STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155400	A. BUILDING 00 B. WING	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL CARE STRATEGIES	4600 E JACKSON ST MUNCIE, IN 47303

(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 the Investigation of Complaints IN00416468, IN00416362, IN00415198 and IN00415737. Complaint IN00416468 - No deficiencies related to the allegations are cited. Complaint IN00416362 - No deficiencies related to the allegations are cited. Complaint IN00415198 - No deficiencies related to the allegations are cited. Complaint IN00415737 - Federal/State deficiencies related to the allegations are cited at F689. Unrelated deficiencies are cited. Survey dates: September 5 and 6, 2023. Facility number: 000269 Provider number: 155400 AIM number: 100267720 Census Bed Type: SNF/NF: 56 Total: 56 Census Payor Type: Medicare: 2 Medicaid: 48 Other: 6 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	September 29, 2023 Ms. Brenda Buroker Director of Long Term Care 2 North Meridian St. Indianapolis, IN 46204 Re: Survey Event ID 8R5L11 Dear Ms. Buroker: Please find attached my Plan of Correction for deficiencies cited during this Complaint Survey. I am respectfully requesting paper compliance. If you have any questions, please feel free to contact me. Sincerely, Karsen Rauch, HFA Administrator Cardinal Care Strategies	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karsen Rauch	HFA - Administrator	09/29/2023

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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	Quality review completed September 13, 2023.			
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 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 interviews and record review, the facility failed to report accurate information regarding allegations of abuse for 1 of 3 allegations of abuse reviewed (Resident B and Resident E).	F 0609	PROPOSED PLAN OF CORRECTION F609	09/29/2023

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	Findings include: Review of a facility reported incident, submitted by the Administrator, dated 8/7/23 at 9:01 p.m. involving Resident E and Resident B indicated the following: Resident E was watching TV when Resident B asked her to turn it down several times without success. They lived across the hall from each other. Resident B became verbally frustrated with Resident E. There were no injuries. The physician, DON and the Administrator were immediately notified. Psychosocial support was provided immediately and continuously. An investigation was initiated and completed. Psychosocial support continued for both residents. Resident B became agitated with Resident E because he kept asking her to turn the volume down to her TV. Resident E had a hard time hearing. A nurse walked down and was able to diffuse the situation. The nurse explained it was late and Resident B asked for her to turn down the volume because he was trying to sleep. 15 minute checks for 72 hours were applied for both residents. Headphones were offered, accepted, and connected to Resident E's TV. A typed statement by the Administrator, dated 8/8/23, indicated she had talked with Resident B and E about their disagreement the night before. Resident E explained she wasn't able to hear very well and she didn't think it was fair she had to turn her TV down. The Administrator explained it was during quiet hours and she needed to understand and be compassionate about others trying to sleep. Resident E understood how a loud TV may be irritating to those who were trying to sleep. The Administrator offered to supply her with Bluetooth headphones that could connect to her		1 – Upon notification of deficiency, Administrator reviewed findings and comprehended the concerns outlined in the 2567 with reporting accurate information. Administrator updated a written procedure for investigating abuse, neglect, exploitation, or mistreatment. Along with that Administrator reviewed the Policy and Procedure for Long-Term Care Abuse and Incident Reporting. 2 – The facility has determined that all residents have the potential to be affected. 3 – The Management team will educate all staff on the Abuse Investigation Procedure. The Administrator will communicate the findings of the 2547 and elaborate on the parts of the Abuse Investigation Procedure that can help with ensuring accurate reporting and internal documentation. 4 – Any and all allegations of abuse will be investigated per the regulation guidelines. The Administrator will conduct an audit for each investigation and make sure all steps are being followed. The Administrator will take all pieces of the allegations and report them to the state. Beyond that, The Administrator will accurately follow up with the state and make sure all details are	

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	TV to use at night. She was satisfied with the solution. The Administrator spoke with Resident B and he explained his frustration. The Administrator told about the solution they came up with and he seemed satisfied with the situation as well. A SS (Social Service) note for Resident E, dated 8/8/23 at 4:22 p.m. indicated it was reported last evening Resident E was involved in a verbal altercation with another resident, which resulted in damages to a company television. Staff reported Resident E sat on the side of her bed, in her room, watching television and another resident approached her doorway and asked her to turn her television down, as it could be heard in hallway, Resident E replied, "No!". The other resident asked if she could at least close her door. Resident E stated to him "No mother f--ker!" The other resident took his foot pedal off his wheelchair and stated, "I'll show you mother f--ker," and hit and broke Resident E's television. Staff immediately separated the residents. The Administrator, DON and SS, the physician, the psychiatric nurse practitioner and her sister were notified. Both residents were placed on 15 minute checks. SS met with Resident E to follow-up on psychosocial well-being related to involvement and she reported she was doing okay. The TV was replaced. SS encouraged and provided Resident E with headphones and she agreed to try them. SS also encouraged her to communicate with others in an appropriate manner, she stated understanding. She appeared to be in good spirits and participated in activities such as, craft and BINGO. Her care plan was reviewed and revised, as needed. Staff would continue to monitor and report any changes in mood and/or behavior. During an interview with Resident E, 9/5/23 at 7:40		included in the report, from the investigation findings. As a means of quality assurance, results of the reviews and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased based on compliance. 5 – Corrective action completed by 9/29/2023.	

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a.m., she indicated she had her TV on, Resident B told her to shut her door. She told him f--k no. He went back to his room wrapped a ball cap around his fist and came back into her room and beat her TV and broke it.

During an interview with Resident B, on 9/5/23 at 8:20 a.m., he indicated he asked Resident B to turn her TV down. He could feel it vibrating in his bed. Resident B told him to shut his door and called him a mother f--ker. He had the aides go over to ask her to turn it down and she would just send them on their way. His head had been hurting for days because he had head injuries in the past. He asked her again and she again, called him a mother f--ker. He took off his foot rest from his wheelchair and hit the TV with it and broke it. Maintenance took his TV for a few days and then brought it back. He thought they replaced her TV and she had earbuds with it, but she still kept her TV loud.

During an interview with the DON and the SS, on 9/6/23 at 4:04 p.m., the DON indicated she did not see the reportables that were sent to the state and she did not know what was reported regarding Resident B and E. SS indicated the residents would normally tell the State Agency exactly what happened, she documented accurate information in the resident's nurses notes.

An undated facility policy tilted, "ABUSE PREVENTION AND PROHIBITION POLICY," provided by the Administrator, on 9/6/23 at 12:35 p.m., indicated the following: "...Facility investigation of suspected abuse will include...2. Description of the event as reported...."

3.1-28(c)

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F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 thoroughly investigate allegations of abuse for 1 of 3 allegations of abuse reviewed (CNA 16 and Resident F). Findings include: During an interview with Resident F, on 9/5/23 at 10:55 a.m., he indicated as he was going into the lounge bathroom to spit some nicotine out of his mouth, CNA 16 grabbed a hold of his left arm and told him he had a bathroom in his own room. CNA 16 then punched him in the arm. Resident F's clinical record was reviewed on 9/6/23 at 11:32 a.m. Diagnoses included schizophrenia, depression, attention and concentration deficit and mild cognitive impairment of uncertain or unknown etiology.	F 0610	PROPOSED PLAN OF CORRECTION F610 1 – Upon notification of deficiency, a written procedure for investigating abuse, neglect, exploitation, or mistreatment was updated. That procedure was communicated to all parties who would be involved in the investigation process. Also, an abuse in-service was conducted with all staff. 2 – The facility has determined that all residents have the potential to be affected.	09/29/2023

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	A quarterly MDS (Minimum Data Set) assessment, dated 5/20/23, indicated he was moderately cognitively impaired. He had verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others), he had other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) and he rejected evaluation or care that occurred one to three days during the assessment period. He had a current care plan for making false accusations towards staff as exampled by he stated staff punched him in the arm (8/11/23). His interventions included inform family and follow up with family as needed (8/14/23), investigate accusations as needed (8/14/23) and listen to him and allow him to voice his concerns (8/14/23). A late entry social service note, dated 8/11/23 at 5:14 p.m. and created on 8/14/23 at 10:15 a.m., indicated she met with Resident F to follow-up on psychosocial well being related to the reported incident. No signs or symptoms of distress were noted. A nurse practitioner note, dated 8/11/23 at 5:43 p.m., indicated she was notified that Resident F reported to the Administrator a staff member grabbed his arm last night. The Administrator investigated it, and staff had redirected Resident F towards his room by placing a hand on his arm. Resident F had a history of false accusations and delusions. An investigation was being done by the Administrator. No visible markings or wounds		3 – The Management team will educate all staff on abuse policy. The Administrator will communicate the updated investigation procedure to all involved parties. 4 – Any and all allegations of abuse will be investigated per the regulation guidelines. The Administrator will conduct an audit for each investigation and make sure all steps are being followed. The Administrator will keep records of each step of the investigation and will continue to audit each party involved for 6 weeks and until compliance is maintained. As a means of quality assurance, results of the reviews and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased based on compliance. 5 – Corrective action completed by 9/29/2023.	

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	noted on him. No psychosocial distress was noted. A medication administration note, dated 8/11/23 at 7:45 p.m., indicated acetaminophen 500 mg was given to Resident F, per his request, for pain in his arm. A social service note, dated 8/14/23 at 10:15 a.m., indicated she met with Resident F to follow-up on psychosocial well being related to reported incident. No signs or symptoms of distress was noted. The completed facility investigation was provided by the Administrator on 9/6/23 at 11:35 a.m. Review of the investigation report indicated it contained the reportable incident to the State Agency, a handwritten statement by the QMA who was working with CNA 16 the evening of the alleged abuse, an email dated 8/14/23 at 11:21 a.m. from the Administrator to the SSD, the NP and the DON, a typed statement by the Administrator, three resident interviews questioning if abuse was experienced at the facility, and a skin observation for Resident F dated 8/11/23 at 8:00 a.m. A typed statement provided by the Administrator, on 9/6/23 at 12:35 p.m., indicated if abuse was reported to her (the Administrator), she would immediately collaborate with the DON, the NP, the physician and the social worker on the situation. She reported it to the State Agency based off the initial information she received within two hours of her notification. She would start her investigation which would include her personally interviewing any staff members involved and suspend staff members as necessary. She would speak with the resident(s), who made the allegation personally and get their statements on			

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	the incident. The social worker would also begin resident interviews. During an interview with CNA 16, on 9/6/23 at 12:03 p.m., he indicated Resident F tried to go into the lounge bathroom. He tried to encourage the resident to go use his own bathroom. Resident F tried to fight him by screaming at him and waving his arms. Resident F said to him that he could go wherever the h-ll he wanted to go and he couldn't stop him. Resident F started to get up out of his wheelchair and took one step forward, and acted like he was going to fall and he wasn't near a railing to grab hold of. He grabbed Resident F's arm with his index finger and thumb and he sat back down. He wheeled Resident F to his room to use his bathroom. Resident F thought anything around him was his, if there was a drink left at the nurses station he would take it and drink it. Resident F felt like he could use any bathroom that he wanted to. The facility suspended him on Friday and then on Sunday, Resident F changed his story. He felt being suspended after 18 years of being a CNA was "retarded". They had been using the lounge bathroom as an employee bathroom. He didn't punch Resident F, the resident just said that because he was throwing a tantrum. During an interview with SS and the DON, on 9/6/23 at 4:04 p.m., the SS indicated her role in an abuse allegation/investigation was to complete interviews with three to five residents and psychosocial follow ups with the resident. She randomly picked three to five residents with a BIMS of 15 (cognitively intact residents) and interviewed them. She would interview more residents if the three to five residents indicated problems. She would update the resident's care plan. The DON's role during an abuse			

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	allegation/investigation was she made sure the Administrator was notified, made sure the residents were safe, and she tried to help start the process of the investigation. She would contact the nursing staff and do a skin assessment on the resident. If there was harm or if the resident was hurt, she would notify the NP. An undated facility policy tilted, "ABUSE PREVENTION AND PROHIBITION POLICY," provided by the Administrator, on 9/6/23 at 12:35 p.m., indicated the following: "...EMPLOYEE TO RESIDENT...5. The Administrator or his/her designer, with assistance from the HR director, will conduct a thorough investigation of the incident within five working days...PROCEDURE: a. Investigation of abuse...The investigation will include i. Who was involved. ii. Residents' statements a. For non-verbal residents, cognitively impaired residents or residents who refuse to be interviewed, attempt to interview residents first. If unable, observe resident completed an evaluation of resident behavior, affect and response to interaction and document findings...." 3.1-28(d)			
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 possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			

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	Based on observation, interview and record review, the facility failed to provide adequate supervision to prevent falls for residents' who were at a high risk for falls (Resident D and Resident K) for 2 of 3 residents reviewed for falls. Findings include: 1. On 9/5/23 at 4:55 a.m., Resident D was in a recliner in the common area with her legs elevated, wearing non-slip socks. She had a light purple bruising to the left side of her forehead. Resident D's clinical record was reviewed on 9/5/23 at 9:04 a.m. Diagnoses included Alzheimer's disease, epilepsy, unspecified, not intractable, without status epilepticus, unspecified psychosis not due to a substance or known physiological condition, dementia in other diseases classified elsewhere, moderate, with psychotic disturbance, age-related osteoporosis without current pathological fracture, muscle weakness (generalized), and other abnormalities of gait and mobility. Her medications included metoprolol tartrate (blood pressure) 25 mg (milligram) daily, divalproex sodium (seizures) 250 mg twice daily, and escitalopram oxalate (anxiety) 10 mg daily. A quarterly MDS (Minimum Data Set) assessment, dated 7/26/23, indicated she was severely cognitively impaired. She required limited assistance for bed mobility, transfers, walk in her room and the corridor, locomotion on unit. She required extensive assistance for dressing, toilet use and personal hygiene. She used a walker and a wheelchair. She had two or more falls with no injury since admission/entry or reentry or the prior assessment, and one fall with injury (except major	F 0689	PROPOSED PLAN OF CORRECTION F689 1 – Upon notification of deficiency, the nursing staff schedule was altered. We are now scheduling another staff member on the hall that requires more supervision. We also moved the lounge area to the other end of the hall. The residents now spend time in a more visible and high foot traffic area. Along with that, an audit tool was created and started for weekly nursing schedule audits to make sure there is adequate supervision in the required area for the upcoming week. A staff in-service was also conducted to educate them on the new staffing expectations for that hall. 2 – The facility has determined that all residents have the potential to be affected. 3 – The Director of Nursing, Nursing Management and/or the Administrator will educate nursing staff on our new staffing expectations. 4 - The Director of Nursing, Nursing Management and/or the Administrator will conduct 1 weekly audit/review of the nursing staff schedule for the upcoming week. These audits will continue	09/29/2023

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	injury) since admission or the prior assessment. Her fall risk assessments, dated 4/24/23, 7/11/23, 7/15/23, indicated she was at a high risk for falling. Her fall risk assessment, dated 7/19/23, indicated she was at a moderate risk for falling. Her fall risk assessments, dated 8/15/23, 8/20/23, 8/23/23 and 8/24/23, indicated she was at a high risk for falling. She had a current care plan problem of risk for falls related to Alzheimer's, dementia, seizures, impaired mobility, psychosis and effects of medications. She would attempt to throw herself backwards when being redirected from others' rooms (1/14/23). Her interventions included assist with toileting and transfers (1/14/23), she was to utilize non-skid footwear (1/15/23), bed to be in lowest position (1/22/23) anticipate and meet her needs (2/2/23), staff assist her to the dining room and seat her promptly (2/19/23) and she would be a SBA (Stand By Assist) and guided to chair when going from stand to sit position (4/28/23). She had a current care plan for being non-compliant with transfers (4/20/23). Her interventions included attempt at a later time and/or with a different staff member, if possible (4/20/23), document all episodes of non-compliance (4/20/23) and explain rationale for order to her (4/20/23). Her nurses notes indicated the following: On 7/11/23 at 4:38 a.m., she was on the floor screaming. She had pain with palpation and movement, and she was holding the right side of her head.		for 6 weeks and until compliance is maintained. As a means of quality assurance, results of the reviews and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased based on compliance. 5 – Corrective action completed by 9/29/2023.	

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	155400	A. BUILDING 00 B. WING	09/06/2023

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	On 7/11/23 at 4:40 a.m., she was found lying on her right hip screaming and yelling "Ouch that hurts". During the assessment she had limited ROM (Range of Motion) and pain with movement and palpation. She was resistant to move or attempted to get her up as this was not her normal. A new order received to send her to the ER (Emergency Room) for evaluation and treatment. On 7/11/23 at 9:11 a.m., the hospital did a CT (Computerized Tomography) of her head and results were negative. A chest x-ray was completed but did not find enough to treat. They did not do an x-ray to her hips. On 7/11/23 at 9:46 a.m., she returned to the facility with no new orders. On 7/11/23 at 9:59 a.m., the NP (Nurse Practitioner) ordered an x-ray to her bilateral hips/pelvis to be done immediately due to increased pain. On 7/11/23 at 8:54 p.m., the x-ray results did not show findings and no new orders were received. A late entry IDT (Interdisciplinary Team) note, dated 7/12/23 at 7:03 p.m. and created on 7/23/23 at 7:10 p.m., indicated the team met regarding her fall on 7/11/23. She had diagnosis of dementia and Alzheimer's and she was not always aware of her own personnel safety. She was found on the floor next to the door lying on her right hip and holding the right side of her head. She was yelling, screaming and would not bend or move to get off floor. She had pain with palpation during the assessment. A new order was received to send her to the ER for evaluation. Her care plan was reviewed and updated, as needed.			

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	Her new care plan intervention was staff was to provide SBA/guidance with ambulation (7/12/23). On 7/13/23 at 2:09 p.m., she was transferred to the dementia unit to improve the functionally of the facility. An IDT note, dated 7/17/23 at 10:37 a.m., indicated the team met regarding a fall on 7/14, and neurological assessments continued to be within normal limits. She was trying to get up from the couch and needed extra arm support. Armed chairs would be placed in the common areas to support transfers. A late entry IDT note, dated 7/17/23 at 7:51 p.m. and created on 7/23/23 at 7:54 p.m., indicated the team met regarding a fall on 7/15/23. She had diagnosis of dementia, Alzheimer's disease and she frequently was confused as to what was happening in her surroundings. She was found laying on her left side on the floor in the dining area. She said she was going to the kitchen to cook. A head to toe assessment was completed immediately, ROM (Range of Motion) was within normal limits, she had no distress or complaints of pain, no redness or bruising to her head or arms, but she had a slight red mark on the mid section of her back. She was assisted up by two staff members. Her gait was steady and she walked to the dining room chair. She was alert and oriented per her normal and she was talking and laughing. Vitals and neurological checks were within normal limits. Her care plan was reviewed and updated, as needed. Staff were to encourage her to sit in the common areas while awake. Her new care plan intervention was staff to assist her to set in the common area while awake			

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	(7/17/23). On 7/19/23 at 7:00 p.m., she was walking in the dining room, lost her balance, and fell to her knees. She landed on her side, she did not hit her head. Staff immediately were able to assist her up with two staff members. Her gait was steady. Neurological checks and vitals were within normal limits. There was no redness, open areas or bruising. A late entry IDT note, dated 7/20/23 at 8:53 p.m., the team met regarding her fall on 7/19/23. She had diagnosis of dementia, Alzheimer's disease and was frequently unaware of her own personnel safety and limitations. She walked in the dining room, lost her balance and she fell to her knees landing on her side. She did not hit her head. Staff immediately were able to assist her up with two staff members. Her gait was steady. Neurological checks and vitals were within normal limits. There were no redness, open areas or bruising. Her care plan was reviewed and updated as needed. Staff were to encourage her to use her walker while ambulating. A NP note, dated 8/15/23 at 5:16 p.m., indicated she was being seen for an acute visit for a witnessed fall this afternoon. Nursing reported she was walking from common area when she lost her footing and fell to the floor. She landed on her left side, she hit her head on the floor and received a laceration to her left eyebrow and two hematomas, one to her forehead and one to the side of her eye. She did not appear to be in any apparent distress at this time. She was to be sent to the ER for further evaluation of head trauma. On 8/15/23 at 9:01 p.m., she was ambulating with assistance. She wore non skid slippers. She			

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	changed planes from the carpet to the tile, lost her balance, and was lowered to the floor. However, she did hit the right side of her head on the accent table. She had lacerations to her right eyebrow with a small amount of bleeding. The NP was in-house and assessed her for injuries. An order was received to send to the ER for continuation of care. On 8/16/23 at 5:58 a.m., she returned from the hospital at approximately 4:30 a.m. She was alert and oriented per her usual. She was resting quietly in bed. She occasionally yelled out. On 8/16/23 at 10:01 a.m., during the IDT meeting, the nurse who was present during shift was contacted to clarify the incident. While Resident D ambulated with the CNA walking near by for assistance, Resident D's feet started to tangle, and the CNA grabbed hold of her shirt as she was falling to try and prevent from falling without success. She hit her head and a laceration was noted. The clinical record lacked a new intervention for fall prevention. On 8/20/23 at 9:36 p.m., she was found on the floor lying on her back facing up with her head towards the door. She had a copious amount of blood coming from her head. She had a laceration to her left side of her forehead. A new order was received to send her to the ER. A risk assessment, dated 8/20/23 at 8:45 p.m., indicated as the staff member was completing the medication pass and came up the hallway, it was noticed Resident D's door was closed by her roommate. When the door was opened, Resident D was lying on the floor on her back and her head			

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was towards the door. She had a laceration to her the top of her left forehead.

On 8/24/23 at 1:23 p.m., she returned to the facility from the hospital. She had an abrasion to her left knee. She had a dressing to the left side of her forehead. There was a small laceration with discoloration. New orders were Flagyl (antifungal) 500 mg three times daily for 5 days and Omnicef (antibiotic) 300 mg every 12 hours for 5 days for an abdominal wall abscess.

On 8/24/23 at 3:18 p.m., her daughter came up with a plan to move Resident D's bed to better suit her attempts to self transfer. She would also have a mat at bedside while the bed was in low position. Her care plan and staff were updated.

On 8/24/23 at 5:42 p.m., family requested Resident D be moved, within same room, to move her bed by the door. Family reported due to her leaning to the right, her daughters requested the right side of her bed be against the wall, in hopes it would decrease her falls, as she was often non-compliant with transfers and/or did not utilize walker/wheelchair. She had a diagnosis of Alzheimer's disease and she was unable to be provided education due to cognition. Staff would continue to attempt to remind and encourage her to utilize her walker.

Her new care plan intervention was a floor mat to be at bedside while resident in bed (8/24/23).

During an interview with CNA 27, on 9/5/23 at 4:53 a.m., she indicated Resident D got up early in the night and she put her in the recliner in the common area to keep an eye on her.

2. On 9/5/23 at 9:11 a.m., Resident K was observed

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	in bed, her bed was in a low position and a floor mat was next to her bed. On 9/6/23 at 3:36 p.m., she sat in the common area in a recliner with her legs elevated. Resident K's clinical record was reviewed on 9/5/23 at 12:20 p.m. Diagnoses included unspecified dementia, unspecified severity, with other behavioral disturbance, chronic obstructive pulmonary disease, personal history of transient ischemic attack (TIA), cerebral infarction, mood disorder due to known physiological condition with depressive features, mood disorder due to known physiological condition with mixed features, muscle weakness (generalized), unsteadiness on feet, other abnormalities of gait and mobility, cognitive communication deficit, unspecified dementia, moderate, with agitation, unspecified dementia, moderate, with mood disturbance, unspecified dementia, moderate, with psychotic disturbance, unspecified dementia, moderate, with anxiety, dementia in other diseases classified elsewhere, mild, with other behavioral disturbance, and other lack of coordination. Her fall risk assessments, dated 4/12/23, 6/3/23, 6/8/23, 6/13/23, 6/15/23, 7/27/23 and 8/8/23, indicated she was at a high risk for falling. A quarterly MDS assessment, dated 7/19/23, indicated she was severely cognitively impaired. She required extensive assistance for bed mobility, transfers, walking in her room and the corridor, locomotion on the unit, dressing, toilet use and personal hygiene. She did not use a mobility device. She had two or more falls with no injury since admission/entry or reentry or the prior assessment.			

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	Her medications included hydrocodone-acetaminophen (narcotic pain medication) 5-325 mg every 12 hours, brexpiprazole (antipsychotic) 1 mg daily, gabapentin (treat nerve pain) 300 mg twice daily, gabapentin 200 mg daily, buspirone 15 mg three times daily, and trazodone (antidepressant) 50 mg at bedtime. She had a care plan for falls due to dementia with behaviors, impaired mobility, history of CVA (Cerebrovascular Accident), abnormal gait, mood disorders and effect of medications (10/15/22). Her interventions included anticipate and meet her needs (10/15/22), assist with toileting (10/15/22), assist with transfers (10/15/22), she was to utilize foot wear with non-skid soles (10/15/22), observe her when attempting to sit down in chairs and assist as needed to prevent falls (10/18/22), be sure her call light is within reach and encourage her to use it for assistance as needed. She needed prompt response to all requests for assistance (1/1/23), keep resident in common areas while awake (1/11/23),bed in lowest position (1/23/23), she needed activities that minimize the potential for falls while providing diversion and distraction such as coloring, interacting with peers/staff, getting her nails painted (1/25/23), bright tape added to call light as a visual cue for use (2/4/23), assist/encourage her to lay down after meals (3/13/23), she was to be laid in bed when she was fatigued (4/13/23), she was to receive a shower in morning after morning meds (6/5/23). A nurse practitioner note, dated 7/13/23 at 6:22 p.m. indicated she had a dementia diagnosis and a progressive cognitive decline. Due to her lack of safety awareness, she required more supervision. She may move to the dementia hall.			

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	A social service note, dated 7/14/23 at 5:00 p.m., indicated she moved rooms due to medical necessity. She was a high fall risk and the room was located closer to nurse's station/lounge area for closer monitoring. An incident note, dated 7/27/23 at 6:03 p.m., indicated she had an unwitnessed fall. Upon entering the room, she was laying on her right-side in front of closet on the floor. She was unable to walk and she leaned to her right side. She was not yelling out. A new order was received to send her to the ER for evaluation and treatment. The clinical record lacked an IDT review and a new fall intervention. An incident note, dated 7/28/23 at 6:02 p.m., indicated the nurse was called to the dining room on the 200 hall. Resident K was laying on the floor. She had skin tears on the middle two knuckles on her right hand. She was helped to her wheelchair. Neurological checks continued. The clinical record lacked an IDT note and a new fall intervention. An incident note, dated 8/8/23 at 6:22 p.m., indicated she lost her balance and fell forward, hitting her head on the floor. She had a hematoma above her right eye. A new order was received to send her to the ER due to striking her head. A nurses note, dated 8/9/23 at 2:51 a.m., indicated she returned to the facility. She sustained no injuries from prior fall other than "scalp bruise" to right side of forehead. The clinical record lacked an IDT note and a new			

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	fall intervention. During an interview on 9/5/23 at 9:13 a.m., CNA 5 indicated she made sure she toileted Resident D before putting her in the recliner. She didn't put her in her room. She tried to get up on her own and it was safer for her to be in the common area. Resident K usually got out of bed closer to lunch. She hollered out and screamed, she couldn't talk. She felt she hollered out in pain related to her previous falls. Resident H didn't try to get up when she was in bed, she kept her changed and she liked to be covered with a blanket. She tried to keep the residents in the common area. It was kind of hard with one CNA in the dementia unit. She tried to pick and choose what residents she took care of. She would assist the easier residents first before she assisted Resident D, K and H. During an interview with QMA 7, on 9/5/23 at 10:44 a.m., she indicated she had to walk with Resident H. If she was unsteady, she put her in her wheelchair or in a recliner in the common area. She liked to go back to bed. She did stand up on her own and she had to keep an eye on her. Resident D was feisty, it depended on the day, but she tried to walk and was very unsteady. During an interview with QMA 13, on 9/6/23 at 2:15 p.m., she indicated she didn't let Resident D walk by herself. The CNAs pushed her in her wheelchair. She would get up by herself and they had to keep an eye on her, they did not let her be by herself. Someone had to watch her and keep a close eye on them. (During the interview, Resident D sat in the common area. She pulled her blanket off of her legs and began to put her legs to the side of the recliner). Resident K cried out a lot in pain and was on pain medication. They sat Resident H in the common area, but she liked to			

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	lay in bed and she would normally stay in bed, unlike Residents K and H. Working with one CNA in the dementia unit wasn't that bad. If someone needed to use the restroom, she could watch the other residents. During an interview with the DON and the SSD, on 9/6/23 at 4:04 p.m., the DON indicated she had a concern with supervision in the dementia unit. Resident H screamed out, and they tried to decipher if she was in pain or scared. She was non-verbal. She used to tell them her back hurt. They had changed and tried different medications, but she still screamed at times. Related to falls, she had no safety awareness. The SSD indicated Resident D had a number of falls at the prior facility she was at. They tried to let her be independent. When she would see her walker in front of her, she had a destination, and they tried not to leave her walker in front of her anymore. She was much better as a stand by assist. Resident D was a true dementia resident, whenever she was on the go she would say that she was putting clothes in the dryer, going to make macaroni and cheese, or going to get the kids. The DON indicated Resident D had a walker, her back was hunched, she would lose her balance and tip backwards, and her neck leaned over to her right. Resident K had an overall decline, another hard one to figure out. Her falls increased with pain medication. The NP put her on doxepin and that was when she had the major fall. The decision would be made by her son to put her on hospice and to keep her comfortable. Her dementia had progressed. Her dementia contributed to her falls. The DON indicated they normally staffed a QMA or a Nurse on 200 hall and Swan hall. If the CNA needed assistance on the 200 hall right away, needed to toilet someone or leave the hall, they could call the nurse or the			

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	QMA to help. They had staffed two CNAs in the dementia unit, but there wasn't enough to do for two CNAs. There were 11 residents in the dementia unit. An undated facility policy, titled "Fall Policy and Protocol," provided by the Administrator on 9/6/23 at 9:49 a.m. indicated the following: "...Policy: The facility to the best of its ability strives to provide an environment that is free from accident hazards over which the facility has control and provides supervision...to each resident to prevent avoidable accidents...Procedure...5. The interdisciplinary team (IDT) will conduct a more thorough review of the event to determine if the initial investigation is complete and include the most likes causation. The IDT team will as part of their review, determine if initial intervention is sufficient or if modification is needed. At that time Care plans will be updated, and any changes will be communicated to the staff caring for the resident...." This Federal Tag relates to Complaint IN00415737. 3.1-45(a)(2)			