STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155282	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Spring Senior Living at Northwood	2515 Newton St Jasper, IN 47547

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. Based on observation, interview, and record review, the facility failed to ensure care plan conferences were held for 4 of 5 residents reviewed for unnecessary medications. (Resident 6, Resident 7, Resident 11, Resident 44) Findings include: 1. On 6/11/25 at 8:20 A.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to anxiety, osteoporosis, depression, and early-onset cerebellar ataxia (a neurological disorder that primarily affects the cerebellum, a part of the brain responsible for coordinating movement and balance). The most recent quarterly Minimum Data Set (MDS) assessment, dated 5/20/25, indicated Resident 6 was cognitively intact. Resident 6's clinical record was reviewed for care plan conferences in the last year and lacked documentation of a care plan conference between 5/10/24 and 2/7/25. 2. On 6/11/25 at 11:30 A.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety, depression, and dementia with behaviors. The most recent quarterly MDS assessment, dated 5/19/25, indicated Resident 7 was cognitively intact. Resident 7's clinical record was reviewed for care plan conferences in the last year and lacked documentation of a care plan conference between 8/1/24 and 5/22/25. 3. On 6/11/25 at 2:22 P.M., Resident 11's clinical record was reviewed. Diagnoses included, but were not limited to, dementia without behaviors, depression, epilepsy, and anxiety. The most recent quarterly MDS assessment, dated 4/15/25, indicated Resident 11's cognition was severely impaired. Resident 11's clinical record was reviewed for care plan conferences in the last year and lacked documentation of a care plan conference after 9/25/24. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 6/12/25 at 9:12 A.M., Resident 44's clinical record was reviewed. Diagnoses included, but were not limited to, psychotic disorder with hallucinations, vascular dementia with behaviors, and stroke. The most recent quarterly MDS assessment, dated 3/12/25, indicated Resident 44 was cognitively intact. Resident 44's clinical record was reviewed for care plan conferences in the last year and lacked documentation of a care plan conference after 8/8/24. During an interview on 6/12/25 at 12:00 P.M., the Social Services Director (SSD) indicated residents should have care plan conferences quarterly and as needed and should be documented in the clinical record. On 6/13/25 at 9:53 A.M., a current Comprehensive Care Plan Policy, revised March 2022, was provided by the Director of Nursing (DON) and indicated, . care plan meeting/care conferences are to take place per state specific regulations (admissions, change of condition, quarterly, annual or as requested by resident/POA or facility). 3.1-3(n)(3)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to ensure notification to family/resident representative with a change in resident condition for 4 of 5 residents reviewed for falls. Family/resident representatives were not notified following falls. (Resident 39, Resident 43, Resident 52, Resident 56) Findings include: 1. On 6/11/25 at 2:33 P.M., Resident 39's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease, dementia, anxiety, and depression. The most recent quarterly Minimum Data Set (MDS) assessment, dated 4/9/25, indicated a severe cognitive impairment and two or more falls since the previous assessment. A Health Status note, dated 3/27/25 at 3:04 P.M., indicated Resident 39 stood up from a wheelchair on his own, lost his balance, and fell on the right shoulder. The note lacked documentation that the family or resident representative was notified of the fall. An Interdisciplinary Team (IDT) note, dated 3/28/25 at 10:06 A.M., indicated they reviewed the fall and interventions, but lacked documentation that the family or resident representative was notified of the fall. 2. On 6/11/25 at 1:51 P.M., Resident 43's clinical record was reviewed. Diagnoses included, but were not limited to, seizure disorder and depression. The most recent quarterly MDS assessment, dated 5/19/25, indicated a severe cognitive impairment. Resident 43 had no falls since the previous assessment. A Health Status note, dated 5/1/25 at 11:18 P.M., indicated Resident 43 was found on the floor on his right side. The resident could not recall what had happened, but did indicate he hit his head. The note lacked documentation that the family or resident representative was notified of the fall. An IDT note, dated 5/2/25 at 10:02 A.M., indicated they reviewed the fall and interventions, but lacked documentation that the family or resident representative was notified of the fall. 3. On 6/11/25 at 10:18 A.M., Resident 52's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, and schizophrenia. The most recent quarterly MDS assessment, dated 3/6/25, indicated cognition could not be assessed, and had two or more falls since the previous assessment. A Health Status note, dated 12/3/24 at 4:27 A.M., indicated Resident 52 had fallen. The note lacked documentation that the family/resident representative was notified of the fall. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note, dated 1/31/25 at 9:19 A.M., indicated Resident 52 fell while ambulating in the hallway. The note lacked documentation that the family/resident representative was notified of the fall. 4. On 6/12/25 at 7:36 A.M., Resident 56's clinical record was reviewed. Diagnosis included, but was not limited to, dementia. The most recent quarterly MDS assessment, dated 5/28/25, indicated a severe cognitive impairment, and a fall with injury since the previous assessment. An IDT note, dated 3/4/25 at 10:08 A.M., indicated Resident 56 was found on the floor in his room. The note lacked documentation that the family/resident representative was notified of the fall. On 6/12/25 at 2:20 P.M., the Assistant Director of Nursing (ADON) indicated all information that had been provided was part of the resident's clinical record. She indicated the facility had other internal documents that may have more information, but they were not part of the clinical record. On 6/13/25 at 9:53 A.M., the Director of Nursing (DON) provided a current Assessing Falls and Their Causes policy, last revised 3/2018, that indicated When a resident falls, the following information should be recorded in the resident's medical record . Notification of the physician and family, as indicated . Notify the following individuals when a resident falls . The resident's family 3.1-5(a)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to provide a required notice to a resident being discharged from Medicare services for 1 of 3 residents reviewed. No record of a SNF-ABN (Skilled Nursing Facility-Advanced Beneficiary Notification) notice was available that indicated the resident was notified of a discharge from Medicare services with days remaining prior to the resident's discharge from the facility. (Resident 75) Finding includes: On 6/9/25 at 10:00 A.M., Resident 75's discharge from Medicare services was reviewed. Resident 75 was discharged from Medicare services on 2/24/25 when benefit days were not exhausted. Resident 75 discharged from the facility on 2/24/25. A copy of the Notice of Medicare Non-Coverage (NOMNC) notice was not provided. On 6/9/25 at 11:30 A.M., the Social Service Director (SSD) indicated a Notice of Medicare Non-Coverage (NOMNC) notice was provided to Resident 75, but the facility lacked documentation in the clinical record that the resident was notified. On 6/9/25 at 11:35 A.M., the SSD supplied a copy of a SNF Beneficiary Notice Scenarios guideline dated 04/2018. The guideline indicated a NOMNC notification form should have been issued when a .Resident is being discharged from Part A (Medicare) and is leaving the SNF immediately following the last covered skilled day, with skilled benefit days remaining/available. 3.1-4(f)(2)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, and record review, the facility failed to ensure resident's drug regimens were free from unnecessary drugs for 2 of 5 residents reviewed for falls. A resident was given an antipsychotic without a physician's order and a gradual dose reduction (GDR) wasn't done for a resident taking an antipsychotic and antianxiety medication. (Resident 39, Resident 6) Findings include: 1. On 6/11/25 at 2:33 P.M., Resident 39's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease, dementia, anxiety, depression, and psychotic disorder. The most recent quarterly Minimum Data Set (MDS) assessment, dated 4/9/25, indicated a severe cognitive impairment, and use of an antipsychotic medication. Physician orders included, but were not limited to, the following: Haldol (an antipsychotic medication) Injection Solution 5 MG (milligram)/ML (milliliter) Inject 5 mg intramuscularly every 6 hours as needed, ordered 11/25/24 and discontinued 12/2/24 at 3:18 P.M. Haloperidol Lactate (Haldol) Oral Concentrate 2 MG/ML Give 0.25 ml by mouth two times a day, ordered 12/27/24 and discontinued 1/10/25. A Nurses Note, dated 12/2/24 at 11:22 P.M., indicated Resident 39 was given a 5 mg injection of Haldol. At that time, there was no current physician's order for Haldol. The physician's order for Haldol had been discontinued previously that day at 3:18 P.M. A Health Status note, dated 12/3/24 at 2:40 A.M., indicated Resident 39 had fallen in his room, and that a Haldol injection had been administered earlier in the shift. Resident 39's Medication Administration Record (MAR) for December 2024 lacked documentation that Haldol was given on 12/2/24. On 6/13/25 at 9:23 A.M., The MDS Coordinator (previously the Dementia Director) indicated Resident 39 had been given Haldol on 12/1/24 and was not followed up on in a timely manner. She indicated that was the reason it had been discontinued on 12/2/24 after she had discussed the issue with the prescribing provider. On 6/13/25 at 10:42 A.M., the Assistant Director of Nursing (ADON) indicated she spoke with the nurse that gave Resident 39 Haldol on 12/2/24, but he did not remember the incident or giving the medication. 2. On 6/11/25 at 8:20 A.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to anxiety, osteoporosis, depression, and early-onset cerebellar ataxia (a neurological disorder that primarily affects the cerebellum, a part of the brain responsible for coordinating movement and balance). (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The most recent quarterly MDS assessment, dated 5/20/25, indicated Resident 6 was cognitively intact, substantial to maximum assist (staff perform over half the effort) for bed mobility, transfers, and toileting. She received an antipyschotic and an antianxiety medication. Physician's Orders, included, but were not limited to, the following: Klonopin (antianxiety) 0.5 milligram (mg) tablet, give 0.5 mg by mouth in the morning for early-onset cerebellar ataxia, ordered 6/11/24 (continued from previous order) Klonopin 1 mg tablet, give 1 mg by mouth at bedtime for early-onset cerebellar ataxia, ordered 6/11/24 (continued from previous order) Abilify (antipyschotic) 5 mg tablet, give 5 mg by mouth at bedtime for adjustment disorder with depressed mood, ordered 9/24/24 discontinued 10/3/24 Abilify (antipyschotic) 10 mg tablet, give 10 mg by mouth at bedtime for adjustment disorder with depressed mood, ordered 10/3/24 and discontinued 11/7/24 Abilify (antipyschotic) 15 mg tablet, give 15 mg by mouth at bedtime for adjustment disorder with depressed mood, ordered 11/7/24 and discontinued 5/15/25 Abilify (antipyschotic) 20 mg tablet, give 20 mg by mouth at bedtime for adjustment disorder with depressed mood, ordered 5/15/25 A current Antianxiety Care Plan, last revised 11/27/24, included, but was not limited to, an intervention to consult with the health care provider to consider dosage reduction when clinically appropriate, initiated 6/18/19. A current Antipyschotic Care Plan, last revised 11/15/24, included, but was not limited to, an intervention to consult with the health care provider to consider dosage reduction when clinically appropriate, initiated 9/25/24. The clinical record lacked documentation of a contraindication for a GDR or a rationale to continue the medications from a prescribing practitioner. During an interview on 6/12/25 at 11:33 A.M., the Assistant Director of Nursing (ADON) indicated she could not provide documentation signed by the prescribing physician or nurse practitioner for the contraindication from the resident's clinical record. On 6/13/25 at 9:22 A.M., Licensed Practical Nurse (LPN) 16 indicated if a resident was having behaviors that warranted an antipsychotic, the nurse would need to call the doctor and get an order. The order would then be documented in the clinical record. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/25 at 10:32 A.M., a current Tapering Medications/Gradual Drug Dose Reduction Policy, revised July 2022, was provided by the Director of Nursing (DON) and indicated, After medications are ordered for a resident, the staff and practitioner shall seek an appropriate dose and duration for each medication . within the first year after a resident is admitted on a psychotropic medication or after the resident has been started on a psychotropic medication, the staff and practitioner shall attempt a GDR in two separate quarters (with at least one month between the attempts) . After the first year, the facility shall attempt a GDR at least annually, unless clinically contraindicated . and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior . On 6/13/25 at 11:00 A.M., the Director of Nursing (DON) provided a current Intramuscular Injections policy, last revised 3/2011, that indicated Verify that there is a physician's medication order for this procedure 3.1-48(a) 3.1-48(b)(2)

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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. Based on observation, interview, and record review, the facility failed to ensure adequate supervision and assistive devices were provided to prevent accidents for 4 of 5 residents reviewed for falls. Complete and thorough assessments were lacking after each fall, care plans were not updated with each fall, current interventions were not in place to at times of falls and a comprehensive review of all falls was not completed. (Resident 39, Resident 43, Resident 52, Resident 56) Findings include: 1. On 6/11/25 at 2:33 P.M., Resident 39's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease, dementia, anxiety, and depression. The most recent quarterly Minimum Data Set (MDS) assessment, dated 4/9/25, indicated a severe cognitive impairment, and two or more falls since the previous assessment. Resident 39 required supervision or touching assistance with eating and bed mobility, substantial to maximum assistance (helper does more than half the effort) with transfers, and was totally dependent on staff for toileting and bathing. Current physician orders included, but were not limited to: Assist of one staff with transfers and ambulation, dated 5/1/25 A current Risk for Falls Care Plan, last revised 3/7/25, included, but was not limited to, the following interventions: staff to walk with the resident when he was agitated to reduce behaviors and promote overall safety, dated 2/11/25. Occupational Therapy for wheelchair assessment, dated 4/10/25. Educate and remind staff to utilize gait belt for all transfers for safety, dated 4/29/25. Fall risk assessments were completed on the following dates (for the previous 12 months): 1/8/25 High risk for falls 3/12/25 Moderate risk for falls 4/5/25 Medium risk for falls From 12/1/24 through current, Resident 39 experienced the following falls: Fall 1 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/3/24 at 2:40 A.M. Certified Nurse Aide (CNA) alerted nursing staff resident was on the floor. The upper body was on the fall mattress and the lower half on the floor. The resident had been given a Haldol (antipsychotic) injection three hours prior to fall (no current order for the Haldol). The resident indicated he was going to the restroom and had moved the floor mattress trying to walk between the mattress and air unit causing the fall. An Interdisciplinary Team (IDT) note, dated 12/3/24 at 10:08 A.M., indicated the resident was noted to have behaviors and agitation, and was moved to the common area to be observed by staff. The resident's current orders were to be reviewed for medication changes and the care plan was updated on 12/3/24 to reflect the review. A Post Fall Vitals form was completed following fall, but lacked neurological (neuro) checks. (A neurological assessment for falls prevention aims to identify underlying neurological conditions that may increase a person's risk of falling and to guide interventions that can reduce that risk of additional falls.) The record lacked a falls assessment following the fall. Fall 2 2/5/25 at 9:15 A.M., Resident fell forward out of the wheelchair and experienced a hematoma with swelling that was decreased with an ice pack. An IDT note, dated 2/6/25 at 10:13 A.M., indicated the resident was probably sleeping in the wheelchair and fell forward out of it. The new intervention was to have anti-rollbacks on the wheelchair, and to remind staff to encourage resident to sit in recliner or lay down after meals. The falls care plan was not updated with anti-rollbacks until 2/14/25 (after Fall 4), and offer to lay down between meals was added on 3/17/25 (after Fall 5). The following neuro checks were documented following the fall: 2/5/25 at 9:15 A.M. 2/5/25 at 10:15 A.M. 2/5/25 at 10:45 A.M. 2/5/25 at 6:13 P.M. 2/5/25 at 11:30 P.M. 2/6/25 at 6:22 A.M. 2/6/25 at 2:32 P.M. 2/6/25 at 11:20 P.M. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/7/25 at 9:15 A.M. 2/7/25 at 5:21 P.M. 2/8/25 at 9:00 A.M. The record lacked a falls assessment following the fall. Fall 3 2/10/25 at 6:56 P.M., Resident was wheeling self in the hall, stood up and fell when walking on his own. Fall was witnessed by staff. An IDT note, dated 2/11/25 at 9:54 A.M., indicated resident would benefit from walking with staff throughout the day when agitated to reduce behaviors. The care plan was updated on 2/11/25 to include walking with resident when agitated. The record lacked a falls assessment following the fall. Fall 4 2/14/25 at 1:44 P.M. Resident was found lying on the left side in the dining area. An IDT note, dated 2/14/25 at 3:47 P.M., indicated resident was found on the floor with the wheelchair behind him. Staff believed resident was propelling self in wheelchair with feet and slid out of it. The new intervention was to place a Dycem in the wheelchair. The care plan was updated on 2/14/25 to include an intervention for anti-rollbacks to wheelchair and Dycem in the wheelchair. The following neuro checks were completed following the fall: 2/14/25 at 1:25 P.M. 2/14/25 at 1:56 P.M. 2/14/25 at 2:31 P.M. 2/14/25 at 2:55 P.M. 2/14/25 at 3:25 P.M. 2/15/25 at 2:07 A.M. No neuro checks were documented after 2/15/25 at 2:07 A.M. The record lacked a falls assessment following the fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fall 5 3/12/25 at 7:25 A.M. Resident wheeling self to room, stood and fell to the floor. An IDT note, dated 3/14/25 at 10:06 A.M., indicated staff would offer to lay down after meals. The care plan was updated 3/17/25 to include an intervention to offer to lay down between meals. The following neurological checks were completed following the fall: 3/12/25 at 7:25 P.M. 3/12/25 at 7:55 P.M. 3/12/25 at 8:25 P.M. 3/12/25 at 8:55 P.M. 3/13/25 at 4:47 P.M. 3/13/25 at 4:50 P.M. 3/13/25 at 4:51 P.M. 3/13/25 at 9:12 P.M. 3/14/25 at 6:38 A.M. 3/14/25 at 1:18 P.M. No neuro checks were documented after 3/14/25 at 1:18 P.M. Fall 6 3/27/25 at 3:04 P.M. Resident stood up from wheelchair, and fell to right side. Fall was witnessed and did not hit head. An IDT note, dated 3/28/25 at 10:06 A.M., indicated the new intervention was to assist resident to a regular chair during meals. The care plan was updated 3/28/25 with new intervention, and resolved 5/12/25. The record lacked a falls assessment following the fall. Fall 7 4/9/25 at 8:31 P.M. Resident fell out of wheelchair while sitting in the hall resulting in a 2-inch laceration (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	above the left eyebrow. Fall was witnessed. An IDT note, dated 4/10/25 at 10:16 A.M., indicated a new intervention for therapy to do a wheelchair assessment. The care plan was updated on 4/10/25 for Occupational Therapy to do a wheelchair assessment. The record lacked a falls assessment following the fall. Fall 8 4/28/25 at 4:43 P.M. Resident stood from the wheelchair at the dining room table. The resident's hands slipped from the table and the resident fell. Fall was witnessed and did not hit head. An IDT note, dated 4/29/25 at 10:07 A.M., indicated a new intervention to remind staff to use gait belt for transfers. The care plan was updated 4/29/25 to remind staff to use gait belt. The record lacked a falls assessment following the fall. On 6/12/25 at 11:09 A.M., the Director of Therapy Services indicated they did a screen for Resident 39's wheelchair on 2/14/25 when anti-rollbacks were placed on the wheelchair. At that time, the wheelchair was appropriate for the resident and nothing further was done. On 6/12/25 at 11:22 A.M., Resident 39 was observed sitting in a wheelchair in the dining room. At that time, the resident's room was observed with a dark red colored tape around both call lights. 2. On 6/11/25 at 1:51 P.M., Resident 43's clinical record was reviewed. Diagnoses included, but were not limited to, legally blind, seizure disorder, and depression. The most recent quarterly MDS assessment, dated 5/19/25, indicated a severe cognitive impairment. Resident 43 had no falls since the previous assessment. Resident required partial to moderate assistance (helper does less than half the effort) with eating and transfers, and substantial to maximum assistance (helper does more than half the effort) with toileting, bathing, and bed mobility. Current physician orders included, but were not limited to: extensive assist of one to two staff with gait belt, pivot to wheelchair, dated 4/10/25. A current Risk for Falls Care Plan, last revised 4/21/25, included, but was not limited to, the following interventions: Clip call light to resident's clothing for safety due to poor vision, dated 5/2/25. Transfer to recliner after meals with call light in reach for safety, dated 5/25/25. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Spring Senior Living at Northwood	2515 Newton St Jasper, IN 47547

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A current Activities of Daily Living (ADL) Care Plan, last revised 4/21/25, included, but was not limited to, the following interventions: Resident requires 2pgbs (2 person gait belt assist) and walker for transfers, dated 4/14/25. Falls risk assessments included the following (for the previous 12 months): 4/13/25 Medium risk. Resident 43 experienced the following falls from 12/1/24 through current: Fall 1 5/1/25 at 11:18 P.M., a progress note indicated resident was found on the floor lying on the right side. A walker was observed turned over. Resident could not recall what had happened, but did indicate he hit his head. An IDT note, dated 5/2/25 at 10:02 A.M. indicated a new intervention to clip call light onto resident's clothing for safety due to poor vision. The care plan was updated 5/2/25. The following neurological checks were completed following the fall: 5/1/25 at 10:00 P.M. 5/1/25 at 10:30 P.M. 5/1/25 at 11:00 P.M. 5/1/25 at 11:30 P.M. 5/2/25 at 12:00 A.M. 5/2/25 at 12:43 P.M. No neurological checks were documented after 5/2/25 at 12:43 P.M. The record lacked a falls assessment following the fall. Fall 2 5/4/25 at 8:23 A.M. a progress note indicated resident was found lying on the left side with head against the siding by the wall at 7:30 A.M. in the dining room. Resident had a red raised area on the back of the head measuring 3 cm (centimeters) x 3 cm. Also a 3 inch abrasion to the left shoulder blade. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An IDT note, dated 5/5/25 at 10:00 A.M. indicated staff believed resident stood up and wheelchair rolled out from under him causing him to lose his balance and fall. New intervention was to place anti-rollbacks on the wheelchair. The care plan was updated 5/5/25 to include anti-rollbacks. One neurological check was documented on 5/6/25 at 1:30 A.M. The record lacked a falls assessment following the fall. Fall 3 5/22/25 at 6:28 P.M. a progress note indicated an unwitnessed fall at 6:00 P.M. Resident was found lying on the floor on his right side in the middle of the room. An IDT note, dated 5/23/25 at 9:43 A.M., indicated a new intervention to offer resident to sit in recliner after meals. The care plan was updated 5/25/25 to include recliner after meals. The clinical record lacked documentation of neuro check on 5/23/25 at 4:45 P.M. The record lacked a falls assessment following the fall. On 6/10/25 at 9:56 A.M., Resident 43 was observed sitting in his room in a recliner with eyes closed. A call light was observed clipped to the left arm of the recliner. On 6/12/25 at 8:04 A.M., Certified Nurse Aide (CNA) 9 was observed to bring Resident 43 back to his room from the main dining room and transferred the resident from the wheelchair to the recliner by herself. The resident was then observed sitting in the recliner with a call light clipped to the left arm of the recliner. On 6/12/25 at 11:14 A.M., Resident 43 was observed sitting in his room in a recliner. A call light was observed clipped to the left arm of the recliner. 3. On 6/11/25 at 10:18 A.M., Resident 52's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, and schizophrenia. The most recent quarterly MDS assessment, dated 3/6/25, indicated cognition could not be assessed, and two or more falls since the previous assessment. Resident was dependent on staff with eating, toileting, bathing, and bed mobility, and required substantial to maximum assistance (helper does more than half the effort) with transfers. Falls assessments for the previous 12 months were completed on the following dates: 8/9/24 High risk 11/14/24 Moderate risk (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/29/24 High risk 12/1/24 Medium risk 12/1/24 Medium risk 1/10/25 High risk 3/1/25 High risk 5/30/25 High risk From 12/1/24 through current, Resident 52 experienced the following falls: Fall 1 12/1/24 at 10:20 P.M. a progress note indicated resident was standing at the treatment cart, closed eyes, and fell backward hitting head on the floor resulting in a hematoma on the back of the head. Resident was sent to the emergency room where a scan of the head was negative for any acute findings. The clinical record lacked documentation that an IDT review was completed following fall. The falls care plan was not updated with a new intervention following fall. Fall 2 12/3/24 at 4:57 A.M. a progress note indicated resident had a witnessed fall. Resident came around the corner hitting door frame with left shoulder. The note did not indicate if the resident hit her head or not. The clinical record lacked documentation that an IDT review was completed following fall. The falls care plan was not updated with a new intervention following fall. Neuro checks were not completed following fall. Fall 3 12/11/24 at 2:42 P.M. a Health Status note indicated resident was walking on unit wearing new house shoes that family had brought. While walking by nurses' station, resident got feet tangled and fell on her bottom. An IDT note, dated 12/12/24 at 10:26 A.M., indicated it was believed the new shoes were what caused the fall. Family was asked to take house shoes home on next visit. The falls care plan was not updated with a new intervention following fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A falls risk assessment was not completed following fall. Fall 4 12/20/24 at 1:48 P.M. a Health Status note indicated resident was found sitting on the floor unable to state what happened. An IDT note, dated 12/23/24 at 10:59 A.M., indicated the care plan would indicate resident would sit on the floor intentionally. The care plan was updated 12/23/24 to include resident sits on the floor at times, resolved 3/17/25. The care plan was not updated at that time to include an actual intervention for staff to follow to prevent falls. Neuro checks were not completed following fall. A falls risk assessment was not completed following fall. Fall 5 1/10/25 at 6:31 P.M. a progress note indicated resident was standing at the medication cart and fell backwards from a standing position. Resident hit head on the floor resulting in bleeding and swelling. An IDT note, dated 1/13/25 at 10:22 A.M., indicated it was believed the resident's blood pressure was dropping causing her to fall. The new intervention was request a medication review. The falls care plan was not updated with a new intervention following fall. The clinical record lacked documentation of neuro checks following fall. Fall 6 1/18/25 at 4:20 A.M. a Health Status note indicated the resident fell onto left side of body and did not hit head. Fall was witnessed. The clinical record lacked documentation that an IDT review was completed following fall. The falls care plan was not updated with a new intervention following fall. A falls risk assessment was not completed following fall. Fall 7 1/18/25 at 7:20 P.M. a Health Status note indicated the resident had a witnessed fall at 4:20 P.M. The resident fell onto her left side and did not hit her head. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An IDT note, dated 1/21/25 at 10:48 A.M., indicated a new intervention was for Physical Therapy to evaluate and treat for a walker. The falls care plan was not updated following the fall. A falls risk assessment was not completed following fall. Fall 8 1/31/25 at 9:19 A.M., a progress note indicated resident fell while ambulating in the hall. An IDT note, dated 1/31/25 at 10:28 A.M., indicated resident had a walker but due to low cognition was unable to remember to use it. Bright colored tape to be applied to the walker. The falls care plan was updated with new intervention on 1/31/25 and resolved 2/24/25. A falls risk assessment was not completed following fall. Fall 9 2/2/25 at 2:15 P.M. a Health Status note indicated resident fell in another resident's room resulting in a minor cut to the back of the head measuring 1 cm x 2 cm and scant bruising to the right eyelid. An IDT note, dated 2/3/25 at 10:22 A.M., indicated staff would encourage resident to participate in activities. The falls care plan was not updated following fall. The clinical record lacked documentation of neuro checks following fall. A falls risk assessment was not completed following fall. Fall 10 2/22/25 at 1:54 A.M. a Health Status note indicated resident was found lying on the right side next to the bed. A hematoma was observed above the right eyebrow. An IDT note, dated 2/24/25 at 9:50 A.M., indicated a new intervention for a scoop mattress. The falls care plan was updated to include a scoop mattress on 2/24/25. A falls risk assessment was completed on 3/1/25. The following neuro checks were completed following fall: 2/22/25 at 11:33 A.M. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/22/25 at 7:30 P.M. 2/23/25 at 3:30 A.M. The clinical record lacked documentation of neuro checks after that. Fall 11 4/27/25 at 4:27 P.M. a progress note indicated resident was found on the floor lying on her back to the left side of the bed with a 1 cm laceration to the bridge of the nose with a moderate amount of bleeding. An IDT note, dated 4/28/25 at 10:23 A.M., indicated an intervention to move the left side of the bed against the wall and move the bedside table away from the bed. The falls care plan was updated on 4/28/25. The following neuro checks were completed following fall: 4/27/25 at 3:30 P.M. 4/27/25 at 3:40 P.M. 4/27/25 at 4:01 P.M. 4/27/25 at 4:30 P.M. 4/27/25 at 5:01 P.M. The clinical record lacked documentation of neuro checks after that. Fall 12 4/30/25 at 5:18 A.M., a Nurses Note indicated resident tried to transfer herself and flipped from the bed to the floor resulting in three bumps: two on the left side of the face and one on the head. Fall was unwitnessed. An IDT note, dated 4/30/25 at 10:11 A.M., indicated pain and anxiety medication would be increased and mattress would be placed to the floor for safety. The falls care plan was updated on 4/30/25. The following neuro checks were completed following fall: 4/30/25 at 1:30 A.M. 4/30/25 at 4:30 A.M. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/30/25 at 5:00 A.M. 4/30/25 at 6:00 A.M. 4/30/25 at 6:30 A.M. 4/30/25 at 7:00 A.M. 4/30/25 at 3:00 P.M. 4/30/25 at 11:00 P.M. The clinical record lacked documentation of neuro checks after that. 4. On 6/12/25 at 7:36 A.M., Resident 56's clinical record was notified. Diagnosis included, but was not limited to, dementia. The most recent quarterly MDS assessment, dated 5/28/25, indicated a severe cognitive impairment, and a fall with injury since the previous assessment. Resident required setup or cleanup assistance with eating, toileting, and transfers, supervision or touching assistance with bed mobility, and partial to moderate assistance (helper does less than half the effort) with bathing. Current physician orders included, but were not limited to: activity level: assist of one staff with walker, dated 3/7/25. A current Risk for Falls Care Plan, last revised 3/5/25, included, but was not limited to, an intervention to clip call light to resident's clothing for safety, dated 10/8/24. Falls risk assessments included the following (for the previous 12 months): 8/26/24 Medium risk 10/4/24 High risk 3/4/25 Moderate risk 5/28/25 Moderate risk Since 12/1/24, Resident 56 had experienced the following falls: Fall 1 3/3/25 at 2:41 P.M. a Nurses Note indicated resident was found on the floor lying on the right side. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An IDT note, dated 3/4/25 at 10:09 A.M., indicated a fall had occurred at 2:41 P.M. A new intervention placed for bed stoppers under all four wheels of the bed, locked wheels on bed, and non skid strips to right side of the bed. The falls care plan was updated the following day (after Fall 2). The clinical record lacked documentation that neuro checks were completed following fall. A falls risk assessment was completed the next day, 3/4/25. Fall 2 3/4/25 at 10:08 A.M. An IDT note indicated resident was found on the floor. Resident stated he was trying to transfer self from the bed to the recliner, tripped and fell. Head of bed to be elevated, staff to check on resident more frequently through the night, and toilet resident upon rising, after meals, at night and as needed. The falls care plan was updated 3/4/25 to include bed stoppers, bed in lowest position, and wheels locked, also anti-rollbacks on wheelchair. On 3/5/35 the care plan was updated to include administration of medication for dizziness. The following neuro checks were completed following fall: 3/4/25 at 5:28 P.M. 3/5/25 at 1:09 A.M. 3/5/25 at 7:12 P.M. 3/5/25 at 9:18 A.M. 3/6/25 at 3:21 A.M. 3/6/25 at 11:02 A.M. 3/6/25 at 10:28 P.M. 3/7/25 at 7:14 A.M. Fall 3 4/21/25 at 1:30 P.M. a progress note indicated resident reported to staff that he fell out of bed and got up on his own. A skin tear was noted to the right hand and elbow, and a bump to the back of the head. An IDT note, dated 4/23/25 at 10:13 A.M., indicated a new intervention for a scoop mattress to bed. The falls care plan was updated with the new intervention on 4/23/25. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The following neuro checks were completed following fall: 4/21/25 at 7:00 A.M. 4/21/25 at 7:30 A.M. 4/21/25 at 8:00 A.M. 4/21/25 at 9:00 A.M. 4/22/25 at 1:00 A.M. 4/23/25 at 1:00 A.M. The clinical record lacked documentation that neuro checks were completed after that. On 6/11/25 at 8:51 A.M., Qualified Medication Aide (QMA) 7 was observed to assist Resident 56 to the toilet and then back to bed. After situating the resident in bed, a call light was observed coiled on the floor under the head of the bed. QMA 7 left the room without providing the call light to the resident. On 6/12/25 at 11:18 A.M., Resident 56 was observed lying in bed with the lights out and television on. Two call lights were observed lying over the bedside table with dark red tape around them. Neither call light was clipped to the resident's clothing. On 6/12/25 at 9:10 A.M., the Assistant Director of Nursing (ADON) indicated prior to the current neuro check form, the Post Fall Neuros/Vitals form was the only one that was being used and only included vital signs, not neurological checks. She indicated staff was educated on using the new form, as well as charting directly in the clinical record. At that time, the new neuro check form was provided and indicated neuro checks needed to be completed at the following times following a fall: Every 15 minutes x 1 hour Every 30 minutes x 2 hours Every hour x 4 hours Every 8 hours x 72 hours On 6/12/25 at 2:20 P.M., the ADON indicated everything that was provided was included in the clinical record. She indicated the facility had internal documents with additional information, but none of that information was included in the resident's clinical record. On 6/13/25 at 10:32 A.M., the Director of Nursing (DON) provided a current Falls policy, last revised 3/2018, that indicated .the nurse shall assess and document/report the following . Neurological status . Falls should also be identified as witnessed or unwitnessed events . the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/13/25 at 10:32 A.M., the DON provided a current Neurological Assessment policy, last revised 10/2010, that indicated Neurological assessments are indicated . Following an unwitnessed fall . Following a fall or other accident/injury involving head trauma On 6/13/25 at 9:53 A.M., the DON provided a current Care Plans policy, last revised 3/2022, that indicated Assessments of residents are ongoing and care plans are revised as information about the resident and the residents' conditions change . The interdisciplinary team reviews and updates the care plan . when there has been a significant change in the resident's condition . when the desired outcome is not met 3.1-45(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to provide a sanitary environment to help prevent the development and transmission of communicable diseases and infections for 3 of 3 residents observed for incontinence care. Hand hygiene was not completed between glove changes, staff washed hands with less then 15 second lather, an incontinence pad was held between the bed and the staff's knees (with the inside of the incontinence pad against her scrub pants), staff left a visibly soiled incontinence pad on a resident after toileting him, and residents were not offered to wash their hands after toileting. (Resident 7, Resident 45, Resident 6) Findings include: 1. On 6/11/25 at 8:51 A.M., Qualified Medication Aide (QMA) 7 was observed to provide toileting assistance to Resident 56. Prior to assisting the resident on the toilet, QMA 7 washed her hands for 9 seconds, then put on gloves. The resident was assisted to sit on the toilet. The inside of the resident's brief was visibly wet and bulging with brown spots on the inside of it. When the resident was finished and stood up, QMA 7 wiped him, removed her gloves and washed her hands for 7 seconds. QMA 7 told the resident to pull up his brief and pants which he did, then exited the bathroom. QMA 7 did not touch the brief or assess that it was soiled. At that time, QMA 7 indicated Resident 56 did not have any cream ordered for incontinence care. On 6/12/25 at 8:04 A.M., Certified Nurse Aide (CNA) 9 indicated briefs would bulge when wet, and would be flat if dry. She indicated when taking a resident to the toilet, it was good practice to just change the brief whether they appeared to be soiled or not just in case. 3. On 6/11/25 at 8:53 A.M., QMA 46 and Licensed Practical Nurse (LPN) 21 were observed toileting Resident 45. QMA 46 failed to perform hand hygiene after he cleaned Resident 45's buttocks and perineal area. QMA 46 removed gloves and performed a 13 second hand lather. QMA 46 and LPN 21 failed to offer for Resident 45 to perform hand hygiene after he used the bathroom. During an interview on 6/11/25 at 10:00 A.M., the Infection Preventionist indicated when washing hands, staff should wash or scrub their hands for at least 20 seconds with soap. Staff should change gloves if they were visibly soiled or when going from a dirty to clean task and perform hand hygiene between glove changes. If a resident's incontinence pad was soiled, staff should put on a clean one. Staff should offer to wash the resident's hands after toileting and they should not hold resident belongings, clothing, or incontinence pads against themselves or their scrubs. On 6/13/25 at 10:32 A.M., the Director of Nursing (DON) provided a current Handwashing/Hand Hygiene policy, revised August 2019, that indicated, .Hand hygiene is the final step after removing and disposing of personal protective equipment .The use of gloves does not replace handwashing .Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers . 3.1-18(b) 3.1-18(l) (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 6/11/25 at 9:21 A.M., incontinence care was observed on Resident 6 performed by CNA 34 and QMA 46. Resident 6 was laying on her back in bed. QMA 46 got a clean incontinence pad from the package and laid it across the footboard of the bed. QMA 46 unfastened the soiled brief, performed incontinence care of the groin area, took off gloves, and put a new pair of gloves on without performing hand hygiene between. CNA 34 assisted resident to roll on her right side. She placed the clean incontinence pad between her knees and the side of the bed (with the inside of the incontinence pad against her scrub pants), wiped the resident's buttocks, and laid the new incontinence pad under the resident. CNA 34 took off gloves and put a new pair of gloves on without performing hand hygiene between. QMA 46 fastened the incontinence pad and both QMA 46 and CNA 34 proceeded to help Resident 6 get dressed.