STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155822	A. BUILDING 00 B. WING	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDAR CREEK HEALTH CAMPUS	18275 BURR STREET LOWELL, IN 46356

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F 0000 Bldg. 00	This visit was for the Investigation of Nursing Home Complaints IN00434144 and IN00435373. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. This visit included the Investigation of Residential Complaint IN00434472. Complaint IN00434144 - No deficiencies related to the allegations are cited. Complaint IN00435373 - Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00434472 - State deficiency related to the allegations is cited at R0240. Survey dates: June 3, 4, and 5, 2024 Facility number: 013144 Provider number: 155822 AIM number: 201246060 Census Bed Type: SNF/NF: 31 SNF: 24 Residential: 33 Total: 88 Census Payor Type: Medicare: 18 Medicaid: 24 Other: 13 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	The submission of this plan of correction does not indicate an admission by Cedar Creek Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Cedar Creek Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shelly Dyek	Executive Director	06/19/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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F 0689 SS=J Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure adequate supervision was provided to a cognitively impaired resident with a history of exit seeking and failed to ensure an alarmed door was effectively secured to prevent elopement for 1 of 6 residents reviewed for elopement risk. (Resident M) This deficient practice resulted in Resident M exiting the facility and being picked up by a stranger who activated 911. The immediate jeopardy began on 5/25/24 when a cognitively impaired male resident, with a history of exit seeking and a Wanderguard (door alarm bracelet used to monitor residents who wander) in place, exited the facility without staff knowledge and ambulated 0.3 miles away from the facility. The resident was absent from the facility for approximately 35 minutes, had just been medicated with an as needed anti-anxiety medication (Xanax), and was also at risk for falls. The Administrator, Assistant Director of Nursing (ADON), RN Clinical Support Nurse, and the Area Executive Director were notified of the immediate jeopardy at 3:47 p.m. on 6/3/24. The immediate jeopardy was removed, and the deficient practice corrected, on 5/26/24, prior to the start of the survey and was therefore Past Noncompliance.	F 0689	We received PNC on 5/26/24	06/07/2024

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	Finding includes: An Indiana Department of Health (IDOH) Incident Report, dated 5/26/24 at 6:29 p.m., indicated Resident M exited the facility and was returned to the facility without injury on 5/25/24 at 7:30 p.m. The five day follow-up report indicated an investigation had been completed and the root cause of the elopement was the exit door becoming lodged by a rug in the entryway. The door remained in the opened position and the resident exited through the opened door. The facility nurse had not seen the resident on the unit and had begun searching for him. Upon arrival to the front exit door, the nurse found a local police officer who had been talking to a staff member about the resident. The police officer had indicated a "Good Samaritan" had seen the resident and called 911, who had responded and assisted with the return of the resident. Resident M was assessed, and no injury was found. The Wanderguard bracelet was in place and functioning. The EMS (Emergency Medical Services) Run Record, dated 5/25/24, indicated the EMS Unit was notified on 5/25/24 at 7:01 p.m. and arrived on the scene at 7:07 p.m. on 5/25/24. The narrative indicated upon arrival, they found an 87-year-old male who was only oriented to self, sitting in the passenger seat of an SUV (sport utility vehicle). The driver of the SUV stated she noticed the male walking down the sidewalk and leaning against the fence. The resident was confused and "not making sense to her." She assisted the resident into her vehicle and called 911. The resident was unable to voice where he lived or date of birth. He indicated at one time he lived at [Facility Name]. The local police department went to the facility			

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	and confirmed he currently resided at the facility. The Good Samaritan drove the resident back to the facility and the EMS Unit followed behind to ensure the facility did not want any further services from them. The resident entered the facility at 7:27 p.m. The facility Investigation Summary, dated 5/29/24, indicated Resident M exited the facility at 6:47 p.m. unattended and was found approximately 0.3 miles from the property by a Good Samaritan, who had stopped and notified 911. They stayed with the resident until the police and EMS arrived. The resident returned to the facility without injury. The timeline per the facility's camera indicated on 5/25/24 at 6:47 p.m., Resident M exited the facility through an open door. At 6:48 p.m., Environmental Services #2 arrived at the door, adjusted the rug and closed the door. She then appeared to touch the keypad. The local police officer arrived at 7:14 p.m. and left the building at 7:17 p.m. At 7:23 p.m., EMS entered the facility with Resident M. The investigation, dated and signed by the Administrator on 5/29/24, included the following staff members' statements: A typed statement, signed and dated on 5/29/24 by LPN 2 (day shift nurse on 5/25/24), indicated on 5/25/24, the resident was wanting to go outside. LPN 2 had asked CNA 3 to walk with the resident around the building and courtyard. CNA 3 walked with the resident. CNA 3's shift ended at 4 p.m. and the resident was sitting at the Nurses' Station. Resident M became restless again and LPN 2 walked him to his room and they reminisced about his past. LPN 2 finished his shift at 6:11 p.m. and the resident was sitting in his recliner in his room with his feet elevated.			

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	A typed statement, signed and dated on 5/26/24 by CNA 3, indicated at 2:00 p.m. on 5/25/24 Resident M had requested to go outside. CNA 3 escorted him to the Healthcare Courtyard and they sat in the Courtyard for "30 to 40 minutes". Resident M asked to go back to his room and then began to exhibit exit seeking behaviors and started heading near the front entrance. The door alarm sounded when Resident M approached the entrance, and CNA 3 successfully redirected him back to his room. CNA 3 provided supervision to the resident until her shift ended at 4 p.m., and reported to LPN 2 she was leaving. A typed statement, signed and dated on 5/26/24 by CNA 11, indicated on 5/25/24, she had seen the resident after dinner walking around the Healthcare Dining room about 6 p.m. CNA 11 didn't hear any alarm go off and was unaware of the resident leaving the facility. A typed statement, signed and dated on 5/26/24 by LPN 1, indicated on 5/25/24 at 6:15 p.m., Resident M was exit seeking and wandering. LPN 1 administered an as needed Xanax 0.25 mg (milligrams). Resident M was wearing a hat, red shirt, black sweatpants, and shoes. LPN 1 was then notified by a CNA and Dietary Aide the resident was outside of the building with EMS. The resident was assisted back into the facility and an assessment was completed and he was found to have no injuries or psychosocial distress. One-on-one care (one staff specifically assigned to the resident) was initiated. After the resident fell asleep, 15-minute checks were initiated. A second typed statement, signed and dated on 5/29/24 by LPN 1, indicated a follow-up interview			

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	was completed with LPN 1. LPN 1 indicated on 5/25/24 at 6:40 p.m., Resident M was sitting at the Buckley Nurses' Station. LPN 1 had left the nursing station area to administer medications to other residents and when she returned, Resident M was no longer sitting on the couch by the Nurses' Station. LPN 1 went to the dining room to see if he was there, as he often sat there, and he was not. LPN 1 stopped and the Eagle Nurses' Station and asked RN 1 if she had seen the resident and RN 1 indicated she had not seen him. LPN 1 then went to the front door and saw two employees talking to a police officer. LPN 1 indicated this was a little bit after 7 p.m. The police officer indicated Resident M was in an ambulance and was being assessed by EMS. LPN 1 indicated she had not heard the door alarm when the resident left the building. The alarm was sounding when the resident returned to the facility. A typed statement, signed and dated on 5/26/24 by Dietary Aide (DA) 10, indicated the resident was seen at 6:15 p.m. when he was collecting room supper trays. The resident was ambulating down the Buckley Hall. DA 10 indicated he had not heard any alarms sounding. A typed statement, signed and dated on 5/29/24 by Environmental Services (ES) 2, indicated on 5/25/24 at approximately 6 p.m., she had exited the Assisted Living Memory Care Unit after delivering clothes and observed the front door, "stuck open". ES 2 moved the rug the door was stuck on and shut the door. She was unable to recall if the alarm was sounding. ES 2 looked around and had not seen a resident, so she continued with her work. A typed statement, signed and dated on 5/26/24 by DA 9, indicated on 5/25/24, she had been			

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	setting the table in the Assisted Living Dining Room when a police officer entered the front door. The police officer asked if the resident resided at the facility, and DA 9 confirmed that he did. DA 9 alerted the nurse. A wheelchair was brought to the door and the officer assisted the resident to sit in the wheelchair. A typed statement, signed and dated on 5/30/24 by CNA 8, indicated on 5/25/24 he was assigned to the Eagle Unit. CNA 8 was leaving the facility on break through the front entrance at 7 p.m. when a police officer asked if he knew Resident M. CNA 8 informed the officer he would get the nurse. LPN 1 then spoke to the officer. The facility Investigation, dated 5/29/24, indicated the timeline for the event on 5/25/24, as viewed on the facility camera, was as follows: At 6:39 p.m., a visitor was leaving the campus. The inside door was stuck wide open on the rug in the vestibule. At 6:47 p.m., Resident M exited through the open doors. At 6:48 p.m., Environmental Services 2 arrived at the door, adjusted the rug, and closed the door. She then appeared to touch the keypad. At 7:07 p.m., there were visitors who entered the door and the door closed behind them. At 7:10 p.m., there were visitors who entered the door and the door again was stuck open. At 7:17 p.m., the police officer entered through the open door. At 7:18 p.m., an Assisted Living resident fixed the rug the door was stuck on and the door closed. At 7:19 p.m., EMS entered the door and the door closed. At 7:20 p.m., employees exited the building and the door closed. At 7:22 p.m., EMS and a staff member exited with			

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	the wheelchair and the door closed. At 7:23 p.m., EMS entered the door with the resident and the door closed. Resident M's record was reviewed on 6/3/24 at 9:50 a.m. The diagnoses included, but were not limited to, dementia. An Admission Fall Risk assessment, dated 12/22/23, indicated a moderate risk for falls. An Elopement Risk assessment, dated 3/1/24, indicated a history of exit seeking, voiced statements of leaving, exit seeking alarm bracelet/device was used, monitored for placement and functioning, and the resident was an elopement risk. A Quarterly Minimum Data Set assessment, dated 3/6/24, indicated a severely impaired cognitive status, had wandering behaviors one to three days during the assessment period, no upper or lower extremity impairments, and required supervision for all activities of daily living which included ambulation. No assistive devices were required, and the resident had no falls since the past review. A Care Plan, dated 7/18/23, indicated the resident was at risk of falling. The interventions, dated 7/18/23, included therapy as needed, assist with transfers as needed, and the call light was to be kept within reach. A Care Plan, dated 7/19/23 and revised 4/30/24, indicated exit-seeking and wandering behaviors were present. The interventions included, a Wanderguard bracelet would be placed and checked for placement and functioning, encourage contact with family, diversion activities			

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	were to be offered, and he was to be directed away for the doors/exits as needed. Added on 4/4/24: the staff were to offer to take a walk with the resident throughout the facility, they were to reminisce about memorabilia and photos in his room. Added on 4/30/24: snacks of choice were to be offered. Added on 5/26/24: 15-minute checks were initiated and added on 5/30/24: the resident had pet cats in the past and enjoys talking about them. Provide distracting conversation. The current 5/2024 Physician's Order Summary included, but was not limited to: - 7/17/23: a Wanderguard bracelet was to be used and changed every month. - 5/23/24: Xanax 0.25 mg was to be given PRN (as needed) twice a day for anxiety attacks. The Medication Administration Record (MAR), dated 5/2024, indicated the exit-seeking behaviors were monitored every shift. He had exit-seeking behaviors on the evening and night shift on 5/2/24, day shift on 5/10/24, and evening shift on 5/5/24. The MAR, dated 5/2024, indicated the Wanderguard bracelet was checked for functioning every day shift and was checked for positioning every shift. A Nurse's Progress Note, dated 5/25/24 at 6:15 p.m. and signed by LPN 1, indicated the resident had been wandering and agitated. The as needed Xanax was administered. He sat at the Buckley Unit Nurses' Station for 15 minutes and began wandering again. There was no documentation in the record to indicate the interventions of staff walking around the facility with the resident or offering a snack			

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	was implemented to assist with the exit-seeking behavior or adequate supervision was provided by staff on 5/25/24 between 6:15 p.m. and 6:47 p.m. A Nurse's Progress Note, dated 5/25/24 at 7:05 p.m. and signed by LPN 1, indicated the resident was no longer sitting at the Buckley Unit Nurses' Station and she began searching for him. When she entered the other side of the building (Assisted Living) a police officer was talking to a CNA and Dietary Aide. The police officer informed the nurse the resident was found stumbling a few blocks from the facility and was being assessed in the ambulance and then would be brought back to the facility. A Nurse's Progress Note by LPN 1, dated 5/25/24 at 7:30 p.m., indicated the resident returned to the facility with EMS and was sitting in a wheelchair and sleeping. A full assessment was completed, and no injuries were found. There was no distress and the resident requested to go to bed. He was assisted to bed and 15-minute checks were initiated. During an interview on 6/3/24 at 9:38 a.m., the ADON indicated up until 8 p.m., the front door (Assisted Living) would only alarm if a Wanderguard went through the door. The resident had his Wanderguard bracelet on. The door was stuck on the rug, and it held the door open. Even with the door being open, the Wanderguard would have set the alarm off. The staff were all interviewed, and no one heard the alarm. The administration looked at the video and Environmental Service 2 was seen adjusting the rug and her hand did something to the keypad about a minute after the resident exited the building. When she was interviewed, she indicated there had been no alarm activated and			

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	she touched the keypad out of habit. During an interview on 6/3/24 at 10:21 a.m., the Maintenance Director indicated the Wanderguard alarm systems were checked with a bracelet every Monday, Wednesday, and Friday. The alarms were functioning on 5/24/24. During an investigation after the incident, they had found the annunciator (panel with warning lights/alarms) in the Assisted Living Nurses' Station (Nurses' Station closest to the front door) had not been wired to the front the door. The door alarm itself still worked, and could be heard in the healthcare area. He was unsure how long the annunciator piece had not been working, as the door alarm had not been wired to it. The Maintenance Director then activated the door alarm with a Wanderguard bracelet, and the alarm could be heard in the Healthcare area. LPN 4, LPN 5, and RN 6 were at the Eagle Nurses' Station, and all indicated they were able to hear the front door alarm when it was activated. During an interview on 6/3/24 at 11:23 a.m., Environmental Services 2 indicated she could not remember if the front door alarm was activated or if she just responded because the door was left open. She indicated the door had been caught on the rug. She had not gone outside to look around, though she did look out the door and had not seen anyone. She moved the rug and shut the door. She indicated if the alarm had been sounding, she would have reset the alarm on the keypad and did not remember doing that. She indicated she only remembered the door being wide open because it was caught on the rug. She indicated the alarm was activated often with residents going on the bus or out with family, and no one had educated her on what she was supposed to do if the alarm was activated.			

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	During an interview on 6/3/24 at 12:35 p.m., LPN 1 indicated she had started work at 6:00 p.m. and received in report Resident M had been wandering, agitated, and exit-seeking. He was sitting on the couch near the Buckley Nurses' Station, which is by the back (skilled unit) entry door. LPN 1 heard the Wanderguard beeping then, because he was sitting close to the door. The PRN Xanax was administered due to his anxiety, then LPN 1 left the nursing station area to administer medications to a few other residents. When she returned, the resident was no longer sitting at the Nurses' Station. LPN 1 went to the Dining Room because Resident M did like to sit at his table there, and he was not there. LPN 1 asked RN 7 if she had seen him, and RN 7 had not seen him. When LPN 1 arrived at the front door area, she saw a police officer talking to CNA 8. The police officer informed her a "citizen" saw the resident stumble while he was walking and called 911. The ambulance responded and would be bringing the resident back to the facility. LPN 1 indicated she had not heard the alarm ring. During an interview on 6/3/24 at 12:52 p.m., RN 7 indicated she worked 2 p.m. to 10 p.m. on 5/25/24 on the Eagle and Halstead Units. She last saw the resident around 4 p.m. She had not heard the Wanderguard alarm ringing. The Wanderguard was in place and was functional when he was brought back to the facility. During an interview on 6/3/24 at 12:57 p.m., CNA 8 indicated 5/25/24 was his first day of orientation and he was assigned to the Eagle Unit. He was exiting the front door to go on break when the police officer came in and asked him if the resident resided at the facility. CNA 8 indicated he was just learning the residents and was unsure, then LPN 1			

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	arrived and spoke with the officer. During an interview on 6/4/24 at 8:57 a.m., the Administrator indicated the observation of the video from the facility camera indicated the alarm had been sounding. They were able to see Environmental Services 2 putting the code in on the keyboard. She had thought the alarm was activated by the door being held open by the rug. The employee was observed looking out the door, but not going outside to look around. A facility policy for elopement/missing resident, dated 12/31/23 and identified as current by the ADON, indicated when a door alarm was sounding, the staff were to respond promptly to the sounding door alarm. The charge nurse, facility supervisor or Executive Director should call staff to a central area and designate staff to perform a head count, have two staff exit the alarming door and go in opposite directions around the building perimeter, one staff was to review the sign out log and 24 hours nurse report, one or more staff were to search the facility, and if necessary, one or more staff were to expand the search to the facility premises. If the resident was not found on the property, the local police department, physician and responsible party was to be notified. A facility policy titled, "Alarm Checks", dated 12/31/23 and received from the Area Executive Director as current, indicated the door alarms were to be checked by the Director of Plan Operations or designee daily during the typical business days. The Administrator was to be notified immediately if the alarms were non-functioning. The individual alarms were to be checked daily for functioning and every shift for placement.			

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	The past noncompliance immediate jeopardy began on 5/25/24. The immediate jeopardy was removed, and the deficient practice corrected by 5/26/24 after the facility implemented a systemic plan that included the following actions: - The rug in the vestibule was removed. - All residents in the facility were reviewed for elopement risk. - The residents who were assessed as an elopement risk have Wanderguard bracelets initiated. - All Physician's Orders for the bracelets and checking for functioning and placement were reviewed and were up to date. - All exit doors have been evaluated to ensure the Wanderguard is functioning. - Elopement binders have been updated - As of 5/26/24, 93 of 122 employees have been educated on the elopement/missing resident policy and all remaining staff will be educated upon their return to work. - An elopement drill was completed without concerns. This citation relates to Complaint IN00435373. 3.1-45(a)(2)			
R 0000 Bldg. 00	This visit was for the Investigation of Residential Complaint IN00434472. This visit included the Investigation of Nursing Home Complaints IN00434144 and IN00435373. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. Complaint IN00434472 - State deficiency related to the allegations is cited at R0240.	R 0000	The submission of this plan of correction does not indicate an admission by Cedar Creek Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Cedar Creek Health	

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	Complaint IN00434144 - No deficiencies related to the allegations are cited. Complaint IN00435373 - Federal/State deficiencies related to the allegations are cited at F689. Survey dates: June 3, 4, and 5, 2024 Facility number: 013144 Residential Census: 33 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.		Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, record review, and interview, the facility failed to ensure a resident with multiple falls received one on one care as deemed necessary to prevent further falls for 1 of 3 residents reviewed for falls and behaviors. (Resident B) Finding includes: During an observation on 6/4/24 at 3 p.m., Resident B was walking with the assistance of a staff member. The resident's gait was unsteady. During an observation on 6/5/24 at 9:24 a.m., the resident was walking in the hallway with a CNA.	R 0240	1.Resident B had no negative outcomes. All residents have the ability to be affected. 2.All falls and behaviors to have an interdisciplinary team note. 3.Educated Director of Assisted Living on interdisciplinary team notes for falls and behaviors. 4.Audit 5 residents a week x2 months, 3 residents a week x2 months, 1 resident a week x2 months 5.All findings will be brought to QA monthly for reporting, reviewing and trending for a	06/07/2024

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	The resident's ambulation was very unsteady with missteps and stumbles. Resident B's record was reviewed on 6/5/24 at 10:39 a.m. The diagnoses included, but were not limited to, frontal/temporal neurocognitive disorder and dementia. The resident was admitted into the Legacy Unit (memory care) on 5/9/24. An Admission Evaluation and Service Plan, dated 5/9/24, indicated physical assistance was required for mobility and transfers. She was a fall risk, was anxious and/or agitated, and had a severely impaired cognitive status. The interventions for the anxiousness and/or agitation indicated regular time outdoors would be provided, daily rhythm programs, and redirection and encouragement would be provided. The interventions for the risk for falls included the following: 5/9/24 the Nurse Practitioner would assess her medications and personal items were to be kept in reach, 5/13/24 anti-tippers were placed on the wheelchair, 5/15/24 dycem was placed on the wheelchair seat, 5/25/24 anti-roll backs were placed on the wheelchair, and 5/28/24 verbal reminders not to ambulate/transfer without assistance was added to the interventions. The Care guide, dated 5/9/24, indicated the resident had impulsive behaviors, used a wheelchair, required physical assistance with transfers, and was a fall risk. The Nurses' Progress Notes since admission indicated the resident had multiple falls related to unassisted transfers and ambulation on 5/9/24 at 11:45 a.m., 5/11/24 at 2:59 p.m., 5/13/24 at 9 a.m., 5/14/24 at 7:56 p.m., 5/19/24 at 8:57 p.m., 5/21/24 at 2:15 p.m., 5/24/24 at 7:40 p.m., 5/25/24 at 10 a.m., 5/25/24 at 5:33 p.m.		minimum of 6 months or until 100% compliance is obtained.	

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	A Fall Event, dated 5/9/24 at 11:45 a.m., indicated a fall occurred in the common area due to an unassisted transfer. There were no injuries. A Fall Event, dated 5/11/24 at 2:59 p.m., indicated an unwitnessed fall occurred due to an unassisted transfer. The Nurses' Progress Notes indicated the following: On 5/13/2024 at 1:28 p.m., the resident was sitting in a wheelchair, suddenly stood up and fell. She hit her head on the wall. Neurological assessments were initiated and the resident was assessed with no injuries. On 5/14/2024 at 9:01 p.m., the nurse was called and responded to the Legacy Unit due to the resident had fallen. Another staff nurse witnessed the fall and could not get to the resident in time to prevent the fall. There were no injuries. On 5/17/24 at 11:45 a.m., the facility met with the family and informed them the resident required one on one care continually. A family member indicated they were aware one on one assistance was needed. On 5/18/24 at 1:59 a.m., the resident was in the wheelchair, awake and restless. She received an as needed (PRN) anti-anxiety medication as ordered by the physician and the medication was not effective. She was propelling the wheelchair and playing with a blanket and baby doll. Snacks and fluids were offered and accepted. She leaned forward in the wheelchair often, would pick at the carpet and put on and take off her shoes. She propelled herself into the furniture. The resident required one on one care for safety purposes.			

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	On 5/18/24 at 8:36 p.m., the resident required one on one care all shift and had no regards to her safety. She frequently tried to get up and walk with an unsteady gait. She was unable to be redirected and was restless. On 5/19/2024 at 9:10 p.m., the resident was found lying on the floor next to her bed at 8:30 p.m. by the CNA. The nurse was notified and a full assessment was completed. There were no injuries. The resident was assisted back to bed. On 5/20/24 at 11:34 a.m., the Power of Attorney (POA) was notified the resident required a one on one sitter services or hospice services due to the decline in her health status. On 5/21/24 at 3:14 p.m., the resident was found lying on the floor beside the roommate's bed. There were no injuries. She was assisted into a wheelchair and one on one care was required. On 5/22/24 at 4:40 a.m., the resident attempted to climb out of bed and was wide awake. She was assisted to the wheelchair and offered a snack. She was offered her baby doll and still remained restless. On 5/22/24 at 9:46 a.m., she required one on one care all morning. On 5/23/24 at 2:18 p.m., she required one on one care at all times. On 5/24/24 at 12:56 p.m., the POA notified the facility and was looking for a possible sitter service for the resident.			

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	On 5/24/24 at 10:12 p.m., the resident was in the TV lounge and slid out of her wheelchair onto her knees. Staff responded to the resident after the fall. There were no injuries. She was assisted back into her wheelchair and received one on one care the rest of the evening until she was assisted to bed. On 5/25/24 at 10:17 a.m., the resident required one on one care. The CNA was assisting another resident and Resident B was found on her knees in front of her wheelchair. There were no injuries. On 5/25/24 at 5:30 p.m., the nurse was called to the Legacy Unit. The resident was observed on the floor in the dining room. The CNA reported the resident did not hit her head and she was unable to get to the resident in time to prevent her from falling. There were no injuries. On 5/26/24 at 9:15 a.m., the resident required one on one care all morning. On 5/26/24 at 8:42 p.m., the resident required one on one supervision when she was awake. On 5/28/24 at 9:45 a.m., the resident was hitting out at staff. The attempts to redirect increased her agitation. Interventions of activities, food, music, massage, and repositioning were unsuccessful. On 5/28/24 at 1:06 p.m., indicated at approximately 11:38 a.m., the resident stood up and began to ambulate by herself with an unsteady gait. She was difficult to redirect with multiple interventions by numerous staff. She was given food, drink, assisted to the toilet, and assisted her to her room and back to the common areas. The resident placed her hands on a staff members breasts and around the staff members neck, without			

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	squeezing. She began to walk briskly towards the dining room, attempted to grab things from off the tables and other resident's wheelchairs. At each "resting period", the staff were switched out to ensure the resident remained safe. She required one on one care and continued to disrobe in the common area and grab at staff. The POA was notified and indicated at this time the family was not able to come and assist with the resident's one on one care. The POA was looking for alternative options. On 5/28/24 at 9:16 p.m., the resident required one on one supervision while she was awake. On 5/29/24 at 3:52 a.m., the resident was combative during a.m. care. She calmed after multiple attempts to assist her with dressing. On 5/29/24 at 10:48 a.m., the Unit Manager indicated she arrived on the Legacy Unit at 7:45 a.m. and the resident was observed to require one on one care. The resident was walking the unit with an unsteady gait. A gait belt was used for safety. The resident had been incontinent and care was provided. Breakfast was served and she consumed 100% of the food and multiple cups of fluids. She was assisted with ambulating through out the unit and and the facility. She continued to ambulate with staff. She had a brief nap and upon waking was ambulating around the unit with assistance. She then laid down in bed and napped. When staff entered the room approximately 20 minutes later, the resident was found on the floor asleep. The resident's family had indicated upon admission the resident enjoyed lying on the floor due to her severe scoliosis. This would be added to the resident's profile and a fall mat mat next to the bed would be initiated.			

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	On 5/30/24 at 2:41 a.m., the nurse was called to the Legacy Unit by the CNA due to the CNA was providing care to another resident and Resident B was ambulating in the hallway and coming to the doorway of the other resident. She removed her brief at the doorway and urinated. The resident was resistant and difficult to redirect. On 5/30/24 at 3:45 a.m., one on one care was required. On 5/30/24 at 12:10 p.m., the POA was notified and was informed the resident was requiring one on one care. The POA indicated they were seeking alternate placement. On 5/31/24 at 12:57 a.m., the resident was resistive to care and difficult to redirect and it required four staff members to assist with the resident. On 6/4/24 at 10:22 a.m., the resident was walking the unit with supervision. She was very impulsive and attempted to pick at things that were on the floor. She sat down on the floor in the common area. On 6/4/24 at 10:58 p.m., the resident attempted to get out of bed by herself. One on one care was provided. 6/5/24 at 10:02 a.m., one on one care was required at all times. Review of the Legacy Unit schedules from May 17, 2024 to June 6, 2024, indicated there was one CNA scheduled for the Legacy Unit on days, evenings, and night shift. There were 14 residents on the Legacy Unit. There was one nurse/QMA scheduled to work both the assisted living and			

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	the Legacy Unit for a total of 33 assisted living residents. During interviews on 6/5/24 at 12:22 p.m., the Unit Manager indicated she had spoken with the family regarding the resident requiring one on one care. She acknowledged there was one CNA on the unit and the nurse worked both units with 13 other residents on the Legacy Unit to care for. The Area Executive Director indicated the facility started scheduling one person to come in for the one on one care for the resident on 6/4/24. The Administrator indicated the one on one staff was scheduled for 8 a.m. to 8 p.m. She indicated there was no one scheduled to do one on one care 8 p.m. to 8 a.m. This citation relates to Complaint IN00434472.			