last few months. He indicated staff had not called and not come to work and continue to work for the facility. He indicated he had not heard of any disciplinary action being taken on habitual offenders who violate the attendance policy. He indicated employees who had terminated employment continued to be placed on the schedule for weeks after they no longer work for the facility. He indicated people were added to the schedule on their days off without their knowledge. See F689 for additional information on a resident residing on the northwest unit eloping from the facility and falling in the parking lot. During a confidential interview, on 9/26/24 at 10:10 AM, a staff member indicated they did not have sufficient staff to monitor residents when they were wandering. During an interview, on 9/26/24 at 7:04 PM, LPN 25 indicated she had worked the day shift and was supposed to leave at 6:30 PM. She indicated there were two nurses and one CNA on the unit on the day shift, so much of her day was consumed with answering call lights, toileting residents and other immediate care needs. She indicated she was finishing passing medications that were overdue because she had fallen so far behind. During an interview, on 9/26/24 at 7:06 PM, LPN 23 indicated she was on the hall with 38 residents and no aide on 9/23/24. She indicated a resident had fallen behind the doors and she had no one on the unit to monitor the residents on the unit while she enlisted help from another hall to help her get the resident up off the floor. She indicated names were placed on the schedule for people who no longer work in the facility. She indicated 7 residents on the unit required the use of a mechanical lift and two assist to transfer. She indicated when she reports to work and does not have an aide to work with, the facility management would only give her suggestions of people to call and ask if they are willing to pick up a shift. She said the responsibility to call people in lies on the employees in the building who are already struggling to provide care for the residents. See F677 for more information on a resident not receiving showers as scheduled due to low staffing. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview, on 9/26/24 at 7:06 PM, Licensed Practical Nurse (LPN) 22 indicated evening shift showers were not being done consistently for the prior few months due to lack of staff to complete them. See F689 for more information on a resident requiring two staff to assist to transfer being lowered to the floor due to only one staff member being present on the unit. A fall investigation, dated 9/17/24 at 9:20 PM, indicated Resident 64 was sitting in the recliner in the lounge with her feet up and scooted down to the foot of the recliner. The CNA on duty attempted to scoot the resident back in the chair but was alone on the hall with no one to assist her so she had to lower the resident to the floor. During an interview on 10/1/24 at 10:22 AM, the Director of Nursing indicated she indicated staffing was her biggest concern in the building. She indicated some CNA staff had returned to school and were unable to work, many nurse aides in training had quit during their training and others had not completed their certification as anticipated. She indicated the facility had been using agencies in the past, but their corporate office had not allowed any staffing use since June 2024. The Facility Assessment Tool, last updated 6/26/24-6/28/24, was reviewed during Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (QAPI) committee. The Facility Assessment Tool indicated an average daily census of 77-85; the facility consisted of 100 licensed beds with 16 beds in memory care. Current census was 82. Staffing included: Projected needed hours per day: CNA Day Shift 60-75 hours CNA Eve Shift 45-67.5 hours CNA Night Shift 22.5-30 hours 3-4 Hours worked as verified per as worked schedule and payroll records indicated the following: 9/1/24 Day shift: 38 hours Evening shift: 20.25 hours Night shift: 0 hours 9/2/24 Day shift: 31.5 hours Evening shift: 39.25 hours Night shift: 7.5 hours (continued on next page)

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	155118	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Lagrange Skilled Nursing Facility, The	787 N Detroit St Lagrange, IN 46761

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9/3/24 Day shift: 30.75 hours Evening shift: 25 hours Night shift: 7.5 hours 9/4/24 Day shift: 15.5 hours Evening shift: 18 hours Night shift: 7.5 hours 9/5/24 Day shift: 32 hours Evening shift: 30.5 hours Night shift:0 hours 9/6/24 Day shift: 37.75 hours Evening shift: 28 hours Night shift: 22.5 hours 9/7/24 Day shift: 36.25 hours Evening shift: 22 hours Night Shift: 7.75 hours 9/8/24 Day shift: 30.25 hours Evening shift: 25.75 hours Night shift: 15 hours (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9/9/24 Day shift: 38 hours Evening shift: 27.5 hours Night shift: 5 hours 9/10/24 Day shift: 30 hours Evening shift: 23 hours Night shift: 15.75 hours 9/11/24 Day shift: 38 hours Evening shift: 38.5 hours Night shift: 18.5 hours 9/12/24 Day shift: 38.5 hours Evening shift: 27.75 hours Night shift: 7.5 hours 9/13/24 Day shift: 39 hours Evening shift: 15.5 hours Night shift: 7.5 hours 9/14/24 Day shift: 45.25 hours Evening shift: 29.75 hours Night shift: 7.5 hours (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9/15/24 Day shift: 30.25 hours Evening shift: 44.75 hours Night shift: 15 hours 9/16/24 Day shift: 26 hours Evening shift: 27.75 hours Night shift: 7.5 hours 9/17/24 Day shift: 28.75 hours Evening shift: 12.75 hours Night shift: 0 hours 9/18/24 Day shift: 15 hours Evening shift: 22.25 hours Night shift: 15.5 hours 9/19/24 Day shift: 30 hours Evening shift: 42.75 hours Night shift: 15 hours 9/20 /24 Day shift: 53 hours Evening shift: 31.25 hours Night shift: 15 hours (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9/21/24 Day shift: 37.5 hours Evening shift: 27.25 hours Night shift: 7.5 hours 9/22/24 Day shift: 31 hours Evening shift: 18.25 hours Night shift: 0 hours 9/23/24 Day shift: 47.25 hours Evening shift: 36.5 hours Night shift: 0 hours 9/24/24 Day shift: 37.5 hours Evening shift: 24 hours Night shift: 8 hours 9/25/24 Day shift: 30 hours Evening shift: 33 hours Night shift: 15 hours 9/26/24 Day shift: 45 hours Evening shift: 38.25 hours Night shift: 14.5 hours (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9/27/24 Day shift: 38 hours Evening shift: 37.25 hours Night shift: 15.25 hours The Facility Assessment Tool, last updated 6/26/24-6/28/24, reviewed during Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (QAPI) committee, was provided by the Executive Director on 9/25/24 at 9:30 AM. The tool indicated resources necessary to care for residents competently during day-to-day operation and emergencies. The tool is used to make decisions concerning the direct care of staffing needs to ensure residents are provided care, so residents maintain and or attain their highest practicable physical, mental and psychosocial well-being. The tool included a staffing plan based on a resident daily census between 77-85 and included a budgeted and staffing plan. This citation is related to complaints IN 00443025, IN00443527, IN00443716 and IN00443976. 3.1-17(a)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 46756 Based on observation, interview, and record review, the facility failed to ensure nursing staffing numbers including the facility name, date, facility census, total number and actual hours worked per shift by licensed and unlicensed direct care staff were posted in an area accessible to residents and visitors. for 82 of 82 residents resided in the building. Findings include: During an observation, on 9/25/24 at 1:00 PM, a plastic document holder was observed in the front lobby area next to postings of Resident Rights and names, addresses and phone numbers of state agencies. A set of doors at the end of the lobby were locked with a push- button activator to open the doors leading to the area of the building where residents resided. The doors required a keypad code to be entered to reach the lobby area from the area where the residents resided. An additional door was observed, with a keypad entry and exit code required, which lead to the locked dementia unit. During an interview, on 9/25/24 at 3:29 AM, the Administrator indicated the signs had been recently moved to their current location. He was unsure of the location of the posting of nursing hours, but indicated he would find out. During an observation and interview, on 9/25/24 at 3:53 PM, the Administrator pointed to the empty plastic document holder near the resident rights posting and indicated the nursing hours should be posted in that location, and he would provide a copy. During a record review, on 9/25/24 at 3:57 PM, a document titled daily staffing 9/26/24 was reviewed. The document indicated the census was 80, but no nursing hours were indicated on the form. During an interview on 9/25/24 at 4:20 PM, the Director of Nursing indicated the Daily Staffing form posted in the lobby was dated 9/26/24, indicated the next day's date and a census of 80, which should have reflected a census of 82. During an observation, on 9/30/24 at 11:51 AM, a staffing notice, dated 9/27/24, was posted in the lobby. A current undated policy titled BIPA Staffing Posting Requirement indicated the facility specific shift schedule for the 24-hour period should be posted. The policy indicated the post should include the number and category of nursing staff employed or contracted by the facility for each 24-hour period, as well as the number of hours worked by licensed staff and staff who are directly responsible for resident care. The policy indicated the data must be in a conspicuous, prominent location, accessible to residents and visitors.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45794 Based on observation, interview and record review, the facility failed to ensure specific resident behaviors were identified, investigated and communicated with individualized interventions for a resident with dementia for 1 of 1 resident reviewed (Resident 49). Findings include: On 9/26/24 at 11:15 AM, Resident 49 was observed standing up from dining room table. Resident 49 was observed walking while pushing their locked wheelchair. Resident 49 spoke in an agitated voice when they were being followed. Resident 49's record was reviewed on 9/27/24 at 11:36 AM. Diagnoses included alcohol dependence with alcohol induced dementia, anxiety disorder, major depressive disorder, psychotic disorder with hallucinations and mild cognitive impairment. Resident 49's Admission Minimum Data Set (MDS), dated [DATE], indicated Resident 49's Brief Interview for Mental Status (BIMS) was 10 (moderate cognitive impairment). The MDS indicated Resident 49 required partial to moderate assistance with mobility, bathing and dressing. The MDS indicated Resident 49 had diagnoses of non-Alzheimer's dementia, anxiety and depression. Resident 49's Care Plan, dated 7/29/24, indicated the resident displayed behaviors of hitting, kicking, pinching, throwing things, delusions, hallucinations, raising of voice, making sexual comments, irritability, lashing out and being nervous around other people. The target goal was the resident would have no side effects from medications and their needs would be met without injury to self or others through 12/10/24. Interventions included calling family, minimize private interactions with another specific resident, redirection, watch TV, discuss archery and play music. Resident 49's Care Plan did not include resident specific stressors or triggers to their behaviors. The Care Plan interventions did not include attempting to identify resident specific triggers or stressors. Resident 49's Care Plan did not address their diagnosis of dementia. An Incident Description, dated 7/14/24 at 7:00 AM, indicated Resident 49 allegedly touched another resident's breast. A facility staff member indicated Resident 49 had adjusted the other resident's blanket. A Resident Witness indicated Resident 49 had indicated the resident had pulled the other resident's shirt to expose them. A Resident Witness indicated Resident 49 was touching the other resident's breasts. Camera footage indicated Resident 49 had adjusted the other resident's blanket. An Incident Description, dated 7/15/24 at 2:00 PM, indicated Resident 49 had punched a staff member in the ear. Resident 49 had been delusional thinking another resident was being killed by visitors. An Interdisciplinary (IDT) Note, dated 7/22/24 at 9:01 PM, indicated Resident 49 had been triggered at the same time of day (3-5 pm), but the trigger had been unknown at that time. A new intervention was for activity staff to engage with resident during the trigger time. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 49's Kardex (summary care plan for direct care staff) indicated the resident resided on a secure dementia unit. The Kardex did not indicate the resident displayed behaviors of hitting, kicking, pinching, throwing things, delusions, hallucinations, raising of voice, making sexual comments, irritability, lashing out and being nervous around other people. The Kardex indicated staff were to minimize private interactions with another specific resident. A progress note, dated 8/11/24 at 3:22 PM, indicated Resident 49 thought they were having a mental breakdown no intervention was documented. A progress note, dated 9/4/24 at 11:19 PM, indicated Resident 49 was found in bed with a female resident. Resident 49 was only wearing a brief. A progress note, dated 9/5/24 at 4:51 PM, indicated Resident 49 had placed their hand on their penis and stated the penis had different flavors for different staff. A progress note, dated 9/13/24 at 5:01 PM, indicated Resident 49 had become agitated at another resident due to the other resident attempting to push the resident's wheelchair. Resident 49 pushed the other resident's hands away. An IDT note, dated 9/16/24 at 11:17 AM, indicated Resident 49 believed their personal space was being invaded on 9/13/24 when they pushed another resident's hands away. A progress note, dated 9/18/24 at 5:14 PM, indicated Resident 49 had kissed another resident on the mouth in the dining room. In an interview on, 10/1/24 at 11:40 AM, Qualified Medication Aide (QMA) 28 indicated direct care staff members were made aware of only new behaviors during shift report. QMA 28 indicated the facility learned the residents' specific behaviors as they got to know the residents. QMA 28 indicated they had not been educated to observe for specific events or stressors that had happened prior to resident behaviors. In an interview on, 10/1/24 at 1:36 PM, The Social Service Director (SSD) indicated the kiss between another resident and Resident 49 on 9/18/24 was a brief peck on the lips. The SSD indicated the incident was not reportable as both the residents had a diagnosis of dementia. The SSD indicated the kiss was not sexual. The SSD indicated the other resident was a willing participant. The SSD indicated although Resident 49 has displayed sexual behaviors the kiss was friendly. The SSD indicated Resident 49's sexual behaviors had improved with medication and the resident was now easily redirected. A current facility policy, dated 8/18/23, provided by the Regional Nurse Consultant on 9/30/24 at 9:30 AM, indicated the facility would investigate resident behaviors in an effort to determine the root cause of the behavior. An undated current facility policy, provided by the Regional Nurse Consultant on 9/30/24 at 9:30 AM, indicated the facility memory care unit could not accept residents who displayed behaviors that may result in harm to self or others. 3.1-37

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 46756 Based on observation, record review, and interview, the facility failed to ensure a process was in place to identify and correct deficiencies from re-occurring for 82 of 82 residents residing in the facility Findings include: The facility annual survey completed on 12/1/2023 identified noncompliance regarding failure to report, failure to investigate incidents, failure to follow care planned interventions to prevent accidents, failure to maintaining minimum staffing levels to ensure safety, and failure to investigate and identify underlying causes of resident specific behaviors. The facility indicated the noncompliance would be corrected by 1/8/2024. In an interview, on 9/30/24 at 11:40 AM, the Administrator indicated Resident 19's elopement had not been reported to the proper agencies. See F609 for additional information about failure to report incidents requiring reporting. In an interview, on 10/2/24 at 1:42 PM, the Director of Nursing (DON) indicated Former Employee 45, working on the Assisted Living unit, was looking out the large main window in the Facility's Assisted living (located midway down the unit) and observed Resident 19 exit the building. The DON indicated Employee 45 went to find the Resident 19 (through half the corridor of the Assisted living, through the facility's lobby, through one set of doors, through anti-room, through second set of doors, and to the outside of the building). The DON indicated Former Employee 45 indicated before she could reach Resident 19 she fell out of her wheelchair outside the facility. The DON indicated the incident was reviewed and was decided it was not an elopement (a resident who leaves a healthcare facility without authorization or supervision) and was not investigated as an elopement. See F610 for additional information about failure to investigate incidents. In an interview, on 9/30/24 at 2:50 PM, the DON indicated Resident 32 should not have been unsupervised in the shower room. The DON indicated Resident 32's Care Plan should have included interventions for fall precautions. The DON indicated fall risk precautions should have been included on the resident's Kardex. During an interview, on 9/30/24 at 1:34 PM, the Social Services Director (SSD) indicated upon admission, when a resident had a history of smoking, a smoking evaluation should be performed by therapy. The resident's ability to open and close the facility door and handle smoking materials appropriately would be assessed. The SSD indicated staff was aware of who smoked by common knowledge and by reading the Kardex. Residents must follow smoking assessment recommendations to be allowed to continue to smoke. She indicated a care plan should be in place to inform the staff of a resident's smoking status and any special instructions, such as signing out of the building to smoke, care of smoking materials and any devices needed to smoke safely (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	See F689 for additional information about failure to follow care planned interventions to prevent accidents. In an interview on 10/1/24 at 10:22 AM, the Director of Nursing indicated she was aware that Resident 64 fell from the recliner twice in the same day. She indicated short staffing was a factor in the falls. During an interview on 10/1/24 at 10:22 AM, the Director of Nursing indicated she indicated staffing was her biggest concern in the building. She indicated some CNA staff had returned to school and were unable to work, many nurse aides in training had quit during their training and others had not completed their certification as anticipated. She indicated the facility had been using agencies in the past, but their corporate office had not allowed any staffing use since June 2024. See F725 for additional information on failure to maintain minimum staffing levels to ensure safety. In an interview on, 10/1/24 at 1:36 PM, The Social Service Director (SSD) indicated the kiss between another resident and Resident 49 on 9/18/24 was a brief peck on the lips. The SSD indicated the incident was not reportable as both the residents had a diagnosis of dementia. The SSD indicated the kiss was not sexual. The SSD indicated the other resident was a willing participant. The SSD indicated although Resident 49 has displayed sexual behaviors the kiss was friendly. The SSD indicated Resident 49's sexual behaviors had improved with medication and the resident was now easily redirected. See F744 for additional information about failure to investigate and identify underlying causes of resident specific behaviors. A QAPI (Quality Assurance Performance Improvement) committee list was provided by the Executive Director (ED) on 9/25/24 at 9:15 AM. The member list included the Administrator, Director of Nursing, Medical Director, MDS coordinator, Housekeeping Supervisor, Business Office Manager, Social Service Director, Unit Managers, Dietary Manager, and Therapy Lead. The QAPI Plan, dated 8/2024, was reviewed. The QAPI Plan indicated concerns including falls, pressure ulcers, and other matrix related tops were recommended for review by the electronic medical record reporting system. In an interview on, 10/1/24 at 2:05 PM, the Administrator indicated he began work in the building in mid-August, identified staffing as the most critical problem in the facility and directed his team to direct their energies toward ensuring enough staff was always in the building to care for the residents. He initiated a program to meet each morning and check for staffing needs as a management team prior to any manager beginning their workday. He indicated he was beginning attendance accountability for the staff. He indicated use of agency to fill staffing needs began on 9/29/24. Additional QAPI focus areas were not available for review due to the critical nature of the staffing concerns. The facility failed to ensure identification of trends, and implement interventions to prevent repeat concerns related to Reporting abuse allegations (F609), investigating Abuse allegations and accidents (F610), Preventing accidents (F689), Maintaining staffing to esure the anticipated and unanticipated needs of the resident scould be met (F725) and implement dementia care interventions (F744). (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A current policy titled Clinical Policy and Procedure Quality Assurance/Performance Improvement Program (QAPI), last revised 3/9/22, indicated the QAPI program should provide a process that will enhance the care and experience for all residents, improve the work environment for stakeholders, and quality of all services provided by the facility. 3.1-52