STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155627	A. BUILDING 00 B. WING	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY WEST	1720 ALBER ST WABASH, IN 46992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 26, 27, 28, 31, and August 1, 2023. Facility number: 000578 Provider number: 155627 AIM number: 100267810 Census Bed Type: SNF/NF: 21 Total: 21 Census Payor Type: Medicaid: 14 Other: 7 Total: 21 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 7, 2023.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal laws. Facility's date of alleged compliance is August 20th, 2023. The facility is respectfully requesting paper compliance for the alleged deficiencies in this plan of correction.	
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Katherine Wright	Administrator	08/20/2023

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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	events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to report resident-to-resident abuse for 1 of 2 resident altercations reviewed for State Agency reporting (Resident 6 and Resident 17). Findings include: During an interview on 7/27/23 at 10:15 a.m., Resident 6 indicated her previous roommate (Resident 17) and she argued periodically. The last time they argued, it became physical. Resident 6 was in bed when Resident 17 came over to her bed, grabbed Resident 6's face, and said "Don't you ignore me." Resident 6's clinical record was reviewed on 7/27/23 at 1:27 p.m. Her diagnoses included multiple sclerosis, generalized anxiety disorder, bipolar disorder, major depressive disorder, and delusional disorder.	F 0609	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the policy of this facility to report allegations of abuse, neglect, exploitation, mistreatment, or misappropriation. Corrective actions for resident #6 & resident #17 have taken place by reviewing resident records and separating resident rooms. Residents are satisfied with the corrective actions and plans of care have been updated for both residents. **How other residents having the potential to be affected by the same deficient practice will be**	08/20/2023

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	Her medications included aripiprazole (antipsychotic) 2.5 mg (milligrams) daily and sertraline (antidepressant) 75 mg daily. A quarterly Minimum Data Set (MDS) assessment, dated 6/14/23, indicated the resident was cognitively intact. She was totally dependent on the assistance of two staff members for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. She was totally dependent on assistance of one staff member for eating, and locomotion off and on the unit. Her upper and lower extremities range of motion was impaired on both sides. A care plan initiated on 3/23/23 and revised on 6/27/23 indicated she had made accusations (which had been investigated and determined to be unsubstantiated) against unidentified people. The goal initiated on 3/23/23 with a target date of 9/5/23 indicated the resident will feel safe. Interventions included all resident accusations will be investigated (initiated 3/23/23) and listen to resident, gather as much information as possible (initiated 3/23/23). A General Progress Note, dated 6/18/23 at 11:19 p.m., indicated the resident had put on her call light and reported her roommate was being mean and yelling at her. The roommate became upset and indicated the resident was lying and to "shut up." Three times, the staff were called to intervene in the argument. The roommate "became physical" with the resident and they were separated. Review of Resident 17's clinical record was completed on 8/1/23 at 3:12 p.m. Diagnoses included dementia and psychotic disorder with hallucinations due to known physiological		**identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. Residents who currently reside in the facility and incoming residents will be educated on accurately reporting allegations of abuse. Administrator/designee in-serviced all staff on the Abuse Policy and reporting abuse to the Abuse Coordinator. Additionally, any staff that fails to comply with the points of this in-service will be further educator/or disciplined as indicated. All staff will be educated on accurately reporting allegations of abuse upon hire, annually and on an as needed basis. **What measures will be put into place and what systemic changes will be made to ensure that deficient practice does not recur:** Administrator/designee in-serviced all staff on the Abuse Policy and reporting abuse to the Abuse Coordinator. Additionally, any staff that fails to comply with the points of this in-service will be further educated/or disciplined as indicated. Residents who currently reside within the facility and any new residents will be informed as to who they should report any abuse allegation to. Administrator completed a 30 day look back of nurses progress notes for any other incidents on 8/4/23. No other incidents identified.	

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	conditions. Her medications included risperidone (antipsychotic) 0.25 mg two times a day. A significant change MDS assessment, dated 6/20/23, indicated the resident was moderately cognitively impaired. She required supervision with assistance of one staff member for walking in room and corridor. A Progress Note, dated 6/18/23 at 10:30 p.m., indicated the resident yelled at her roommate (Resident 6). Staff responded three times between 6:00 p.m. and 7:00 p.m. to calm the residents. The Director of Nursing (DON) and Administrator were notified and they both advised to separate the residents. When the nurse went to separate the residents, they seemed to be settled. Near 8:00 p.m., Resident 17 went and shook her roommate (Resident 6) to wake her up. Resident 17 indicated Resident 6 touched her first. Then Resident 17 indicated she did not touch her roommate (Resident 6). The residents were separated. An investigation of the resident-to-resident altercation, provided by the Administrator, was received and reviewed on 7/28/23 at 10:01 a.m. The concern description of the Concern/Grievance record indicated Resident 6 expressed concern over an incident with her previous roommate (Resident 17). She indicated Resident 17 was mean to her and yelled at her. Her roommate was upset over who paid more money for the room. An interview on 6/19/23 with Resident 6, by the Social Services Designee (SSD), indicated Resident 6 said Resident 17 was mean to her and accused her of lying. She indicated Resident 17 did not hit her or become physical. She was worried Resident 17 would get too close to her and could get physical.		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The corrective action will be monitored in monthly QAPI by the IDT. The Administrator/Designee will audit the 24 hour report daily 5 x a week for 4 weeks, then 3 x a week for 4 weeks and weekly x 4 months until facility maintains 100% compliance. The Administrator will conduct random interviews with staff and resident, 5 residents and 5 staff members a week x 4 weeks, then 3 staff members and 3 residents for 4 weeks, then 5 staff members and 5 residents monthly x 4 months. Any identified issues will be remedied by utilizing the facility QAPI process. The QAPI action plan will be followed, reviewed and updated as needed in the monthly facility QAPI meeting. **By what date the systemic changes for each deficiency will be completed:** Facilities date of alleged compliance is August 20th, 2023	

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	An interview on 6/19/23 with Resident 17, by the SSD, indicated Resident 17 said she yelled at Resident 6 and hurt her feelings. She indicated the nurse took Resident 6's side and believed Resident 6's lies. She was not physical with Resident 6 and only yelled at her. During an interview, on 7/28/23 at 2:26 p.m., the Administrator indicated she did not report to the State Agency the allegation of abuse because after the investigation, she determined during the resident-to-resident altercation nothing physical happened, and no cussing or threats were involved. During an interview, on 7/28/23 at 3:03 p.m., LPN 51 indicated she was the nurse on duty during the resident-to-resident altercation. She was uncertain if Resident 17 touched Resident 6 or not. Resident 6 initially reported Resident 17 grabbed her face and whipped her head around. A CNA on duty at the time had reported to the nurse she saw Resident 17 near Resident 6's bed. She did not see Resident 6 touch Resident 17 at any time. The residents were immediately separated. Later, after the residents were separated, Resident 6 indicated Resident 17 did not touch her. A current, undated policy, titled "Abuse Prevention Program," provided by the Administrator on 7/27/23 with the entrance conference paperwork, indicated the following: " ...When an alleged or suspected case of abuse or neglect is reported to the Administrator, the Administrator, or person in charge of the facility, will notify the following persons or agencies of such incident immediately. State Licensing and Certification Agency (i.e. ISDH) ...Abuse involving one resident upon another resident will be reported to ISDH ...."			

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	3.1-28(e)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to report weight gains of 2 lbs (pounds) or greater for heart failure protocol, as ordered by the physician, for 2 of 5 residents reviewed for unnecessary medications (Resident 5 and 16). Findings include: 1. During a random observation, on 7/26/23 at 10:12 a.m., Resident 16 was was sitting in a recliner with feet elevated, her eyes were closed, connected to oxygen via nasal cannula, and was opened-mouth breathing. During an interview, on 7/26/23 at 1:17 p.m., Resident 16 indicated she retained fluids, had trouble breathing for last couple of weeks, had started on oxygen the day prior, and had also had an X-ray taken. Her clinical record was reviewed on 7/28/23 at 1:27 p.m. Diagnoses included combined systolic and diastolic congestive heart failure, chronic atrial fibrillation, and shortness of breath.	F 0684	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the policy of this facility to report to the physician an increase in weight on residents with a physician order to monitor weight increases. Resident records were reviewed for resident's #5 and #16. Physician was notified on 8/2/23 of resident weight gain, physician changed daily weights to weekly weights on 8/2/23, there were no additional parameters with the physicians' new orders. Resident's plan of care have been updated. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**	08/20/2023

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	Current physician orders included the following; a. Heart failure: daily weight-after voiding and before breakfast and medications with same clothes every day. Notify physician of 2 lb gain in one day and 4 lb gain in 5 days, the order date was 3/29/23. b. Heart failure: edema assessment, check for edema at all extremities each shift and document amount of pitting 0, 1+, 2+, 3+, 4+, the order date was 3/30/23. c. Levofloxacin (antibiotic) 500 mg (milligram), one tablet daily for seven days for infection, the order date was 7/25/23. d. Bumetanide (diuretic) 2 mg, one tablet twice a day for fluid retention, the order date was 7/26/23. e. Oxygen at 2 L/M (Liters per Minute) per nasal cannula continuously, the order date was 7/26/23. f. Oxygen saturation checks daily, the order date was 7/27/23. A 7/5/23 quarterly MDS (Minimum Data Set) assessment indicated she was cognitively intact and had received a diuretic every day. She had a current care plan, dated 4/6/23, for heart failure. The goal, with a target date of 9/27/23, indicated she would not have an acute exacerbation of heart failure symptoms. Interventions, dated 4/6/23, indicated continued resident education on heart failure protocol and disease management, follow heart failure protocol that was listed on MAR (Medication Administration Record) and TAR (Treatment		All residents being monitored for heart failure protocol have the potential to be affected by the deficient practice. Each resident needing a daily weight for heart failure monitoring have an individual log that will be monitored by the DON/Designee daily. The DON/Designee will immediately notify the physician of any changes greater than 2lbs in 1 day or 4lbs in 5 days. **What measures will be put into place and what systemic changes will be made to ensure that deficient practice does not recur:** DON/Designee educated the nursing staff on following physician orders and to notify the physician when weights are outside of the parameters on 8/2/23, any staff that fails to comply with the points of this in-service will be further educated/disciplined. The DON/Designee will monitor residents with weight parameters daily 5 x a week x 4 weeks, then 3 x a week for 4 weeks, then monthly x 4 months. Any identified issues will be remedied by utilizing the QAPI process. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The corrective action will be monitored in monthly QAPI by the	

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	Administration Record), changes monitored, and physician notified as needed. An intervention, revised on 7/26/23, indicated medications would be administered as ordered. She had a current care plan, dated 7/26/23, for displayed complications with gas exchange due to pneumonia and received oxygen therapy. The goal, with a target date of 9/27/23, indicated she would not exhibit signs or symptoms of respiratory distress through next review. Interventions, dated 7/26/23, indicated oxygen was administered as ordered, lung sounds monitored as needed, head of bed elevated to facilitate breathing, oxygen saturations monitored as ordered and as needed, and physician notified of any changes. She had a current care plan, dated 7/26/23, for an infection and taking an antibiotic for seven days for pneumonia. The goal, with a target date of 9/27/23, indicated she would be free of signs and symptoms of infection through next review date. Interventions, dated 7/26/23, indicated enhanced barrier precautions, physician kept updated on un-resolving symptoms, lab work and medications as ordered, and adverse affects of antibiotic would be reported to the physician. Review of Resident 16's daily weights indicated the following: Weight on 6/11/23 was 282.4 lbs and her weight on 6/12/23 was 285.0 lbs. This was a 2.6 lb weight gain in one day. Weight on 6/12/23 was 285.0 lbs and her weight on 6/13/23 was 287.6 lbs. This was a 2.6 lb weight gain in one day.		IDT. The DON/Designee will monitor residents with weight parameters daily 5 x a week x 4 weeks, then 3 x a week for 4 weeks, then monthly x 4 months. Any identified issues will be remedied by utilizing the facility QAPI process. The QAPI action plan will be followed, reviewed, and updated as needed in the monthly facility QAPI meeting. **By what date the systemic changes for each deficiency will be completed:** Facilities date of alleged compliance is August 20th, 2023	

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	Weight on 6/19/23 was 286.0 lbs and her weight on 6/20/23 was 288.4 lbs. This was a 2.4 lb weight gain in one day. Weight on 6/24/23 was 290 lbs and her weight on 6/25/23 was 292.0 lbs. This was a 2.0 weight gain in one day. Weight on 7/12/23 was 284.4 lbs and her weight on 7/13/23 was 287.8 lbs. This was a 3.4 lb weight gain in one day. Weight on 7/18/23 was 287.2 lbs and her weight on 7/19/23 was 289.5 lbs. This was a 2.3 lb weight gain in one day. The clinical record lacked physician notification of daily weight gains. A Dietary Progress Note, dated 7/5/23 at 2:27 p.m., indicated weights showed significant fluctuations, 250 lbs - 285 lbs, over the past three months, and diuretic treatment with fluid shifts gains and losses. A progress note, dated 7/24/23 at 10:51 p.m., indicated the resident complained of feeling short of breath earlier that evening, and her oxygen saturation was 95% on room air. A breathing treatment had been given with some relief. Her left lower lobe was more diminished than her normal and she complained of pain to her lungs when she inhaled. Staff offered to send her to the emergency room and she declined. Her vital signs were within normal limits. Oxygen was started at 3 L/M for comfort and nitroglycerine had been given. A progress note, dated 7/25/23 at 11:26 a.m., indicated new orders for a chest X-ray, anterior,			

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	posterior, and lateral view, and CBC (Complete Blood Count) and CMP (Comprehensive Metabolic Panel) labs to be drawn had been obtained. A progress note, dated 7/25/23 at 12:17 p.m., indicated she continued to complain of shortness of breath, oxygen saturation was 95% on room air, and lung sounds were clear to upper lobes and diminished in lower lobes. Oxygen at 3 L/M via nasal cannula per resident's request. A progress note, dated 7/25/23 at 4:06 p.m., indicated the Nurse Practitioner had been notified of lab and X-ray results. The chest X-ray indicated enlarged cardiac size with bilateral hilar congestion and mild pulmonary edematous changes. The possibility of underlying infiltrates could not be ruled out. A progress note, dated 7/25/23 at 5:31 p.m., indicated an new order had been received to increase the bumetanide from 1 mg to 2 mg twice a day and added Levoquin 500 mg for seven days. A progress note, dated 7/26/23 at 10:05 p.m., indicated she continued to complain of shortness of breath, oxygen saturation was 85%, lung sounds clear to upper lobes, diminished in lower lobes, and remained on 3 L/M of oxygen. 2. During an observation, on 7/27/23 at 1:42 p.m., Resident 5 was ambulating with a walker in the hall, with edema (swelling) visible to bilateral lower extremities from below her knees to the tops of her feet. Her clinical record was reviewed on 7/27/23 at 1:12 p.m. Diagnoses included acute on chronic diastolic congestive heart failure.			

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	Current physician orders included the following; a. Heart failure: edema assessment, check for edema at all extremities each shift and document amount of pitting 0, 1+, 2+, 3+, 4+, the order date was 2/13/23. b. Heart failure: daily weight-after voiding and before breakfast and medications with same clothes every day. Notify physician of 2 lb gain in one day and 4 lb gain in 5 days, the order date was 2/13/23. c. Torsemide (diuretic) 60 mg, one tablet daily for congestive heart failure, the order date was 4/20/23. A 6/15/23 quarterly MDS assessment indicated she was cognitively intact and received a diuretic every day. She had a current care plan, dated 1/7/23, for heart failure. The goal, with a target date on 8/21/23, indicated shoe would not have an acute exacerbation of heart failure symptoms, The interventions, dated 1/7/23, indicated medications administered as ordered, head of bed elevated when in bed at all times due to shortness of breath when lying flat, changes monitored and physician notified as needed, and oxygen provided as ordered. Review of Resident 5's daily weights indicated the following: a. Weight on 7/4/23 was 258.2 lbs and her weight on 7/5/23 was 260.8 lbs. This was a 2.6 lb weight gain in one day.			

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	b. Weight on 7/23/23 was 259.8 lbs and her weight on 7/24/23 was 262.4 lbs. This was a 2.6 lb weight gain in one day. The clinical record lacked physician notification of daily weight gains. During an interview, on 8/1/23 at 10:20 a.m., LPN 5 indicated daily weights were documented on the MAR. If physician notification was required, it was documented in progress notes or on the MAR. During an interview, on 8/1/23 at 10:30 a.m., the DON indicated the physician notifications for daily weight gains were documented in progress notes or with the MAR or TAR. During an interview, on 8/1/23 at 2:08 p.m., the Nurse Consultant indicated their heart failure protocol was the physician orders. They did not have a policy for this, they just followed the physician orders. Review of a current, undated, facility policy titled "PHYSICIAN ORDERS-(FOLLOWING PHYSICIAN ORDERS)," provided by the DON on 8/1/23 at 1:53 p.m., indicated the following: "...Policy: It is the policy of the facility to follow the orders of the physician...." 3.1-37(a)			
F 0689 SS=D 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			

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	155627	A. BUILDING 00 B. WING	08/01/2023

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	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 to failed to provide adequate supervision for a resident with a history of falls and failed to develop and implement person-centered, individualized interventions to reduce the risk of falls, for 1 of 4 residents reviewed for accidents (Resident 23). Findings include: Resident 23's clinical record was reviewed on 7/28/23 at 3:07 p.m. He had admitted to the facility on 6/1/23 and transferred to an acute hospital on 6/24/23. Diagnoses included pathological hip fracture, weakness, unsteadiness on feet, abnormalities of gait and mobility, and dementia. Physician orders included the following: a. Monitor incision to left hip each shift for signs/symptoms of infection or worsening, dressing placement, and surrounding tissue until healed, the order date was 6/1/23. b. Weight bearing as tolerated to left hip/leg, the order date was 6/1/23. c. Oxycodone (opioid)-acetaminophen 7.5-325 mg (milligram), one tablet every eight hours as needed for chronic pain, the order date was 6/2/23. d. Apply skin prep daily to left elbow, order date was 6/20/23. e. Levaquin (antibiotic) 750 mg, one tablet daily	F 0689	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #23 no longer resides in the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Any resident that has a fall with fracture has the potential to be affected by the alleged deficient practice. Residents who have fallen/are at risk for falling have had plans of care reviewed and updated as needed. **What measures will be put into place and what systemic changes will be made to ensure that deficient practice does not recur:** The Interdisciplinary Team will meet within 24hrs of a resident that has had a fall to review and update plans of care to individualize the specific plan to meet the residents needs. MDS/Designee will review fall care plans weekly x1 month, bi-weekly x5 months with any identified issues being remedied by utilizing the facility QAPI process.	08/20/2023

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	for infection for five days, the order date was 6/20/23. A Fall Risk Review, dated 6/1/23 at 11:48 p.m., indicated he was at a high risk for a fall. He had a history of falls within the last three months, required assistance with ambulation, had a balance problem while standing/walking, and required use of assistive devices. A baseline care plan, dated 6/7/23, indicated the resident required two person physical assistance with bed mobility and one person physical assistance with transfers, to walk in his room, and with locomotion on the unit. He had a history of falls, had a fall at home that resulted in a fracture, and had pain to his left left hip related to post-operative repair of the fracture. The baseline care plan did not include personalized interventions to reduce his risk for falls. An admission MDS (Minimum Data Set) assessment, dated 6/8//23, indicated he was cognitively intact. He required extensive assistance with bed mobility, transfers, dressing, toilet use, personal hygiene, and with locomotion on and off the unit. Walking in room or corridor had not occurred. He had a fracture related to a fall in the last month, prior to admission. A Nurse Practitioner Skin and Wound Note, dated 6/13/23 at 11:40 a.m., indicated he had admitted to the facility for physical and occupational therapy after surgical repair of left hip fracture secondary to fall at his home. He had limited ambulation ability and was confused. A progress note, dated 6/14/23 at 5:22 a.m.,		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The corrective action will be monitored in monthly QAPI by the IDT. MDS/Designee will review fall care plans weekly x1 month, bi-weekly x5 months with any identified issues being remedied by utilizing the facility QAPI process until facility maintains 100% compliance. The QAPI action plan will be followed, reviewed and updated as needed in the monthly facility QAPI meeting. **By what date the systemic changes for each deficiency will be completed:** Facilities date of alleged compliance is August 20th, 2023	

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	indicated he had several episodes of yelling out and had episodes of hallucinations such as "did you see that airplane in here" and "do you see where I cleaned up all that oil that spilled." He complained of pain throughout the night, received an oxycodone, and had rested in his chair afterwards. A progress note, dated 6/17/23 at 9:47 a.m., indicated antibiotic therapy was ordered for urinary tract infection. A Care Plan Summary note, dated 6/19/23 at 12:58 p.m., indicated the interdisciplinary team met with the resident and his daughter to discuss his progress in therapy, goals of care, and discharge plan. Therapy indicated he had made functional progress but his cognition impeded his making further progress, and they were primarily working on rebuilding strength, safety awareness, and endurance. A progress note, dated 6/21/23 at 6:59 p.m., indicated the resident ambulated to the dining room with a walker and one staff assist for breakfast. A progress note, dated 6/23/23 at 1:53 p.m., indicated he was oriented to self only at that time, and had previously been oriented to time and place. His gait was unsteady and transferred with one assist. A progress note, dated 6/24/23 at 12:25 a.m., indicated he had an unwitnessed fall in his room. He was assessed, then assisted up with two staff. He had hit his head on the closet door, had a large raised area to back of his head, and a reddened area on mid/left back. He complained the left side of his buttocks hurt. Active range of motion was			

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	per his normal. A progress note, dated 6/24/23 at 12:56 p.m., indicated he had been up several times without assistance and forgot he was unsteady on his feet. He had no complaints of pain from fall the night before. An SBAR (Situation, Background, Assessment, Recommendation) Summary for Providers, dated 6/24/23 at 7:50 p.m., indicated a change in condition related to altered mental status and a fall. He had an increased level of confusion, was on follow up from a fall the previous night, and was reluctant to rest or stay off his feet. An order was received to send resident to the emergency room for evaluation and treatment. A progress note, dated 6/25/23 at 11:06 a.m., indicated the resident's daughter went to the facility to pick up his belongings and told them he wouldn't be back. He had a current care plan, dated 6/27/23, for risk of falls related to history of falls with injuries. The goal, with a target date of 9/6/23, indicated he would not have any injuries due to falls through next quarterly review. The interventions, all initiated 6/27/23, included areas kept clutter free, call light kept in reach in room, encouraged resident to use call light to seek assistance, offer scheduled toileting as needed, notify and update physician and family as needed, and evaluate possible causes of falls and address to the extent possible. The clinical record did not include person-centered, individualized interventions to reduce the resident's risk for falls prior to his fall on 6/24/23.			

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	During an interview, on 8/1/23 at 11:13 a.m., the DON indicated he had been sent to the hospital due to altered mental status related to a fall. The hospital indicated he had sustained a dislocation of his right elbow from the fall. Review of a Facility Report Incident, provided by the DON on 8/1/23 at 11:15 a.m., indicated the incident date was 6/27/23 at 10:01 a.m. He had an unwitnessed fall in his room, assessment indicated a raised area to the back of his head, and he complained of pain to his right elbow. The physician had been notified and an order to send the resident to the emergency room for evaluation and treatment had been received. The preventive measures taken indicated immediate fall interventions in place and care plan updated, neurological checks had been initiated, resident representative had been notified and no concerns. The follow up, added 7/4/23, indicated a report from the hospital had been received and indicated a dislocation of his right elbow. Contributing factors to resident's fall were determined to be a diagnosis of dementia, unsteadiness on feet, weakness, and abnormalities of gait and mobility. He had not returned to the facility. Review of a current, undated, facility policy titled "INCIDENTS/ACCIDENTS/FALLS," provided by the DON on 8/1/23 at 1:53 p.m., indicated the following: "...11. All falls will have a site investigation by appropriate staff in an effort to define the "root cause" of the fall. This will help provide information to enable staff to roll out interventions to prevent another similar occurrence. Note: Each fall needs a new intervention rolled out...." 3.1-45(a)(2)			

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