| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155718 | A. Building<br>B. Wing | 02/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Northview Health and Living | 1235 W Cross St<br>Anderson, IN 46011 |

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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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>48384<br><br>Based on observation, interview, and record review, the facility failed to ensure a resident's dignity was maintained during dining by providing assistance with their meal. (Resident 49)<br><br>Findings include:<br><br>During a dining observation on 2/21/25 at 12:32 p.m., Resident 49 struggled to get food on her fork. She held the fork upside down and tried to get a bite of a cookie. She attempted to take a bite, and tried again as there was no food on the fork. At 12:46 p.m., CNA 9 asked the resident if she was okay. The resident nodded yes, and continued to unsuccessfully try to get food on her fork. The rest of her food was uneaten and out of her reach. At 12:49 p.m., CNA 9 helped her turn the utensil around and the resident was able to get a few bites of beans into her mouth. The plate with collard greens, fried potatoes, and cornbread remained out of Resident 49's reach. The resident coughed following a bite of beans and CNA 9 told her to take a drink. The drink was not within reach. The resident tried to reach the chocolate pudding, but it was out of reach. At 1:03 p.m., CNA 9 moved the pudding closer to the resident. The lunch plate remained out of the resident's reach.<br><br>During an interview with CNA 9, on 2/21/25 at 1:11 p.m., she indicated she moved food closer to Resident 49 when it was necessary. She thought a divided plate might have been helpful because the resident had a tendency to eat one thing at a time.<br><br>During an observation on 2/24/25 at 12:40 p.m., Resident 49 had her fork in the correct position and her lunch plate was within reach. Her drinks were out of reach. She held the fork just beneath her chin, not taking a bite. At 12:44 p.m., an unidentified staff member sat down and assisted her with her lunch.<br><br>(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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 2/25/25 at 12:06 p.m., Resident 49 was sitting in a wheelchair alone at a dining table. At 12:39, her meal was delivered and a staff member cut up a baked sweet potato. Her drinks were not within reach. She repeatedly reached towards her plate, with no silverware in hand. She touched the food with her fingers, then withdraw her hand. At 12:43, she peeled off a piece of sweet potato skin, then tried to flick it off her finger. She tried to eat some of the potato with her finger, without success. She pointed at the sweet potato. At 12:45 p.m., she reached for her pudding, touched the bowl, then lowered her hand. At 12:46, LPN 7 offered a fork to the resident and helped her get a bite of the sweet potato. LPN 7 stood next to the resident, offered her a drink, and continued to assist her for approximately five minutes. LPN 7 remained standing throughout. At 12:51 p.m., LPN 7 ceased assisting her with her meal. Resident 49 made attempts to get food on her fork, dropped the fork, and was given a clean fork by LPN 7. The resident's attempts to get a bite of food were unsuccessful. At 12:54 p.m., CNA 9 gave the resident a drink and offered her a bite of food. At 12:56 p.m., CNA 9 returned to another resident to assisted with their lunch. Resident 49 continued to attempt to use the fork to eat her meal without success.<br><br>During an interview with LPN 7, on 2/25/25 at 2:30 p.m., she indicated she wondered if Resident 49 was having trouble seeing. Usually, the resident fed herself, but was not doing well at lunch and seemed to be distracted.<br><br>During an interview with the Assistant Director of Nursing (ADON), on 2/25/25 at 2:38 p.m., she indicated Resident 49 might have been experiencing a problem with depth perception. She was going to notify staff.<br><br>During an interview with CNA 8, on 2/25/25 at 2:39 p.m., she indicated Resident 49's need for assistance had increased. The resident sometimes got her utensils confused and was a very slow eater. Sometimes, the staff took the resident's plate to her unit and she finished eating there.<br><br>Resident 49's clinical record was reviewed on 2/24/25 at 2:45 p.m. Diagnoses included type 2 diabetes mellitus, hypertension, major depressive disorder, and unspecified dementia, unspecified severity, with anxiety.<br><br>Current physician orders included health shake once daily at lunch for weight loss, fortified food program with meals, regular diet, regular texture, regular/thin consistency, as tolerated; caregivers may cut meats bite-sized (7/12/23).<br><br>A 10/2/24, quarterly, Minimum Data Set (MDS) assessment indicated Resident 49 required partial to moderate assist for eating, including the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal was placed before the resident.<br><br>A 12/30/24 quarterly MDS assessment indicated the resident required substantial/maximal assist for eating - including the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A current care plan for activities of daily living (ADL) self care performance deficit, initiated on 7/28/22, indicated the resident needed substantial to dependent assist for toileting, bed mobility, transfers, and set-up for eating and drinking, all related to weakness or debility. One goal of the ADL focus was the resident would feed herself at each meal through the next review date. Eating interventions included the resident will be able to hold cup, feed self, eat finger foods independently, and encourage the resident to participate to the fullest extent possible with each interaction.<br><br>The care plan did not include revisions indicated by the 12/30/24 quarterly MDS assessment which identified the resident's need for substantial/maximal assist for eating.<br><br>A current care plan, initiated 8/3/22, indicated the resident had a nutritional problem or potential for nutritional problems related to type 2 diabetes mellitus, dementia, hypertension, hypercholesterolemia, hypothyrodism, and a vitamin D deficiency. The resident required total assistance, and refused to eat. Meal intakes were inadequate to her nutritional needs and required supplementation. Interventions included maintenance of weight without significant changes through next review, monitor nutritionally related labs as needed/referred, obtain and evaluate weights as ordered/per policy and/or at minimum, monthly. Notify the physician, dietitian and family of any significant changes. Provide medications and adaptive equipment as ordered. A fortified food program was initiated on 6/17/24, as well as a daily health shake supplement. Monitor and record intake, and offer meal substitutions as needed.<br><br>The care plan did not include revisions indicated by the 12/30/24 quarterly MDS assessment which identified the resident's need for substantial/maximal assist for eating.<br><br>A current care plan for a restorative program, initiated on 10/17/22, for active range of motion to all extremities related to a risk for decline in strength and range of motion, post therapy, and dementia. Interventions included encouraging the resident to participate in exercise group and praise her efforts. Give directions slowly and repeat to ensure the resident understands.<br><br>A restorative nursing program assessment, dated 2/19/25 at 4:21 p.m., indicated the resident was receiving active range of motion (ROM) therapy for bilateral upper extremities (BUD). The plan of care did not include receiving therapy for eating/dining.<br><br>A 9/2024 facility policy, titled Care Plan Revisions Upon Status Change, provided by the ADON on 2/25/25 at 4:01 p.m., indicated the following: Policy Explanation and Compliance Guidelines: .2) Procedure for reviewing and revising the care plan when a resident experiences a status change: a) Upon identification of a change in status, the nurse will notify the MDS Coordinator, the physician, and the resident representative, if applicable. b) The MDS Coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options .d) The care plan will be updated with the new or modified interventions<br><br>3.1-35(d)(2)(B) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>48384<br><br>Based on observation, interview, and record review, the facility failed to provide assistance and cuing with dining to maximize residents' current abilities for 2 of 2 residents reviewed for activities of daily living (ADLs). (Residents 49 and 223)<br><br>Findings include:<br><br>During a dining observation on 2/21/25 at 12:32 p.m., Resident 49 struggled to get food on her fork. She held the fork upside down and tried to get a bite of a cookie. She attempted to take a bite, and tried again as there was no food on the fork. At 12:46 p.m., CNA 9 asked the resident if she was okay. The resident nodded yes, and continued to unsuccessfully try to get food on her fork. The rest of her food was uneaten and out of her reach. At 12:49 p.m., CNA 9 helped her turn the utensil around and the resident was able to get a few bites of beans into her mouth. The plate with collard greens, fried potatoes, and cornbread remained out of Resident 49's reach. The resident coughed following a bite of beans and CNA 9 told her to take a drink. The drink was not within reach. The resident tried to reach the chocolate pudding, but it was out of reach. At 1:03 p.m., CNA 9 moved the pudding closer to the resident. The lunch plate remained out of the resident's reach.<br><br>During an interview with CNA 9, on 2/21/25 at 1:11 p.m., she indicated she moved food closer to Resident 49 when it was necessary. She thought a divided plate might have been helpful because the resident had a tendency to eat one thing at a time.<br><br>During an observation on 2/24/25 at 12:40 p.m., Resident 49 had her fork in the correct position and her lunch plate was within reach. Her drinks were out of reach. She held the fork just beneath her chin, not taking a bite. At 12:44 p.m., an unidentified staff member sat down and assisted her with her lunch.<br><br>During an observation on 2/25/25 at 12:06 p.m., Resident 49 was sitting in a wheelchair alone at a dining table. At 12:39, her meal was delivered and a staff member cut up a baked sweet potato. Her drinks were not within reach. She repeatedly reached towards her plate, with no silverware in hand. She touched the food with her fingers, then withdraw her hand. At 12:43, she peeled off a piece of sweet potato skin, then tried to flick it off her finger. She tried to eat some of the potato with her finger, without success. She pointed at the sweet potato. At 12:45 p.m., she reached for her pudding, touched the bowl, then lowered her hand. At 12:46, LPN 7 offered a fork to the resident and helped her get a bite of the sweet potato. LPN 7 stood next to the resident, offered her a drink, and continued to assist her for approximately five minutes. LPN 7 remained standing throughout. At 12:51 p.m., LPN 7 ceased assisting her with her meal. Resident 49 made attempts to get food on her fork, dropped the fork, and was given a clean fork by LPN 7. The resident's attempts to get a bite of food were unsuccessful. At 12:54 p.m., CNA 9 gave the resident a drink and offered her a bite of food. At 12:56 p.m., CNA 9 returned to another resident to assisted with their lunch. Resident 49 continued to attempt to use the fork to eat her meal without success.<br><br>During an interview with LPN 7, on 2/25/25 at 2:30 p.m., she indicated she wondered if Resident 49 was having trouble seeing. Usually, the resident fed herself, but was not doing well at lunch and seemed to be distracted.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview with the Assistant Director of Nursing (ADON), on 2/25/25 at 2:38 p.m., she indicated Resident 49 might have been experiencing a problem with depth perception. She was going to notify staff.<br><br>During an interview with CNA 8, on 2/25/25 at 2:39 p.m., she indicated Resident 49's need for assistance had increased. The resident sometimes got her utensils confused and was a very slow eater. Sometimes, the staff took the resident's plate to her unit and she finished eating there.<br><br>Resident 49's clinical record was reviewed on 2/24/25 at 2:45 p.m. Diagnoses included type 2 diabetes mellitus, hypertension, major depressive disorder, and unspecified dementia, unspecified severity, with anxiety.<br><br>Current physician orders included health shake once daily at lunch for weight loss, fortified food program with meals, regular diet, regular texture, regular/thin consistency, as tolerated; caregivers may cut meats bite-sized (7/12/23).<br><br>A 10/2/24, quarterly, Minimum Data Set (MDS) assessment indicated Resident 49 required partial to moderate assist for eating, including the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal was placed before the resident.<br><br>A 12/30/24 quarterly MDS assessment indicated the resident required substantial/maximal assist for eating - including the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.<br><br>A current care plan for activities of daily living (ADL) self care performance deficit, initiated on 7/28/22, indicated the resident needed substantial to dependent assist for toileting, bed mobility, transfers, and set-up for eating and drinking, all related to weakness or debility. One goal of the ADL focus was the resident would feed herself at each meal through the next review date. Eating interventions included the resident will be able to hold cup, feed self, eat finger foods independently, and encourage the resident to participate to the fullest extent possible with each interaction.<br><br>The care plan did not include revisions indicated by the 12/30/24 quarterly MDS assessment which identified the resident's need for substantial/maximal assist for eating.<br><br>A current care plan, initiated 8/3/22, indicated the resident had a nutritional problem or potential for nutritional problems related to type 2 diabetes mellitus, dementia, hypertension, hypercholesterolemia, hypothyrodism, and a vitamin D deficiency. The resident required total assistance, and refused to eat. Meal intakes were inadequate to her nutritional needs and required supplementation. Interventions included maintenance of weight without significant changes through next review, monitor nutritionally related labs as needed/referred, obtain and evaluate weights as ordered/per policy and/or at minimum, monthly. Notify the physician, dietitian and family of any significant changes. Provide medications and adaptive equipment as ordered. A fortified food program was initiated on 6/17/24, as well as a daily health shake supplement. Monitor and record intake, and offer meal substitutions as needed.<br><br>The care plan did not include revisions indicated by the 12/30/24 quarterly MDS assessment which identified the resident's need for substantial/maximal assist for eating.<br><br>(continued on next page) |

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|---|---|
| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A current care plan for a restorative program, initiated on 10/17/22, for active range of motion to all extremities related to a risk for decline in strength and range of motion, post therapy, and dementia. Interventions included encouraging the resident to participate in exercise group and praise her efforts. Give directions slowly and repeat to ensure the resident understands.<br><br>A restorative nursing program assessment, dated 2/19/25 at 4:21 p.m., indicated the resident was receiving active range of motion (ROM) therapy for bilateral upper extremities (BUD). The plan of care did not include receiving therapy for eating/dining.<br><br>2. Resident 223's clinical record was reviewed on 2/21/25 at 9:38 a.m. Diagnoses included benign prostatic hyperplasia without lower urinary tract symptoms, chronic kidney disease, anxiety disorder, dementia in other diseases classified elsewhere, unspecified severity, with mood disturbance, and type 2 diabetes mellitus.<br><br>A 2/12/25 admission MDS assessment indicated the resident required extensive assistance with transfers, toileting, and eating/drinking.<br><br>A current care plan for activity of daily living self-care performance deficit indicated he needed substantial/maximal assistance for toileting, bed mobility, transfers, and set-up/partial assistance for eating and drinking. The resident would feed himself 50% of each meal and staff would assist him when he could not feed himself.<br><br>A progress note, dated 2/7/25 at 8:17 a.m., indicated the resident required maximum to dependent assistance with bed mobility, eating, toileting, and transfers.<br><br>A progress note, dated 2/13/25 at 2:45 p.m., indicated the resident required minimum to moderate assistance on most tasks.<br><br>During an observation on 2/21/25 at 10:41 a.m., Resident 223 lay flat in his bed. His breakfast tray sat on the bedside table with over half of the food remaining.<br><br>During a dining observation on 2/24/25 at 12:44 p.m., Resident 223 drank some water from his lunch tray, but did not eat the food. He intermittently slept. No staff approached the resident to cue him or assist him with lunch. At 12:55 p.m., CNA 10 approached the resident and asked if he was ready to go. Seventy-five percent of the meal remained on the plate. The CNA did not ask him if he would like something else to eat before assisting him to the activities room.<br><br>During an observation on 2/25/25 at 12:09 p.m., Resident 223 was assisted into the dining room by staff and provided a clothing protector. At 12:18 p.m., drinks were offered. At 12:29 p.m., the resident took a drink of milk and played with the napkin. At 12:34 p.m., his lunch plate was delivered and set-up. He took a bite of the sweet potato at 12:37 p.m. He struggled to get food on his fork. He looked around the room and leaned far over his plate to get a bite. At 12:49 p.m., his cauliflower was half-eaten, and two thirds of his sweet potato remained. There was no staff interaction with Resident 223 after his plate was delivered.<br><br>During an interview with CNA 10 on 2/25/25 at 10:53 a.m., she indicated Resident 223 was often confused.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A current facility policy, titled Activities of Daily Living, and provided by the ADON on 2/25/25 at 4:00 p.m., indicated the following: .Policy: Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrates that such diminution was unavoidable. The facility must provide care and services in accordance with regulations for the following activities of daily living .Dining - eating, including meals and snacks .A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition<br><br>3.1-38(a)(2)(D) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>42685<br><br>Based on record review and interview, the facility failed to implement a fall intervention to prevent further falls for 1 of 3 residents reviewed for falls. (Resident 53)<br><br>Finding includes:<br><br>Resident 53's clinical record was reviewed on 2/21/25 at 11:48 a.m. Diagnoses included heart failure, change of fatty liver, generalized muscle weakness, unsteadiness on feet, need for assistance with personal care, depression and anxiety.<br><br>Current orders included clopidogrel bisulfate (anti-platelet) 75 milligrams (mg) 75 mg by mouth once daily, trazodone hydrochloride (insomnia) 50 mg administer 25 mg by mouth at bedtime, tramadol (opioid pain reliever) 50 mg by mouth every six hours as needed and metoprolol succinate (blood pressure and heart rate) extended release 50 mg by mouth twice a day, staff may use the mechanical lift for transfers with the assistance of two staff members (11/25/24), apply a pull tab alarm to the chair every shift (2/3/25), apply the off-loading boot to the resident's right heel every shift when he is in the wheelchair (2/20/25).<br><br>An annual Minimum Data Set (MDS) assessment, dated 11/28/24, indicated the resident was cognitively intact. He had a functional limitation in range of motion in both lower extremities. The resident was dependent on staff assistance for toileting, bathing, transfers, dressing lower extremities, donning and doffing of footwear, and sit to stand mobility. He had two or more falls with no injury since his last assessment.<br><br>A significant change MDS assessment, dated 1/13/25, indicated the resident had an altered level of consciousness that fluctuated. He used the wheelchair for mobility. The resident was dependent on staff assistance for eating, toileting, bathing, dressing, personal hygiene, transfers, repositioning, and donning and doffing of footwear. He did not have any falls since admission or his prior assessment.<br><br>A current care plan for activities of daily living self-care performance deficit, dated 6/19/23, indicated the resident was dependent on staff assistance for toileting, bed mobility, and transfers. Interventions included the following: the resident required two staff participation with transfers and a mechanical lift (6/19/23), the resident required one to two staff participation with transfers (9/25/23), the resident required one to two staff participation with transfers, may use the mechanical lift (7/3/24), the resident required two staff participation with transfers and the mechanical lift (11/26/24).<br><br>A current fall care plan, dated 8/14/23, indicated the resident had falls on 6/7/24, 10/2/24, 10/7/24, and 2/2/25. Interventions included the following: non-skid socks in place (10/28/23), chair alarm to wheelchair (initiated on 1/29/24 and removed on 11/20/24), two person assistance from staff for transfers (10/2/24), staff educated on the need to follow the care guides (10/8/24), and placed alarm in chair (2/3/25).<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An Interdisciplinary Team (IDT) note, dated 6/7/24 at 7:45 a.m., indicated the resident had a witnessed fall when a CNA attempted to transfer the resident from the bed to the wheelchair without the use of a gait belt. Socks and shoes were on the resident's feet at the time of the fall. The resident lost his balance, fell forward onto the floor, and hit his head on the floor, which resulted in a reddened area. The resident had participated in therapy due to weakness and decline in activities of daily living. The immediate intervention was staff education regarding gait belt assistance with all assisted transfers.<br><br>A fall risk assessment, dated 6/7/24, indicated the resident was at high risk for falls.<br><br>A nurse's note, dated 10/2/24 at 5:15 p.m., indicated the resident had a witnessed fall when he was assisted by a CNA to transfer from the bed to the wheelchair. The resident's knees buckled due to weakness and he was lowered to the floor. A gait belt was in use. The resident had his shoe on his left foot and the boot ordered to his other foot. No injuries were found during the assessment. A new order was received for the resident to have two staff member assistance. The resident representative, provider, and management were notified.<br><br>An IDT note, dated 10/2/24 at 5:15 p.m., indicated the resident was on therapy case load for a decline in activities of daily living when the resident was lowered to the floor on 10/2/24 at 5:15 p.m. The IDT team agreed the resident required two staff member assistance.<br><br>A fall risk assessment, dated 10/2/24, indicated the resident was at high risk for falls.<br><br>A Nurse's note, dated 10/7/24 at 1:53 p.m., indicated the resident had a witnessed fall when he was assisted by a CNA to transfer from the wheelchair to the bed with a gait belt in use. The resident had a non-skid sock on his left foot and the right foot was bare. The resident became weak and was lowered to the floor during the transfer. No injuries were identified during the assessment. The immediate interventions included the CNA was re-educated to follow the CNA Care Guide. The resident representative and provider were notified.<br><br>An IDT note, dated 10/7/24 at 1:30 p.m. indicated the resident was lowered to the floor on 10/7/24 by a CNA who attempt to transfer the resident from the wheelchair to the bed. The resident began to lean back while standing and the CNA eased the resident to the floor. When the nurse entered the room, the resident was upright on the floor parallel with the bed. His right foot was bare because the CNA removed the off-loading boot prior to the transfer. The CNA stood next to the resident with the gait belt grasped. The wheelchair was behind the resident with the brakes locked. The CNA was given re-education for failure to follow the CNA Care Guide that listed the resident as a two staff member transfer. The IDT agreed with the plan of care.<br><br>A fall risk assessment, dated 10/7/24, indicated the resident was at high risk for falls.<br><br>(continued on next page) |

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|---|---|---|---|
| | 155718 | A. Building<br>B. Wing | 02/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Northview Health and Living | 1235 W Cross St<br>Anderson, IN 46011 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 2/25/25 at 2:27 p.m., CNA 6 indicated Resident 53 required assistance from two staff members for transfers. The resident had fallen earlier this month on her shift. The resident was in his wheelchair when she went to lunch. Just as she returned from lunch, she found him on the floor when she went to answer a call light. He was on the floor in his room on his stomach and his wheelchair was beside him. No alarms were sounding when she found him on the floor. His non-skid socks were on his feet. She could not recall any other fall interventions in place when she found him on the floor. CNAs were required to use the CNA Care Guides and followed them for reference every shift. She had a CNA Care Guide in her pocket and provided a copy of the current CNA Care Guide from the Nurses station.<br><br>Review of the CNA Care Guide on 2/25/25 at 2:29 p.m., indicated Resident 53 was a fall risk. In the Equipment Assist column, it indicated the resident used a wheelchair and mechanical lift. The form lacked how many staff were required to provide assistance for the resident's transfers. Four other residents were listed on the form with a mechanical lift and indicated two staff members were required to provide assistance for these residents.<br><br>During an interview on 2/25/25, at 2:47 p.m., LPN 5 indicated Resident 53 had been a high fall risk for quite some time. She believed she was on duty when an aide lowered him to the floor back in October. She did not recall all of the details, but only one aide was present for the transfer during the fall. Education was provided to the aide who lowered the resident to the floor. She was unable to recall what fall interventions were in place when the resident was lowered to the floor on her shift in October. Around July/August of 2024, the resident required one to two person staff assistance. The resident had declined since then and required a mechanical lift and two person staff assistance now. When a resident had a fall, nursing was required to find the root cause of the fall and implement a fall intervention immediately, to prevent further falls. Once a fall intervention was implemented, it remained in place and should have been followed. The care plan interventions did not carry forward on the CNA Care Guides. Instead, management manually updated the CNA Care Guides. They tried to update them the date the intervention change occurred.<br><br>During an interview on 2/25/25 at 3:02 p.m., the ADON indicated she was unable to provide copies of the CNA Care Guides for 10/2/24, 10/7/24, and 2/2/25, as the updates were saved in place of the previous dates. Once care plan interventions were developed, they should have been followed until they were discontinued. When the resident was lowered to the floor by one staff member on 10/2/24, the immediate fall intervention included two person assistance. On 10/7/24 the resident was lowered to the floor again by one staff member. The staff member was educated due to a failure to implement the fall intervention developed on 10/2/24 to prevent further falls.<br><br>A current facility policy, dated 10/2017, titled Comprehensive Care Plans, provided by Unit Manager 11 on 2/25/25 at 4:15 p.m., indicated the following: Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A current facility policy, dated 10/2017, titled Fall Prevention Program, provided by the ADON on 2/25/25 at 4:20 p.m., indicated the following: Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Definitions: A fall is an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not as a result of an overwhelming external force . The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere . Policy Explanation and Compliance Guidelines: . 3. The nurse will indicate . the resident's fall risk and initiate interventions<br><br>3.1-35(g)(1)<br><br>3.1-45(a) |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>42685<br><br>Based on observation, interview, and record review, the facility failed to post complete nurse staffing information daily for residents and visitors. This had the potential to affect 70 of 70 residents in the facility.<br><br>Finding includes:<br><br>During an observation on 2/19/25 at 4:00 p.m., the facility nurse staffing, dated 2/19/25, was posted on a bulletin board in the main hallway across from the dining room. The posting lacked the facility census for the day.<br><br>During an observation on 2/20/25 at 2:55 p.m., the facility nurse staffing, dated 2/20/25, was posted on the bulletin board in the main hallway across from the dining room. The posting lacked the facility census for the day.<br><br>Staffing, dated 2/20/25, was posted as follows for the individual shifts:<br><br>First Shift:<br><br>Registered Nurse - one at 8 hours<br><br>Licensed Practical Nurse - three at 8 hours<br><br>Qualified Medication Aide - two at 8 hours<br><br>Certified Nurse Aide - nine at 7.5 hours<br><br>Total Hours: 113.5 (inaccurate- totals 115.5)<br><br>Second Shift:<br><br>Registered Nurse - one at 4 hours<br><br>Licensed Practical Nurse - three at 8 hours<br><br>Qualified Medication Aide - two at 4 hours<br><br>Certified Nurse Aide - eight at 7.5 hours<br><br>Total Hours: 100 (inaccurate- totals 96)<br><br>Third Shift:<br><br>Registered Nurse - blank<br><br>(continued on next page) |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Licensed Practical Nurse - two at 8 hours, one at 4 hours<br><br>Qualified Medication Aide - one at 8 hours<br><br>Certified Nurse Aide- four at 7.5 hours<br><br>Total Hours: 58<br><br>During an observation on 2/21/25 at 4:18 p.m., the facility nurse staffing, dated 2/20/25, remained posted on the bulletin board in the main hallway across from the dining room. The posting lacked the facility census. The nurse staffing hours worked and totals for the licensed nurses and certified aides were not updated for the current date and remained as listed above.<br><br>During an interview on 2/21/25 at 4:31 p.m., the Business Office Manager indicated the staffing posting was still from 2/20/25. The Scheduler typically did the daily nurse staffing posting. It had not been updated for the current date because she was not working. She was unaware who was assigned to post the staffing in her absence. The daily nurse staffing was always posted in the same location each day, on the bulletin board across from the dining room, by her office.<br><br>During an interview on 2/21/25 at 4:34 p.m., the Administrator indicated the nurse staffing should have been posted in the morning for the current day. The posting remained unchanged from the staffing posted on 2/20/25. The Scheduler was off work and the duties had not been reassigned to someone else. She indicated the staffing posted each day lacked the facility census on the form.<br><br>A current facility policy, dated 10/2017, titled Nurse Staffing Posting Information, provided by the Administrator on 2/24/25 at 10:15 a.m., indicated the following: Policy: It is the policy of this facility to make nurse staffing information readily available in a readable format to residents, staff, and visitors at any given time. Policy Explanation and Compliance Guidelines: 1. The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information: a. Facility name b. The current date c. Facility's current resident census d. The total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: i. Registered Nurses ii. Licensed Practical Nurses/Licensed Vocational Nurses iii. Certified Nurse Aides 2. The facility will post the Nurse Staffing Sheet at the beginning of each shift. 3. The information posted will be: a. Presented in a clear and readable format. b. In a prominent place readily accessible to residents, staff, and visitors |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48384<br><br>Based on observation and interview, the facility failed to appropriately label and date medications for 3 of 5 carts reviewed for medication storage. (100 hall medication cart #1, 100 hall medication cart #2, and 100 hall respiratory cart)<br><br>Findings include:<br><br>During a medication storage observation on [DATE] at 10:13 a.m., accompanied by LPN 15, the 100 hall medication cart #1 had an opened and undated vial of insulin lispro. The vial was ,d+[DATE] full. LPN 15 indicated insulin should be labeled with an opened date.<br><br>On [DATE] at 10:23 a.m., accompanied by QMA 13, the 100 hall medication cart #2 had an opened and undated insulin glargine (Quikpen) with 4 units remaining. QMA 13 indicated the insulin was supposed to be dated when opened.<br><br>On [DATE] at 12:11 p.m., accompanied by QMA 13, the 100 hall respiratory cart was observed with the following: albuterol sulfate (bronchodilator) HFA inhaler with an expiration date of [DATE] lacked an open date; albuterol sulfate HFA inhaler with an expiration date of [DATE] lacked an open date; fluticasone/umeclidinium/vilanterol powder (inhaled medication) breath activated, 100 mcg/6.2 mcg/25 mcg, with an expiration date of ,d+[DATE] lacked an open date; albuterol sulfate HFA with an expiration date of [DATE] lacked an open date and was expired; ipratropium-albuterol (bronchodilator) solution 0XXX, d+[DATE].5 mg/3 mL, with an expiration date of [DATE] lacked an open date; albuterol 108 mcg/act HFA inhaler with an expiration date of [DATE] lacked an open date. QMA 13 indicated she dated inhalers when opened. She was not allowed to provide nebulizer treatments.<br><br>During an interview with the Respiratory Therapist on [DATE], at 9:21 a.m., she indicated both inhalers and nebulizer ampules should have been dated when opened. Manufacturer expiration dates were on the packages.<br><br>During an interview with Unit Manager 11, on [DATE] at 12:37 p.m., she indicated insulin, eye drops, and inhalers should be dated when opened. If staff found undated medications, they could ask other staff when the medication was opened. If unsuccessful, those medications should not have been used and staff should have disposed of them properly. If a medication was expired, it should have been appropriately disposed. Staff should have notified the pharmacy to update them on the status of any expired or undated, open medications.<br><br>A current facility policy, titled Medication Administration - Labeling of Medication, was provided by the ADON on [DATE] at 10:30 a.m., and indicated the following: Policy - To ensure that the facility, in coordination with the licensed pharmacist, provide for accurate labeling to facilitate safe administration of medications and consideration of precautions in accordance with the currently accepted professional principles .3) Multi-dose medication vials/devices should be labeled with the date opened/accessed<br><br>3XXX,d+[DATE](o) |