STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 00 B. WING	09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00417903. This visit was in conjunction with a Recertification and State Licensure Survey Complaint IN00417903 - Federal/state deficiencies related to the allegations are cited at F689, F744, F880, F921 & F9999. Survey dates: September 18, 19, 20, 21, 22 & 25, 2023 Facility number: 000450 Provider number: 155801 AIM number: 100273890 Census Bed Type: SNF/NF: 49 Total: 49 Census Payor Type: Medicare: 4 Medicaid: 43 Other: 2 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 4, 2023.	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 10-25-23 to the state findings of the Annual & Complaint Surveys conducted on 09-25-23.	
F 0689 SS=G 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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael Van Hoy	Administrator	10/23/2023

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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	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 observation, interview, and record review, the facility failed to revise care plans and follow interventions to reduce the risk of falls for 2 of 4 residents reviewed for accidents. This deficient practice resulted in a fall with fractures requiring hospitalization and a fall with a closed head injury requiring hospitalization. (Resident M, Resident P). Findings include: 1. On 9/19/23 at 1:13 P.M., Resident M's clinical record was reviewed. Resident was admitted on 11/4/22. Diagnoses included, but were not limited to, Alzheimer's Disease, Major Depressive Disorder, and Diabetes Mellitus. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 5/14/23, indicated Resident M had severe cognitive impairment, required extensive assistance of 2 or more staff for bed mobility and transfers and a total assistance of 2 or more staff for toileting and bathing, and had no falls since the prior MDS assessment on 4/5/23. Current physician orders included, but was not limited to: Low bed at all times while in bed and not receiving care, dated 8/31/23. Toe touch weight bearing on the left side, dated 8/25/23. Maintain Post total hip precautions for L (left) hip arthroplasty, dated 5/25/23.	F 0689	F - 689 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident M has now been reassessed related to their specific fall prevention interventions. The care plan has been revised to reflect the current fall safety interventions and all nursing staff has been in-serviced on the resident's current safety interventions and their responsibility to ensure that those safety interventions are in place at all times. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident P has now been reassessed related to their specific fall prevention interventions. The care plan has been revised to reflect the current fall safety interventions and all nursing staff has been in-serviced on the resident's current safety interventions and their responsibility to ensure that those safety interventions are in place at all times. *The corrective action taken for the*	10/25/2023

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	A current falls care plan, revised 7/17/23, indicated Resident M was at risk for falls due to a history of a wedge compression fracture and included the interventions: Staff to ensure resident using walker at all times while ambulating, dated 11/11/22. Relocate closer to Nurse's station when out of isolation, dated 4/4/23. Assistive device front wheeled rolling walker, dated 11/21/22. Encourage and educate resident on using the call light when needing assistance. Clip call light to shirt for visual reminder when in chair or bed in room, dated 11/21/22. Low bed, dated 8/30/23. Non skid footwear at all times, dated 11/21/22. Non skid strips left side of bed, dated 7/18/23. Therapy as ordered, dated 11/21/22. Transfer assist with 1 staff assist, gait belt and walker at all times, dated 11/21/22. The clinical record indicated Resident M had fallen 5 times since admission. On 11/10/22 at 4:15 A.M., Resident M sustained an unwitnessed fall while attempting to ambulate to the bathroom. The intervention "staff to ensure resident using walker at all times while ambulating" was added to the care plan. On 11/21/22 the following interventions were added: assistive device front wheeled rolling walker, Encourage and educate resident on using the call light when needing assistance. Clip call light to shirt for visual reminder when in chair or bed in room, non-skid footwear at all times, Therapy as ordered, and transfer assist with one staff member, gait belt and walker at all times. On 4/3/23 at 1:00 P.M., Resident M sustained an		*other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A house wide audit has been completed for all residents related to their potential safety risk factors. Each resident's fall risk care plan has been reviewed and revised to reflect the resident's specific fall interventions. All nursing staff has been in-serviced on each resident's current safety interventions and their responsibility to ensure that those safety interventions are in place at all times. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all nursing staff on the facility's fall prevention program policy. The staff was re-educated on the use of safety interventions specific to each resident's needs in an effort to prevent falls and/or prevent injury from a fall. The staff was reminded of their responsibility to ensure that the resident's care plans are updated following each fall and that each staff member is responsible for ensuring that the resident's safety interventions are in place in accordance with their plan of care. *The corrective action taken to monitor to ensure the deficient*	

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	unwitnessed fall. At that time, the resident was in isolation for COVID-19. The resident was unable to recall what happened and was sent to the ER (emergency room) for treatment and evaluation. The intervention "relocate closer to nurse's station when out of isolation" was added to the care plan on 4/4/23. A progress note, dated 5/16/23, indicated that Resident M had been complaining of left hip pain especially when in therapy and was ordered to get a left hip x-ray. A progress note, dated 5/17/23, indicated the x-ray showed an old femoral neck fracture with moderate displacement and bone resorption without callus formation. The resident was sent to the hospital. A progress note, dated 5/18/23, indicated the resident was scheduled for hip surgery. Resident M was readmitted to the facility on 5/21/23. On 6/28/23 at 4:15 P.M., Resident M sustained a witnessed fall while attempting to stand up unassisted from the bed. The fall was witnessed by maintenance staff. The resident hit his head on his bedside table and complained of left hip pain. The resident was sent to the ER. The intervention "non skid strips left side of bed" was added to the care plan on 7/18/23. A progress note, dated 6/28/23 at 6:04 P.M., indicated the resident would be admitted to the hospital with a fracture to his left femur and would require surgery. Resident M was readmitted to the facility on		*practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the resident's safety intervention plan. The tool will monitor to ensure that the resident's safety interventions are in place and that the care plan has been updated following each fall with new appropriate safety interventions added following each fall. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	7/3/23. On 8/22/23 at 8:30 P.M., Resident M sustained a witnessed fall. Staff observed the resident sliding from the bed onto the floor landing on his buttocks, but was unable to reach the resident in time to stop the fall. The care plan was not updated with an intervention. The clinical record lacked documentation of an IDT (interdisciplinary team) meeting. Fall Documentation, dated 8/23/23, indicated the resident needed a low to the floor bed. On 8/25/23 at 2:45 A.M., Resident M sustained an unwitnessed fall while attempting to get out of bed. Resident was observed sitting on the floor with both legs out in front of him. At that time, he complained of left hip pain, the left leg appeared to be longer than the right leg and was rotated inward, and resident was unable to move his left leg. The resident was sent to the ER. The intervention "low bed" was added to the care plan. The clinical record lacked documentation of an IDT meeting. The low bed was added to the care plan on 8/30/23. A progress note, dated 8/25/23, indicated Resident M had a left hip fracture that would be repaired nonsurgically. Orders were given to get repeat films in 2 weeks, monitor pain relief at the facility, and to be toe touch weight bearing on the left side. On 9/18/23 at 10:05 A.M., Resident M was observed lying in bed. The bed was raised. There was a sign next to the bed that indicated "Put my bed back in lowest position before you leave! Thank you!". There were no skid strips next to the bed.			

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	On 9/20/23 at 8:35 A.M., the resident was observed sitting in his recliner in his room. There were no skid strips next to the bed, no walker in the room, and the call light was wrapped around the bed side rail. On 9/20/23 at 10:52 A.M., OT (occupational therapist) 27 and PT (physical therapist) 19 indicated that Resident M came off of toe touch weight bearing orders last week and was now full weight bearing for transfers. They indicated that the resident used a walker previously, but had not used a walker for a while now. On 9/20/23 at 3:22 P.M., Resident M was observed lying in bed. The bed was raised. At that time, the DON (Director of Nursing) indicated the bed was not in its lowest position and it should be. On 9/21/23 at 9:18 A.M., QMA (Qualified Medication Aide) 2 indicated fall interventions for Resident M were a low bed, assistance of 2 staff for transfers using a gait belt, and skid strips next to the bed. At that time, QMA 2 indicated the skid strips were not there. On 9/21/23 at 9:23 A.M., CNA (Certified Nurses Aide) 7 indicated she was not sure what fall interventions were in place for Resident M. On 9/21/23 at 2:52 P.M., Resident M was observed lying in bed. The bed was raised. At that time, the DON indicated the bed was not in the lowest position and should be. She indicated that all staff were gathered earlier that morning and inserviced about Resident M's bed being in the lowest position. 2. On 9/19/23 at 2:16 P.M., Resident P's clinical record was reviewed. Diagnosis included, but			

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	were not limited to, dementia and non-traumatic brain dysfunction. Admission date was 10/11/22. The most recent quarterly MDS Assessment, dated 7/13/23, indicated a severe cognitive impairment. Resident P required extensive assistance of two staff with bed mobility, transfers, eating, and toileting, and was totally dependent of two staff for bathing. Resident P had experienced one fall with injury since the previous assessment. A falls risk assessment, dated 10/12/22 indicated a moderate fall risk on admission. Current physician orders included, but were not limited to, the following: pommel cushion for positioning, dated 3/21/23. A current risk for falls care plan, dated 10/12/22, included, but were not limited to, the following interventions: Fall mat placed at bedside, dated 6/14/23. If resident is in a stationary chair, keep wheelchair out from resident reach/vision to prevent resident from attempting to transfer without assistance, dated 11/4/22. Non skid footwear at all times, dated 10/12/22. Fall incident reports since admission included the following falls: Fall 1 11/4/22 at 12:10 P.M. Fall was witnessed. Resident stood up from a chair, pushed her wheelchair over, and sat on the floor. She did not hit her head. The new intervention at that time was to move wheelchair out of reach, and the care plan was updated. Fall 2 12/4/22 at 12:15 P.M. Fall was not witnessed by			

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	staff. Resident stood from wheelchair attempting to get into bed and fell per roommate, resulting in a facial laceration. First aid applied, and resident was sent to the Emergency Room (ER). At the ER, a CT of cervical spine without contrast and CT of the head without contrast were both negative for injury. The following day, 12/5/22, the Interdisciplinary Team (IDT) reviewed the fall and agreed that an appropriate intervention following the fall was a pad alarm at all time. The falls care plan was not updated with a new intervention. Fall 3 12/29/22 at 7:30 A.M. Fall was not witnessed. Resident fell while ambulating in her room, and hit back of head. Resident was sent to the ER, where she fell again. Resident received three staples to a laceration on the back of head, and a CT was negative. Upon return from the ER, and alert note dated 12/29/23 indicated a new intervention for a self release alarm belt. The falls care plan was updated. Staples were removed 1/13/23. Fall 4 1/16/23 at 11:35 P.M. Fall was not witnessed. Resident was found with neck cocked to the left side against the wall with blood on the wall. The resident was pale and with loss of consciousness, as she was staring with eyes deviated up not blinking or moving. When assessed, pupils were slightly unequal. The roommate indicated the resident had gotten up to walk and tried to grab the wheelchair and fell. Resident regained consciousness after about a minute, and was sent to the ER, where she received three staples to the back of the head (in a different area than the previous fall). Prior to the fall, an alert note dated 1/15/23 indicated "resident got up out of bed and ambulated in the hall, she is placed in her wheelchair, she is making repeated attempts to			

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	ambulate on her own, her gait is too unsteady for this, she is toileted given tylenol and put back to bed, no further attempts to ambulate on her own, bed alarm in place". The falls care plan was not updated with a new intervention. Staples were removed on 1/27/23. Fall 5 6/13/23 at 3:30 P.M. Fall was not witnessed. Resident was found on the floor with a large hematoma on the left side of the forehead and dilated pupils. Resident was alert to staff, and blood pressure was elevated at 206/93. Resident was sent to the ER and returned same day. An alert note dated 6/13/23 at 8:04 P.M. indicated "Resident received back from hospital with a diagnosis of closed head injury and scalp hematoma, hematoma and bruising noted on the left forehead and a dressing noted on the left elbow ..." Prior to the fall, on 6/13/23 at 1:35 P.M., an alert note indicated "resident noted to be trying to exit the foot of her bed, this resident returned to the correct position per 1, bed in low position and her mat in place." Care plan was updated on 6/14/23 for fall mat at bedside. Progress notes included, but were not limited to, the following: 10/22/22 at 12:39 P.M. "Admission ... While in ER(9/26)fell and hit head causing a hematoma on scalp ..." 1/17/23 at 2:39 P.M. "... Res [resident] is lethargic and unable to stand w/o [without] max assist of 2 ..." 1/30/23 at 1:26 P.M "CNAs' reported concern to this RN about residents L [left] facial droop. Resident was laying asleep on her left side in			

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	recliner with pull tab alarm on, after receiving morning medication. When resident awoke CNAs took resident to dining room to eat. CNAs statedresident [sic] had "L flaccid arm and not making eye contact." Upon RN assessment resident sitting in w/c [wheelchair] leaning to left, but this position not abnormal for resident, neither is residents L facial droop. RN walked behind residents left side, she turned andlooked [sic]. Walked to residents' right side, she turned and looked ... RN does not see any indication to send resident to hospital at this time" 1/30/23 at 3:37 P.M. Nurse Practioner visit indicated "no new orders" 2/13/23 at 6:46 A.M. "this resident is sitting on the floor at this time". The clinical record lacked any other information related to the fall. 3/6/23 at 12:09 P.M. "Resident has slid out of w/c twice in front of nurses. Did not hit head, no injuries. [psych services] called for recommendation". The clinical record lacked any other information related to the fall. 3/6/23 at 12:45 P.M. "OK to increase Klonipin [sic] [an anti-anxiety medication] to 0.5mg TID [three times a day]" 3/14/23 at 10:42 A.M. "HOLD [medication orders] PER LPN/resident lethargic" 3/18/23 at 1:48 P.M. "HOLD this noon clonazepam [an anti-anxiety medication] per LPN d/t sleeping, lethargy" 6/15/23 at 9:57 A.M. "Therapy came to RN and expressed concern that resident is lethargic. Asleep in the chair with head lying R [right] side.			

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	Resps [respirations] 17 even/ unlabored. Resident arouses to stimuli, moves all extremities. Hematoma to L eye unchanged, scabbed over ... Continue to monitor" 6/30/23 at 12:21 P.M. "resident was in bed lying on back and vomitted [sic] small amount. lungs sounded wet upper anterior and diminished throughout posteriorly. when turned to listen she coughed pretty forcefully clearing some. resident was gotten up in chair. reported that resident had vomited couple times past few days. went and listened to resident again and upper airway has cleared some. she is in no distress. abdomen is soft but bowel sounds are diminished. texted [Nurse Practitioner] all the above. awaiting further instructions" 6/30/23 at 2:02 P.M. "[Nurse Practitioner] here to see resident. resident looks better. lungs fairly clear diminished posteriorly. BS hypoactive. she is in no distress. no new orders at this time. resident in bed with head of bed elevated" 7/5/23 at 2:52 P.M. "follow stroke protocol and send to ER for CT scan of brain. Sedating meds held at lunch. Sent to ER ..." 7/6/23 at 6:02 P.M. "... Res admitted with Pneumonia. Will continue to follow up" 7/8/23 at 5:00 P.M. "resident returned from the hospital per transport and is in a wheelchair at this moment, resident transferred per 1 without difficulty, this resident has a fixed glaze at this time and her pupils do not react to light, facial features are not bilateral, adrooping [sic] noted on the left side of her mouth, an MRI in hospital showed negative for stroke [two days prior], bruising noted on her right wrist and left top of			

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	her hand, red sacrum covered with a mepilex at this time, 127/69,P80, T98, R16,02 sat is 93%, resident is in bed on her left side and the bed is in low position, call bell at bedside although resident never utilizes it, no attempts to get out of bed, she is trying to sleep" 7/8/23 at 7:32 P.M. "after 2 attempts made to feed this resident but still not waking up, will try snacks later if she wakes up, in bed in low position, no attempts made to get out on own" 7/10/23 at 10:22 A.M. "Res has been noted to pocket food at meals. Oral care after meals has Un swallowed food. Res is having difficulty swallowing since return from hospital. left side of face has droop and res tends to lean to left side. Will report to Speech therapist and have evaluated. Will monitor" 7/14/23 at 5:48 P.M. "I spoke with [POA] and stated that [resident] is declining and could benefit from a hospice evaluation, [POA] approved completely that we could implement hospice, hospice will be notified ..." 8/5/23 at 6:08 P.M. "Resident has appeared restless throughout this shift more so after 12p, fidgeting around while in w/c causing chair alarm to sound, as well as while in bed, had to be assisted from fall mat in bdrm [bedroom] back into bed multiple x's [times] after 1200" On 9/20/23 at 8:38 A.M., Resident P was observed sitting in a high back wheelchair in the common area with an alarm box hanging from the back of it and clipped to the collar of her shirt. The back of the wheelchair was observed with the left anti-tipper facing down and engaged, and the right was facing up. Resident P was observed to			

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	rock back and forth in the wheelchair. On 9/21/23 at 1:33 P.M., Resident P was observed during the survey on the floor between the bed and a mat on buttocks wearing incontinence brief and no pants. The fall mat was observed 1-2 feet from the bed. Resident P was observed grimacing and moaning. The sock on the left foot was hanging halfway off. Staff was notified and assisted the resident back into the bed. Once back in the bed, Resident P was observed to move around a lot. On 9/21/23 at 2:19 P.M., the Director of Nursing (DON) indicated Resident P had been care planned to come off of the bed onto a mat, and because of that would not be considered a fall every time she rolled out of bed. At that time, Resident P's care plan were reviewed with the DON and she indicated that intervention had not been care planned as intended. On 9/22/23 at 9:25 A.M., Resident P was observed lying in bed. Resident P's wheelchair was observed beside the foot of the bed within sight of the resident. On 9/22/23 at 11:22 A.M., the DON indicated Resident P's wheelchair should be out of reach as well as out of sight while lying in the bed. On 9/25/23 at 9:26 A.M., Resident P was observed sitting in a high back wheelchair in the common area with no socks or shoes on. On 9/21/23 at 2:10 P.M., the DON indicated that, after a fall, the IDT meets and the care plan should be updated with a relevant intervention that is different than before.			

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	On 9/21/23 at 12:49 P.M., the Administrator provided a current non-dated Falls and Fall Risk policy that indicated "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling ... a fall is defined as" Unintentionally coming to rest on the ground, floor or other lower level ... Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred ... If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant ...". This Federal tag relates to complaint IN00417903. 3.1-45(a)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record review, the facility failed to ensure a resident with dementia received the appropriate treatment and services to maintain their highest level of well-being for 1 of 2 residents reviewed for dementia care. (Resident F) Finding includes: On 9/20/23 at 8:35 A.M., Licensed Practical Nurse (LPN) 2 indicated Resident F had behaviors of	F 0744	F - 744 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident F is now receiving behavioral services from a new psychiatric service. In addition, new assessments have been completed for activity preferences, wander risk	10/25/2023

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	leaving her room and getting into bed with other residents especially at night. She indicated an alarm box was placed at the top of her door with a motion sensor to alert staff when she was leaving her room at night, but it had not worked well. She indicated she was unsure what they were going to do as a new intervention. On 9/21/23 at 8:41 A.M., Resident F was observed wandering in Resident T's room. On 9/22/23 at 9:25 A.M., Resident F was observed lying in bed. An alarm box was observed hanging from the side rail, with a cord going under the resident. The lights on the box were not lit. At that time, LPN 25 indicated she was unable to tell if the pad alarm was on or functioning, and did not want to test it because it may wake the resident. After checking the box, LPN 25 indicated the alarm was not on. On 9/22/23 at 9:42 A.M., Hospitality Aide 6 indicated Resident F wandered a lot in and out of other resident rooms, hallways, and at the nurse's station, and had been instructed to re-direct the resident. She indicated it was sometimes difficult to re-direct, and would notify the nurse when she displayed those behaviors. On 9/22/23 at 10:00 A.M., Resident F's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, anxiety, and non-traumatic brain dysfunction. Admission date was 12/30/21. The most recent quarterly MDS Assessment, dated 7/29/23, indicated a severe cognitive impairment. Resident F required limited assistance of one staff with bed mobility, transfers, and eating. The MDS indicated no behaviors.		assessment and social services to address the resident's current needs. The resident will continue to be evaluated by the new behavioral health service and behaviors tracked in accordance with facility policy. A new behavioral care plan has also been developed and implemented to address the resident's current behaviors. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents diagnosed with dementia have the potential to be affected by this deficient practice. All residents diagnosed with dementia have been reviewed to ensure that they are receiving appropriate treatment and services in an effort to maintain their highest level of well-being. In addition, a house wide audit of all employee files has been completed to identify which employees need the required dementia training. Dementia training has now been provided for all those identified employees. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all staff on the facility's policies related to dementia care and behavioral management. The staff members were re-educated on providing the	

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	Resident F's clinical record lacked a current physician's order related to behaviors or behavior monitoring. A current wandering care plan, dated 1/11/22, indicated the following interventions: I will not leave facility unattended through the review date. My safety will be maintained through the review date. I will demonstrate happiness with daily routine through the review date. Monitor for fatigue and weight loss. Pad alarm to bed. A current cognitive loss related to diagnoses of dementia care plan, dated 1/4/22, indicated the following interventions: Activities to assess and provide appropriate level activities for memory improvement. Approach resident warmly and positively. Attempt to limit re-orientation of resident to once per contact. Check frequently for safety. Encourage family/responsible party to visit at frequent intervals. Engage resident in conversation and arrangement of personal effects in room to help re-orientate. Engage resident in conversation during meal time. Establish daily routine with resident. Give on instruction at a time to resident. Praise resident for appropriate verbal response. Provide consistency in scheduling direct care providers on all shifts when possible. Provide verbal reminders to resident as necessary to assist with recall of recent events. A current impaired cognitive function impaired thought processes related to dementia care plan,		necessary treatment and services for those residents with dementia. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implement to monitor that the resident with dementia is receiving the appropriate treatment and services to maintain the highest level of well-being. The tool will monitor to ensure an appropriate plan of care has been developed implemented to provide the necessary care and services to meet their specific needs. The tool will also monitor to ensure that all staff members have received and continue to receive the required dementia training in accordance with the regulations. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	dated 1/4/22, indicated the following interventions: Ask yes/no questions in order to determine my needs. Communicate with myself/family/caregivers regarding residents capabilities and needs. Cue, reorient and supervise me as needed. Discuss concerns about confusion, disease process, nursing home placement with myself/family/caregivers. I will take medications as ordered. Monitor/document for side effects and effectiveness. Use task segmentation to support short term memory deficits. Break tasks into one step at a time for me. A current Activities care, dated 6/9/22, indicated the following interventions: All staff to converse with resident while providing care Assist with arranging community activities. Arrange transportation. Ensure that the activities the resident is attending are: Compatible with physical and mental capabilities; Compatible with known interests and preferences; Adapted as needed (such as large print, holders if resident lacks hand strength, task segmentation), Compatible with individual needs and abilities; and age appropriate. Establish and record the resident's prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary. Introduce the resident to residents with similar background, interests and encourage/facilitate interaction. Invite the resident to scheduled activities. Provide a program of activities that is of interest and empowers the resident by			

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	encouraging/allowing choice, self-expression and responsibility. Provide with activities calendar. Notify resident of any changes to the calendar of activities. Review resident's activation needs with the family/representative. Thank resident for attendance at activity function. The resident needs assistance with activities of daily life as required during the activity. The resident needs 1:1 bedside/in-room visits and activities if unable to attend out of room events. The resident needs assistance/escort to activity functions. Resident F's clinical record lacked resident-centered and resident specific care plans or interventions related to a diagnosis of dementia. Progress notes included, but were not limited to, the following: 7/4/23 at 10:25 P.M. "this resident is wandering into others rooms, she is toileted and put into a dry brief and gown and put to bed, staying in bed at this moment" 8/7/23 at 12:07 P.M. MD Visit "... Patient is found in the common area, resting on sofa. She is easily alerted when name is called. Staff expresses recent change in behaviors. She has been more irritable lately; had an episode of agitation and resistance to care during shower over the weekend. Mood lability noted as well as sexually inappropriate behaviors. Staff shared with me a couple examples of inappropriate behaviors including resident laying next to her roommate in bed with no pants on; she tried sitting on a male co-resident's lap a few times; also kissed a different male co-resident on the lips. These behaviors are very unlike her. When mood			

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	changes and behaviors were addressed with PCP, PCP initially increased tramadol ..." 8/9/23 at 8:51 A.M. "... res [resident] continues to become very busy, confused, wondering [sic], picking up things, etc. in the evening ..." 8/11/23 at 4:01 P.M. "Resident was at BINGO / ICE CREAM PARTY 8/11/23 afternoon (2:00PM - 3:15PM) Resident sat with activity Director during activity and spoke quietly to staff / self the duration of the activity. Resident was speaking about how she would like to "take some of these good looking men back to bed with her" and "if she could just get her hands on one of these men, she would sure show them a good time" This is unusual talk for resident. This staff has noticed that sexual talk has become more frequent with the resident within the past week along with increased agitation and refusal of meals. Nursing staff has been notified of residents changed behavior and is monitoring" 8/12/23 at 2:54 A.M. "res [resident] up and down frequently tonight. Wondering [sic] down hall. Redirected to room several times and has finally gone to sleep. Increased confusion and easily upset with staff. Agitation has increased even with restart of lexapro [an antidepressant medication]. Will monitor and update [psych services]" 8/13/23 at 8:47 P.M. "res [resident] wondering [sic] into other res [resident] rooms getting into their beds and belongings. Res redirected and will come out of her room and roam into others. Monitoring and redirecting. Res [resident] becomes agitated at times with redirection" 8/15/23 at 12:00 A.M. "At last follow-up visit,			

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	resident was restarted on Lexapro as behaviors seemed to be increasing since PCP [primary care provider] discontinued the Lexapro [an antidepressant]. However, nursing staff has not noted any improvement over the last couple weeks; instead, her behaviors continue to worsen. Staff states she has started to become combative at times when redirection attempts are made. Staff is requesting a short-term PRN [as needed] anxiolytic [anti-anxiety] to help manage current behaviors for now. According to recent facility progress notes, resident has been wandering into other rooms, and grabbing others belongings and getting into their beds at times. Staff has to keep a very close eye on her toavoid [sic] conflict" 8/18/23 at 5:34 P.M. "resident is pleasant and cooperative with staff, she is also wandering into others rooms and sitting on the beds, this resident is redirected ..." 8/23/23 at 1:45 A.M. "When making rounds noted that resident was not in her room or in bed. Continued rounds and immediately found resident in room 20 bed A. Noted resident had been incontinent as she had removed her brief and place on floor. Assisted female resident OOB [out of bed] andcovered [sic] her withs [sic] sheet to provide privacy and dignity . She ambulated up the hallway and to BR [bedroom] where she was tolieted [sic] and peri care provided. PJs reapplied and resident assisted to bed. Resident placed on 15 minute checks for her safety d/t [due to] wandering" 9/6/23 at 1:58 A.M. "Resident awake and ambulating past nurse's station. CNA [Certified Nurse Aide] greeted resident but she continued ambulating down the hallway so CNA walked alongside her. CNA asked resident if she needed			

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	to use the commode and motioned towards central BR [bathroom]. Resident said "No I'mjust [sic] going in the room" and ambulated towards door of an occupied room. Staff redirected her easily and assisted back to her room. Resident brief was dry and intact and she wouldn't allow staff to toilet. She climbed back in her bed and laid down. 15 minsafety [sic] checks will be implemented for the remainder of the shift ..." 9/8/23 at 4:09 P.M. "this resident often wanders into others room and sleep in the bed, she is found in another room and easily redirected" 9/12/23 at 12:31 A.M. "wandering up and around nursing desk, easily redirected, resident then lay down on the sofa to rest" 9/14/23 at 2:50 A.M. "Resident up wandering hallway attempted to enter room 22B and and [sic] lay down with resident as staff intervened. Assisted resident back to bed. Bed alarm applied to bed per NM [nurse manager] to monitor resident's movements" 9/20/23 at 5:40 P.M. "calmer since change in medication. Easily redirected. Still up wondering at times. No sexual talks or actions. Will continue to monitor" Resident F's clinical record lacked a care plan conference since 3/8/23. Quarterly wandering assessments from 9/2022 through 9/2023 included the following: 2/16/23 High risk to wander 4/25/23 High risk to wander The clinical record lacked a wandering assessment since 4/25/23.			

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	Resident F's clinical record lacked behavior assessments. Resident F's clinical record lacked preferences or likes/dislikes. The most recent activities assessment was completed 6/30/22. The most recent social services assessment was completed 1/1/22 upon admission. On 9/25/23 at 10:32 A.M., Resident F was observed lying in her roommate's bed. The Activities Director indicated she was not going to wake her as she did not want to cause behaviors and wanted her to sleep. A pad alarm was not observed on the bed. The following anonymous resident interviews were obtained during the course of the survey: Confidential Resident Interview (CRI) 1 - Resident F wandered into our room during the day and evenings and got into my bed. At one point, Resident F grabbed onto my wrist and would not let go. The resident indicated the wrist had been previously broken and hurt when Resident F grabbed it. Both residents in the room indicated it sometimes took two staff members to get Resident F out of the room, and most of the time staff had to be notified that she had wandered into the room. CRI 2 - Resident F wanders at night and several times I have had to call staff to come and get her. It started about a week ago, and has happened maybe three times. CRI 3 - Resident F has been in my room. She			

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	wandered into the room and moved things around. Staff came to get her immediately. CRI 4 - Resident F wandered in my room and tried to get into my bed. Staff would come to take her back to her room. On 9/22/23 at 11:02 A.M., LPN 25 indicated Resident F had dementia and got up out of bed to take care of her "kids". They had been trying to adjust her medications because she recently started going through "some sort of transition". She indicated Resident F had not always had the behaviors she did now. She indicated the alarm at her door was a night shift intervention because of her tendency to enter other resident rooms at night. During the day, staff could easily monitor and redirect due to there being more staff. On 9/22/23 at 11:26 A.M., the Director of Nursing indicated all staff had been educated to redirect Resident F with wandering behaviors as needed. She further indicated there should have been a care plan in place with specific interventions related to wandering. On 9/25/23 at 10:46 A.M., LPN 23 (the nurse on Resident F's hall) indicated she was not really familiar with Resident F. She indicated she thought the resident liked talking about her mom and cooking, and when Resident F had behaviors, she would redirect and walk/talk with her. She was unsure of any proactive interventions for Resident F related to behaviors. On 9/25/23 at 10:50 A.M., the Activities Director indicated Resident F was passively involved in group activities, and would sit with her during activities. She indicated the resident was not interested in participating, but did enjoy being			

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	part of the group. She indicated Resident F liked socializing, and sitting with other residents and staff. Music and TV did not keep her attention very long, and usually turned them on in her room to keep her calm. There were coloring books and workbooks for the resident when she was wandering. When she is in an aggressive mood, staff should walk with her. She indicated being proactive with the resident worked better than reacting when behaviors occurred, as redirection would agitate her more. She indicated preferences for residents were not discussed at staff meetings, and only communicated verbally with report. Any likes or dislikes for the residents would be documented in their electronic medical record. On 9/25/23 at 11:08 A.M., LPN 15 indicated she thought Resident F liked to read and watch TV, as both would keep her attention. At the beginning of a shift, she would do a walk through with the off-going staff, and go over who was a bed check and who was not. Likes and dislikes would only be communicated if it was "different". She indicated she was unaware of any specific incidents of Resident F wandering into other resident's rooms. On 9/22/23 at 8:45 A.M., employee files were reviewed. Four of five employee files reviewed for staff members employed greater than a year lacked documentation of dementia-specific training. On 9/22/23 at 1:33 P.M., a current non-dated Intervention and Monitoring Behavioral Assessment policy was provided and indicated "The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care ...			

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	155801	A. BUILDING 00 B. WING	09/25/2023

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	The resident and family or representative will be involved in the development and implementation of the care plan. Resident and family involvement, or attempts to include the resident and family in care planning and treatment, will be documented ... Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. The care plan will include, as a minimum: (1) frequency; (2) intensity; (3) duration; (4) outcomes; (5) location; (6) environment; and (7) precipitating factors or situations". This Federal tag relates to complaint IN00417903. 3.1-37(a)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers,			

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	visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the			

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	facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure proper hand hygiene was done for 2 of 6 observations of medication administration (Resident L, Resident B) and 1 of 1 observation of a dressing change (Resident T), and the facility failed to ensure toothbrushes were labeled and covered for 1 random observation. Finding includes: 1. On 9/18/23 at 9:14 A.M., LPN (Licensed Practical Nurse) 2 was observed to prepare and administer medications to Resident B. Resident B was standing beside the medication cart. No hand hygiene was observed before or after administering the medications. 2. On 9/18/23 at 9:29 A.M., LPN 2 was observed to prepare Resident L's medications, put them in a drawer, lock the cart, leave the medication cart and walk to the medication room. LPN 2 was observed to come back to the cart, unlock it, obtain the prepared medications, go to Resident L's room and administer the medications to Resident L. No hand hygiene was done before preparing or administering the medications. On 9/21/23 at 10:54 A.M., QMA (Qualified	F 0880	F - 880 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident B is now receiving their medications by staff members who are demonstrating good hand hygiene during medication administration. The nurse identified as LPN 2 has been re-educated on the facility's hand hygiene policy and has successfully completed a return demonstration. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident L is now receiving their medications by staff members who are demonstrating good hand hygiene during medication administration. The nurse identified as LPN 2 has been re-educated on the facility's hand hygiene policy and has successfully completed a return demonstration.	10/25/2023

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	Medication Aide) 2 indicated hand hygiene should be done before and after administering medications. 3. On 9/21/23 at 1:13 P.M., Registered Nurse (RN) 41 was observed to change a dressing for Resident T. After the dressing change was completed, RN 41 removed gloves and washed her hands with a 12 second lather. On 9/25/23 at 11:57 A.M., Certified Nurse Aide (CNA) 29 indicated hands should be washed with soap and water with a 30 second lather. 4. On 9/18/23 at 10:00 A.M., two uncovered and unlabeled toothbrushes were observed sitting on the back of the bathroom sink in Room 26 in between the faucet and wall with three combs resting on them. The bathroom was shared by two residents. At that time, neither resident in Room 26 were aware of who's toothbrushes were in the bathroom. On 9/25/23 at 11:59 A.M., the same toothbrushes were observed in the bathroom of Room 26. At that time, Qualified Medication Aide (QMA) 33 indicated both residents in Room 26 use toothbrushes, but it was unknown who the toothbrushes belonged to that were in the bathroom. She indicated they needed to be gotton rid of. On 9/21/23 at 12:48 P.M., a current Administering Medication policy, undated, indicated "staff follows established facility infection control procedures (e.g. handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable". This Federal tag relates to complaint IN00417903.		*3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident T is now receiving their dressing changes by staff members who are demonstrating good hand hygiene during and following dressing changes. The nurse identified as RN 41 has been re-educated on the facility's hand hygiene policy and has successfully completed a return demonstration. *4.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the two toothbrushes located in the bathroom of room 26 have been discarded and the residents in room 26 have been given new toothbrushes which are labeled with their names and are stored in plastic bags to prevent the spread of infection. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. All residents are now receiving their medications and treatments by staff members who are demonstrating proper hand hygiene in accordance with facility policy and acceptable standards of infection control practices. A house wide audit of all personal	

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	3.1-18(b) 3.1-18(l) 3.1-19(f)		items such as toothbrushes, combs, etc. has been completed to ensure that all personal items are properly labeled and stored properly to prevent the spread of infection. All personal care items are now properly label and stored to prevent the spread of infection. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all staff on the facility's policy on hand hygiene and the personal property policy. All staff members have successfully demonstrated proper hand hygiene in accordance with facility policy and acceptable standards of infection control practices. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the facility staff's practices to ensure proper hand hygiene is being performed per facility policy and that the resident's personal care items are all labeled and stored properly to prevent the spread of infection. This tool will be completed by the Infection Preventionist and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be	

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			reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0921 SS=F Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment for 1 of 1 laundry areas and 3 of 3 resident halls. Washers had debris build up, floors had debris build up, and point of contact water temperatures were over 122 degrees F (Fahrenheit). Findings include: 1. On 9/20/23 8:22 A.M., the laundry room was observed. A washer was observed to have debris build up under the lid, a washer door was observed to have debris build up, the back of the washer had scale build up, the plastic piping behind the washer had debris build up, and the service hallway was observed to have debris build up along the walls. On 9/20/23 at 8:30 A.M., Laundry Aide 2 indicated she tries to clean the washers daily, and the build up on the back of the washer is from the (name of town) water. On 9/21/23 at 1:20 P.M., Housekeeper 2 indicated the floor is swept daily on the service hall, mopped if needed. 2. On 9/18/23 from 11:05 A.M. to 11:51 A.M., the following water temperatures were obtained from	F 0921	F - 921 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified all residents and staff have the potential to be affected by this deficient practice. The laundry area and the service hallway have been deep cleaned and are now clean and free of any debris. The laundry area and service hallway have been placed on a routine cleaning schedule to ensure they remain clean, sanitary and free of debris. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the water temperatures have now been adjusted. The water temperature in the bathroom between room 10 and 12 is now temping at a safe water temperature level. The shower room sink on the long hall is now temping at a safe water temperature level. The bathroom	10/25/2023

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	resident rooms and areas: Bathroom between rooms 10 and 12 was 126.6 degrees Fahrenheit. The resident in room 10 indicated the water in the bathroom continuously ran hot and you had to be careful to not burn yourself. Shower room sink on the long hall was 124.9 degrees Fahrenheit. Bathroom between rooms 9 and 11 was 126.0 degrees Fahrenheit. Bathroom in Room 26 was 130.1 degrees Fahrenheit. The resident in Room 26 indicated you had to watch and not keep the hot water on by itself so it did not get too hot. On 9/18/23 from 11:29 A.M. to 12:20 P.M., the following water temperatures were obtained from resident rooms: Room 27 bathroom was 129.9 degrees Fahrenheit. Room 19 bathroom was 125.9 degrees Fahrenheit. The resident in room 19 indicated the water was pretty hot and had to mix with cold. Room 18 bathroom was 129.6 degrees Fahrenheit. Bathroom between rooms 1 and 3 was 125.0 degrees Fahrenheit. Bathroom between rooms 2 and 4 was 125.1 degrees Fahrenheit. Bathroom between rooms 5 and 7 was 126.3 degrees Fahrenheit.		between room 9 and 11 is now temping at a safe water temperature level. The bathrooms in rooms 26, 27, 19, 18 are now temping at a safe water temperature level. The bathrooms between rooms 1 and 3, rooms 2 and 4, rooms 5 and 7, rooms 6 and 8 are now temping as a safe water temperature level. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents and staff have the potential to be affected by this deficient practice. The laundry area and the service hallway are now clean and have been placed on a routine cleaning schedule to ensure they remain clean and free of debris. The water temperatures will continue to be checked by the maintenance supervisor and temperatures will be adjusted as warranted to ensure resident and staff safety. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all laundry, housekeeping and maintenance staff on the facility's policies related to water temperatures and the cleaning and disinfecting of environmental surfaces policy. The staff has also been directed to properly report any abnormal water temperatures to the maintenance	

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	Bathroom between rooms 6 and 8 was 124.6 degrees Fahrenheit. On 9/18/23 at 11:30 A.M., the Maintenance Supervisor indicated the water temperatures in resident bathrooms were checked weekly, and had not been checked since last week. He indicated the temperatures sometimes ran high in dietary but he had not noticed them running high in the resident rooms. He also indicated a tankless water heater was utilized with a digital setting, and the goal for resident room water temperatures was between 115 and 117 degrees Fahrenheit. At that time, the following resident rooms and areas were checked using his thermometer: Bathroom between Rooms 10 and 12 was 123.8 degrees Fahrenheit. Shower room sink on the long hall was 123.6 degrees Fahrenheit. Bathroom between rooms 9 and 11 was 124.2 degrees Fahrenheit. Bathroom in room 26 was 131.8 degrees Fahrenheit. On 9/18/23 at 11:40 A.M., water temperature logs were obtained that indicated weekly readings from 1/2023 through 9/2023. The readings ranged from 114 to 118 degrees Fahrenheit, with the most recent taken on 9/14/23. On 9/18/23 at 12:19 P.M., Licensed Practical Nurse (LPN) 15 indicated the staff restroom water ran warm. On 9/18/23 at 12:20 P.M., Housekeeper 35 indicated the water in the housekeeping room ran warm.		department for prompt correction. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the facility environment to ensure all areas are clean, sanitary and free of debris. The monitoring includes the laundry and service hallway of the facility. The tool will also monitor water temperatures to ensure they are maintained at a safe water temperature level. This tool will be completed by the environmental supervisor and/or their designee weekly for four weeks, then monthly for three months, then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	On 9/18/23 at 12:21 P.M., Hospitality Aide (HA) 6 indicated during showers, some of the residents would indicate the water was too hot. On 9/22/23 at 1:21 P.M., the Administrator provided a current non-dated Safety of Water Temperatures policy that indicated "Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than 120 [degrees Fahrenheit], or the maximum allowable temperature per state regulation". On 9/21/23 at 11:13 a.m., the Administrator provided the current policy on maintenance/housekeeping with a revision date of 8/15/23. The policy included, but was not limited to, floors throughout the building are to be cleaned in accordance with the cleaning schedule. On 9/21/23 at 11:13 a.m., the Administrator provided the current policy, on cleaning and disinfecting environmental surfaces. The policy was undated. The policy included, but was not limited to, "Housekeeping surfaces (e.g.; floors, tabletops) will be cleaned on a regular basis (e.g.; daily, three times per week) and when surfaces are visible soiled. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g.; daily, three times per week) and when surfaces are visibly soiled...". This Federal tag relates to complaint IN00417903. 3.1-19(f) 3.1-19(r)			
F 9999				

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Bldg. 00	3.1-14 PERSONNEL (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to provide documentation of staff completing a minimum of three hours of dementia-specific training annually for 4 of 5 staff employed greater than 1 year reviewed. (QMA 16, RN 31, QMA 2, CNA 11) Finding includes: On 9/22/23 at 8:45 A.M., employee files were reviewed. Employee files for QMA (Qualified Medication Aide) 16, RN (Registered Nurse) 31, QMA 2, and CNA (Certified Nurses Aide) 11 lacked documentation of dementia-specific training. QMA 16 started employment with the facility on 7/13/17. RN 31 started employment with the facility on 10/3/21. QMA 2 started employment with the facility on 5/21/15.	F 9999	9999 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no residents were identified during the survey, all residents have the potential to be affected by this deficient practice. The staff members identified as QMA 16, RN 31, QMA 2 and CNA 11 have now completed their three hours of dementia specific training for the year. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* although no residents were identified during the survey, all residents have the potential to be affected by this deficient practice. The staff members identified as QMA 16, RN 31, QMA 2 and CNA 11 have now completed their three hours of dementia specific training for the year. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a house wide audit of all personnel files was completed to identify any employee who has not met the annual three-hour dementia specific training requirement. Dementia specific in-services have now been conducted and all staff members are current with the required	10/25/2023

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	CNA 11 started employment with the facility on 9/12/18. On 9/25/23 at 1:35 P.M., the Director of Nursing (DON) provided sign-in sheets for classes "End of Life Dementia Inservice", "Dementia InService", and "Dementia Progression In Service", all dated 2/24/23. She indicated those were the only dementia-specific inservices she could find and that she knew it was not everything staff needed to comply with the State Regulation. She further indicated each of the inservice classes provided were 1 hour in length. QMA 16's name was listed as an attendee on 1 of the 3 inservice sign in sheets. RN 31's name was not found on any of the sign in sheets. QMA 2's name was listed as an attendee on 1 of the 3 inservice sign in sheets. CNA 11's name was not found on any of the sign in sheets. On 9/25/23 at 2:13 P.M., the DON indicated the facility followed all state regulations for inservice and education guidelines. This State tag relates to complaint IN00417903.		annual three hours of dementia specific training. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor employee files to ensure that all employees hired have documentation to support that they have received the initial six hours of dementia specific training and the required three hours of dementia specific training annually thereafter. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	