STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155432	A. BUILDING 00 B. WING	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALBANY HEALTH CARE & REHABILITATION CENTER	910 W WALNUT ST ALBANY, IN 47320

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 7, 8, 9, 10, 13, and 14 Facility number: 000309 Provider number: 155432 AIM number: 100288960 Census Bed Type: SNF/NF: 79 Total: 79 Census Payor Type: Medicare: 5 Medicaid: 58 Other: 16 Total: 79 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 23, 2025.	F 0000	The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.	
F 0576 SS=F Bldg. 00	483.10(g)(6)-(9) Right to Forms of Communication w/ Privacy Based on interview and record review, the facility failed to ensure mail was distributed to residents on Saturdays. This deficiency had the potential to affect 79 of 79 residents who resided in the facility. Finding includes: During a Resident Council group interview, on 1/10/25 beginning at 1:38 p.m., Resident 3	F 0576	1. As of 1/11/25, the Activity Assistants have been instructed to collect and distribute mail to residents on Saturdays. 2. All Activity Assistants and relevant staff will undergo training on the facility's "Mail Distribution" policy by 2/1/25. The training will emphasize the	02/10/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jason Gimre	Administrator	02/04/2025

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	indicated the facility did not deliver mail to the residents on Saturdays. There was no one at the facility to deliver mail because the administrative offices were closed on the weekends. Residents 45, 67, 30, 53, and 62 indicated they did not receive mail on Saturdays. During an interview, on 1/10/25 at 4:00 p.m., QMA 4 indicated he was uncertain if mail was delivered to the facility residents on Saturdays. During an interview, on 1/10/25 at 4:06 p.m., CNA 6 indicated she did not think the residents received mail on Saturdays. If the facility did receive mail, it went to the business office. During an interview, on 1/10/25 at 4:07 p.m., the Dementia Care Director indicated the residents did not get mail on Saturdays because the business office was closed. During an interview, on 1/14/25 at 10:34 a.m., the Activity Director indicated the activity assistants had not been passing mail to the residents on Saturday until this past Saturday, 1/11/24. They had thought the business office was required to gather the mail from the mailbox since the business office sorted the mail. During an interview, on 1/14/24 10:41 a.m., the Administrator indicated when they had hired new activities assistants, the information had not been passed to them to get the mail and deliver it to the residents on Saturdays. A current facility policy, revised 5/2017 and titled "Mail Distribution", provided by the Administrator on 1/14/25 at 11:24 a.m., indicated the following: "...Distribute all mail promptly to the addressed resident unopened ...Deliver the mail to		importance of timely mail delivery and the specific procedures for weekends. New hires will receive this training as part of their orientation process. 3. The "Mail Distribution" policy will be reviewed to determine if any changes need to be made to ensure compliance with weekend mail handling. Monitoring and Compliance: 4. The Activity Director will conduct weekly audits for the next three months to ensure compliance with the mail distribution policy. Audit results will be reviewed in the monthly Quality Assurance (QA) meetings. Any identified issues will be addressed immediately, and corrective actions will be documented. The Administrator will oversee the implementation and ensure that all corrective actions are maintained	

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	the residents within 24 hours of delivery by the postal service ...." 3.1-3(s)(1)			
F 0577 SS=C Bldg. 00	483.10(g)(10)(11) Right to Survey Results/Advocate Agency Info Based on observation, interview, and record review, the facility failed to ensure the most recent Indiana Department of Health (IDOH) survey reports were readily available for review. This deficiency had the potential to affect 79 of 79 residents who resided in the facility. Finding includes: During a Resident Council group interview, on 1/10/25 beginning at 1:38 p.m., Residents 3, 30, 45, 53, 62, and 67 indicated they did not know where the State Department of Health survey reports were located. During an observation, on 1/10/25 at 3:35 p.m., the State Department of Health survey report was located in a binder placed in a wall pocket on the wall beside the Human Resources office. The most recent survey in the binder was from the Annual Recertification and State Licensure Survey completed on 1/22/24. The report lacked the plan of correction. Review of the facility's IDOH survey history indicated Complaint Investigation Surveys were completed on 5/3/24, 9/13/24, and 10/18/24. During an interview, on 1/14/25 at 10:39 a.m., the Human Resources Director indicated she believed the Administrator was responsible for maintaining the State Department of Health survey report	F 0577	1. The Administrator has located and placed all missing survey reports, including the Complaint Investigation Surveys from 5/3/24, 9/13/24, and 10/18/24, into the designated binder as of 1/15/25. 2. All relevant staff, including the Human Resources Director and Administrator, will undergo training on the facility's "Availability of Survey Results" policy by 2/1/25. The training will emphasize the importance of maintaining up-to-date survey reports and ensuring they are readily accessible. 3. The "Availability of Survey Results" policy will be reviewed to determine if any changes need to be made to ensure compliance with maintaining and displaying survey reports. Any necessary updates to the policy will be implemented based on the review findings. 4. The Administrator will conduct monthly audits for the next six months to ensure the survey report binder is up-to-date and	02/10/2025

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	binder that was located in the wall pocket near her office door. During an interview, on 1/14/25 at 10:43 a.m., the Administrator indicated he was responsible for updating and maintaining the survey results binder. He remembered printing out survey reports for this past year, but was uncertain what had happened to the papers as they were not in the binder. A current facility policy, dated 11/1/23, titled "Availability of Survey Results", provided by the DON on 1/14/25 at 12:21 p.m., indicated the following: " ...A readable copy of our company's most recent federal and/or state survey report and plan of correction for any identified deficiencies is maintained in a 3-ring loose-leaf binder titled "Results of the Most Recent Survey" ...The facility will maintain reports of any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility ...." 3.1-3(b)(1)		accessible. Audit results will be reviewed in the monthly Quality Assurance (QA) meetings. Any identified issues will be addressed immediately, and corrective actions will be documented.	
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments Based on interview and record review, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) was submitted for a resident with a new mental health diagnosis and psychotropic medication for 1 of 1 residents reviewed for PASRR. (Resident 59) Findings include: Resident 59's clinical record was reviewed on	F 0644	1. A new PASRR Level I screening was submitted for Resident 59 on 1/15/25 to reflect the resident's current mental health diagnoses and psychotropic medications. 2. The Social Services Designee (SSD) and all relevant staff will undergo training on the Indiana PASRR Level I & Level of Care	02/10/2025

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	1/9/25 at 3:55 p.m. The most current PASRR was completed on 6/20/23. The application submitted indicated that the resident had no known or suspected mental health diagnoses. No mental health medications were listed. Resident 59's diagnoses included psychotic disorder with delusions due to know physiological condition (9/18/23), unspecified mood (affective) disorder (8/28/23), generalized anxiety disorder (6/29/23), other recurrent depressive disorders (6/29/23), and dementia in other diseases classified elsewhere, mild, with agitation (6/29/23). Physician's orders included escitalopram oxalate (antidepressant) 10 milligrams (mg) daily at bedtime (7/24/24), olanzapine (antipsychotic) 5 mg daily in the morning (4/16/24), and olanzapine 7.5 mg daily in the evening (10/15/24). A current care plan for behavioral symptoms included being easily agitated with others, choosing not to have care provided, verbal aggression, refusing medications, repetitive movements of rubbing arms and legs, yelling at staff, rocking, picking at face and arms, delusions, hallucinations, paranoia, name calling, cursing at staff, refusing care, refusing to change clothes, refusing staff assistance to brush hair and perform oral hygiene, repetitive movement of coming in and out of the dining-room, cursing under breath, appearing anxious for unknown reasons, grabbing and shoving peers, cursing and threatening peers, and wanting more food due to forgetting she just ate was initiated on 7/22/23 and revised on 1/3/24. Interventions included the following: administer medications as ordered (9/21/23), provide mental health services as indicated (8/6/23), and remove known triggers (7/22/23).		Screening Procedures by 2/10/25. The training will emphasize the importance of submitting a new PASRR when there are significant changes in a resident's mental health status or new psychotropic medications are prescribed. 3. The "Specialized Rehabilitative Services" policy will be reviewed to determine if any changes need to be made to ensure compliance with PASRR submission requirements. Any necessary updates to the policy will be implemented based on the review findings. 4. The SSD will conduct monthly audits that will be completed daily for 4 weeks, 2 times weekly for 8 weeks, monthly for 3 months, then quarterly for a minimum 6 months to ensure all residents with new mental health diagnoses or psychotropic medications have an updated PASRR. Audit results will be reviewed in the monthly Quality Assurance (QA) meetings. Any identified issues will be addressed immediately, and corrective actions will be documented.	

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	A Nurse's Note, dated 10/9/23 at 3:58 p.m., indicated a new order was received from the psychiatric nurse practitioner (NP) for the resident to be sent to a neuropsychiatric hospital. The resident was transferred via facility van to the neuropsychiatric hospital. A Physician Narrative Progress Note, dated 10/9/23 at 11:14 p.m., indicated the resident was assessed for continued mood swings and behaviors which included agitation, aggression, wandering, anxiety, and confusional states. The resident had been seen by the NP on 10/9/23. The resident was initially calm but showed some signs of paranoia as she walked into the dining room and started looking around. The facility was providing one-on-one care which the resident did not like and said someone kept following her around. The resident was on one-on-one care with staff due to increased physical and verbal aggression as well as increased mood swings. The resident had been found standing over another resident with a pillow over that's resident's face. The resident had multiple incidences of physical aggression over the past several weeks. Her behaviors worsened over the last several weeks. As the resident sat in the dining room, the noise level increased. The resident yelled a profane statement. The NP's plan indicated it was concerning to adjust any medications as it was believed the resident should be sent out to a psychiatric hospital where she could get more one-on-one aggressive treatment, and her medications could be adjusted. A Physician Narrative Progress Note, dated 10/30/23 at 11:28 p.m., indicated the resident was assessed by the psychiatric NP. Her recent hospital stay was reviewed. The resident had			

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	been transferred to a neuropsychiatric hospital due to worsening behaviors, agitation, and severe aggression. While at the hospital, the resident's risperidone (antipsychotic) was increased then discontinued. She started on olanzapine 5 mg twice a day which was increased to 10 mg twice a day on 10/23/24. The resident reported that she thought her mood was okay. She said she kept her necklace hidden, which was a string of pearls because she believed people would steal them. She exhibited paranoia and restlessness while wandering. The staff had reported that the resident was very on edge since return from the neuropsychiatric hospital. During an interview, on 1/14/25 at 4:30 p.m., the Social Services Designee (SSD), who was responsible for PASRR submissions, indicated the PASRR completed on 6/20/23 was the only PASRR completed she had for the resident. The resident should have had a new PASRR submitted when the resident received the mental illness diagnoses. According to the Indiana PASRR Level I & Level of Care Screening Procedures for Long Term Care Services Provider Manual, retrieved from maximusclinicalservices.com on 1/14/24, last revised 4/20/20, "...If a NF [nursing facility] resident's behavioral or mental status significantly changes, the NF must submit a new Level I to report the change through the PASRR process. This applies to people who have a known Level II condition and to people with a previous negative Level I ... Examples of a mental status change event include: A new mental health diagnosis that is not listed on previous LI or Level II. A new psychotropic medication for mental illness ...." A current facility policy, dated 11/1/23, titled			

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	"Specialized Rehabilitative Services", provided by the SSD on 1/14/25 at 5:03 p.m., indicated the following: "...The facility shall provide or obtain services from an outside resource for specialized rehabilitation services ...as well as ensure that residents with Mental Disorder (MD), Intellectual Disability (ID) or related conditions receive services as determined by their Preadmission Screening and Resident Review (PASARR) ...."			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on record review and interview, the facility failed to develop and implement a comprehensive care plan with individualized interventions to maintain the resident's highest practicable mental, physical, and psychosocial outcome for 1 of 1 resident reviewed for a limited range of motion. (Resident 73) Finding includes: During an interview on 1/7/25 at 12:10 p.m., Resident 73 was laying in bed in his room with his door closed. He indicated he was paralyzed from his chest down. He had received therapy when he admitted a few months ago, but therapy ended. He was waiting for insurance to get more therapy. He had not received any restorative care or passive range of motion on his lower extremities to ensure he did not have a decline while he waited on insurance. He had spoken to two different therapy staff members quite some time ago and requested restorative care, but had not received any. He was concerned about losing the progress he had made in therapy. Resident 73's clinical record was reviewed on 1/9/25 at 5:08 p.m. Diagnoses included paralytic	F 0656	1. A comprehensive care plan for Resident 73 was developed and implemented on 1/15/25. This care plan includes individualized interventions to address the resident's risk for a decrease in range of motion and the development of contractures. 2. The MDS Coordinator and all relevant staff will undergo training on the facility's "Comprehensive Care Plan" policy by 2/10/25. The training will emphasize the importance of developing and implementing individualized care plans that address each resident's specific needs, including those at risk for a decrease in range of motion. 3. The "Comprehensive Care Plan" policy will be reviewed to determine if any changes need to be made to ensure compliance with developing and implementing individualized care plans.	02/10/2025

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	syndrome, constipation, complete paraplegia, other reduced mobility, generalized muscle weakness, and need for assistance with personal care. The resident's clinical record lacked a care plan related to being at risk for a decrease in range of motion and/or development of contractures related to the resident's diagnosis of paraplegia. During an interview on 1/13/25 at 5:14 p.m., the MDS Coordinator indicated a care plan for restorative care should have been developed and implemented, but it had not been and was not in the resident's clinical record. A current facility policy, revised 9/18/24, titled "Comprehensive Care Plan," provided by the DON on 1/14/25 at 12:05 p.m., indicated the following: "...It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights , that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment...." Cross Reference F688. 3.1-35 (a) 3.1-35(b)(1)		Any necessary updates to the policy will be implemented based on the review findings. 4. The MDS Coordinator will conduct monthly audits that will be completed daily for 4 weeks, 2 times weekly for 8 weeks, monthly for 3 months, then quarterly for a minimum 6 months to ensure all residents with similar needs have comprehensive care plans in place. Audit results will be reviewed in the monthly Quality Assurance (QA) meetings. Any identified issues will be addressed immediately, and corrective actions will be documented.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on interview and record review, the facility failed to ensure the resident's representative was invited to participate in the ongoing care planning process for 1 of 1 residents reviewed for care	F 0657	1. The Social Services Designee (SSD) contacted Resident 34's representative on 1/15/25 to invite them to the next care plan	02/10/2025

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	planning. (Resident 34) Findings include: During an interview, on 1/8/25 at 11:19 a.m., Resident 34's representative indicated she had been invited one time to a care plan meeting. She had not been invited since that first meeting. She did not know when the meetings were held. Resident 34's clinical record was reviewed on 1/9/25 at 11:54 a.m. Diagnoses included anxiety disorder, delusional disorder, Alzheimer's disease, and unspecified dementia, moderate, with agitation. An annual Minimum Data Set (MDS) assessment, dated 10/29/24, indicated the resident was severely cognitively impaired. An interview about preferences with the resident indicated having her family or a close friend involved in discussions about her care was very important to her. A current care plan indicated Resident 34 did not plan to return to the community and wished to be asked about returning to the community on comprehensive assessments only (initiated 2/11/22 and revised 9/20/23). Interventions included the following: Encourage the resident's family to be involved in the resident's plan of care (initiated 2/11/22). A progress note, dated 4/26/23 at 2:00 p.m., indicated a phone call was placed to the resident's representative to set up a care plan conference. The resident's representative was not reached, and a message could not be left as the voice mail had not been set up. The clinical record lacked more recent		meeting and ensure they are aware of future meetings. 2. The SSD and all relevant staff will undergo training on the facility's "Care Plan Meeting and Invitations" policy by 2/1/25. The training will emphasize the importance of documenting all invitations to care plan meetings, whether made by phone or mail. 3. The "Care Plan Meeting and Invitations" policy will be reviewed to determine if any changes need to be made to ensure compliance with inviting and documenting the participation of resident representatives. Any necessary updates to the policy will be implemented based on the review findings. 4. The SSD will conduct monthly audits that will be completed daily for 4 weeks, 2 times weekly for 8 weeks, monthly for 3 months, then quarterly for a minimum 6 months to ensure all resident representatives are invited to care plan meetings and that these invitations are properly documented. Audit results will be reviewed in the monthly Quality Assurance (QA) meetings. Any identified issues will be addressed immediately, and corrective actions will be documented.	

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	documentation of attempts to invite the resident's representative to participate in the resident's care plan conferences. During an interview, on 1/10/25 at 3:32 p.m., the Social Services Designee (SSD) indicated she invited the short term stay residents' representatives by phone. She invited the long-term stay residents' representatives by mail. During an interview, on 1/14/25 at 10:51 a.m., the SSD indicated if the invitation to the care plan conference was not in the progress notes, then she did not have documentation that the resident's representative had been invited. The resident's representative visited the resident two to three times a week, and the resident's care was often discussed. She had invited the resident representative verbally to care plan conferences, but she did not have documentation of those discussions. A facility policy, revised 2/2019, titled "Care Plan Meeting and Invitations," provided by the DON on 1/14/25 at 3:29 p.m., indicated the following: " ...SSD/Designee will send a standard letter to the Resident Representative or place a call to schedule the care plan meeting ...The SSD/Designee will document that the letter was sent or the phone call was made and the response received from the resident or the resident representative ...." 3.1-35(d)(2)(B)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility Based on interview and record review, the facility failed to provide appropriate restorative care	F 0688	1. Restorative care services, including passive range of motion	02/10/2025

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	services as recommended by therapy for a resident with limited range of motion for 1 of 1 resident reviewed for restorative care. (Resident 73) Finding includes: During an interview on 1/7/25 at 12:10 p.m., Resident 73 was laying in bed. He indicated he was paralyzed from his chest down. He had received therapy when he admitted a few months ago, but therapy ended. He was waiting for insurance to get more therapy. He had not received any restorative care or passive range of motion on his lower extremities to ensure he did not have a decline while he waited on insurance. He had spoken to two different therapy staff members quite some time ago and requested restorative care, but had not received any. He was concerned about losing the progress he had made in therapy. The resident's clinical record was reviewed on 1/9/25 at 5:08 p.m. The resident admitted to the facility on 9/12/24. Diagnoses included, paralytic syndrome, constipation, complete paraplegia, other reduced mobility, generalized muscle weakness, and need for assistance with personal care. A physician's medication order, dated 9/26/24, included baclofen 10 mg tablet- give 20 mg by mouth three times a day for muscle spasms, and was discontinued on 10/21/24. Current physician's medication orders included the following: gabapentin (neuropathy pain reliever) 600 milligrams (mg) oral capsule by mouth three times a day for ascending paralysis, dated 9/13/24; baclofen (muscle relaxer) 20 mg tablet by		exercises, were initiated for Resident 73 on 1/13/25 as per the therapy discharge recommendations. 2. The MDS Coordinator, Restorative Aides, and all relevant staff will undergo training on the facility's "Restorative/ADL Nursing" policy by 2/1/25. The training will emphasize the importance of implementing restorative care services as recommended by therapy and ensuring these services are documented in the clinical record. 3. The "Restorative/ADL Nursing" policy will be reviewed to determine if any changes need to be made to ensure compliance with providing and documenting restorative care services. Any necessary updates to the policy will be implemented based on the review findings. 4.The MDS Coordinator will conduct audits that will be completed daily for 4 weeks, 2 times weekly for 8 weeks, monthly for 3 months, then quarterly for a minimum 6 months to ensure all residents with restorative care recommendations are receiving the appropriate services. Audit results will be reviewed in the monthly Quality Assurance (QA) meetings. Any identified issues will be	

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	mouth every six hours for spasms, dated 10/21/24; Senna-Plus (stool softener) 8.6-50 mg oral tablet by mouth twice daily for constipation, dated 9/13/24; Dulcolax (laxative) rectal suppository 10 mg rectally at bedtime every three days for constipation, dated 10/7/24 Review of the Medication Administration Record from October 2024 through January 2025 indicated the resident's baclofen was increased to four times daily after therapy ended due to increased spasms. An additional medication was added to treat constipation. A current order, dated 9/12/24, indicated the resident's rehabilitation potential was fair. The clinical record lacked current orders for speech therapy, occupational therapy, physical therapy, or restorative care services. A quarterly Minimum Data Set (MDS) assessment, dated 12/21/24, indicated Resident 73 was cognitively intact. Rejection of care behaviors were not exhibited during the assessment period. The resident had a functional limitation in range of motion in the lower extremities with impairment on both sides. He was dependent on staff for assistance with toileting, bathing, lower body dressing, footwear, rolling left and right, and transfers. He required substantial staff assistance for personal hygiene. Walking was not attempted. A manual wheelchair was used for mobility. No days of Therapy Services or Restorative Nursing was received during the assessment period. The resident's clinical record lacked a care plan for restorative care or services to maintain or improve range of motion.		addressed immediately, and corrective actions will be documented.	

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	A Physical Therapy Discharge Summary, dated 10/4/24, indicated Resident 73 was discharged from physical therapy as he had reached maximum potential with skilled services. Discharge recommendations included the Restorative Nursing Program for passive range of motion and was set up with Restorative Aide 10, who was trained to perform these services. A Therapy Discharge Recommendation form, dated 10/4/24, indicated Resident 73's restorative nursing recommendations included passive range of motion. This included one set of 20 repetitions of slow motion secondary to spasticity. A Physiatry progress note, dated 10/8/24 at 3:44 p.m., indicated the resident's current functional status as of 10/8/24 was minimal staff assistance for bed mobility tasks, minimal to moderate assistance from staff was needed for both transfers and toileting using a slide board, minimal assistance from staff was needed for upper body dressing, and maximal assistance was needed for lower body dressing. A Nurse's Note, dated 10/21/24 at 1:27 p.m., indicated the nurse received a new order to increase the baclofen for muscle spasms. A Nurse's Note, dated 11/11/24 at 2:22 p.m., indicated the resident complained of an increase in spasms that were painful. The resident's spouse was aware of the clinical situation because the resident was not wanting to get up to get weighed. The clinical record lacked indication of restorative services being provided to the resident.			

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	During an interview on 1/13/25 at 11:52 a.m., Restorative Aide 15 indicated she and Restorative Aide 10 were assigned to all the residents who were required to receive Restorative Nursing Services. They typically worked with each resident in 15 minute increments each day. Depending on the order, they may be worked with twice daily. This was documented in the clinical record under restorative each time it was completed. These were the Restorative Aides' primary duties each day. Restorative Aide 15 indicated she had never been assigned to provide Resident 73 restorative care. During an interview on 1/13/25 at 5:05 p.m., the Physical Therapist indicated she was familiar with Resident 73. The resident had spoken with her when he was discharged from physical therapy regarding a desire to get restorative care/passive range of motion for his lower extremities. She had completed the "Therapy Discharge Recommendation" form and gave it to the Rehabilitation Director at that time. The form was dated 10/4/24. During an interview on 1/13/25 at 5:09 p.m., the Rehabilitation Director indicated a copy of the resident's Therapy Discharge Recommendation form was given to the previous MDS Coordinator (who was no longer employed at the facility) on the date she received it from the therapy staff. The MDS Coordinator was responsible for the assignment of the residents to a Restorative Aide for initiation of the recommendations. A new MDS Coordinator had started since that time. During an interview on 1/13/25 at 5:14 p.m., the MDS Coordinator indicated Resident 73 was not on her list of residents assigned to receive restorative care. She indicated the resident's chart			

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	lacked any tabs for restorative care where the care should have been documented. She had not been provided a copy of the resident's Therapy Discharge Recommendation form, as this occurred prior to her employment. During an interview on 1/13/25 at 5:22 p.m., the DON indicated the resident had not received restorative care. Therapy recommendations should have been initiated by the previous MDS Coordinator, but was not done. During an interview on 1/14/25 at 12:00 p.m., Restorative Aide 10 indicated she had never provided Resident 73 restorative care because he was not assigned by the MDS Coordinator. The resident was at risk for a decrease in range of motion and contractures due to his paraplegia. A current facility policy, revised 3/2022, titled "RESTORATIVE/ADL NURSING," provided by the DON on 1/13/25 at 5:29 p.m., indicated the following: "...It is the policy of this facility to ensure that a resident without limited range of motion does not experience a reduction in range of motion unless the resident's clinical condition demonstrates it is unavoidable; A resident with limited range of motion receives appropriate treatment and services to prevent further decline; and A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a decline is unavoidable...." 3.1-42(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices			

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	Based on observation, interview, and record review, the facility failed to provide supervision for a cognitively impaired resident with a history of falls to prevent repeated falls for 1 of 2 residents reviewed for accidents. (Resident 129) Findings include: During an observation, on 1/7/25 at 1:19 p.m., Resident 129 was lying in a bed in the low position with a tall mat beside his bed. The resident was awake and watching television. During an observation, on 1/8/24 at 11:53 a.m., Resident 129 was assisted in his wheelchair to his room. He declined to get into bed. He had a brace on his right wrist. During an observation, on 1/9/24 at 2:48 p.m., Resident 129 was lying in bed, turned onto his left side. A tall mat was beside his bed. During an observation, on 1/10/24 at 3:50 p.m., Resident 129 was lying in bed holding and looking at his remote control. The tall mat was beside his bed. He was had his oxygen on per nasal cannula. During an observation, on 1/13/24 at 3:07 p.m., Resident 129 self-propelled his wheelchair out of the dining/activity area. He wore nonskid socks and an oxygen cannula. He held a package of candy bars, a package of chips, and a can of soda he had won at BINGO. Resident 129's clinical record was reviewed on 1/9/25 at 8:53 a.m. Diagnoses included repeated falls, syncope (fainting) and collapse, hypoxemia (low concentration of oxygen in blood), muscle weakness (generalized), difficulty in walking, other lack of coordination, history of falling, unspecified	F 0689	1. There is no corrective action to be completed for resident 129 as all notifications were previously made and treatment given. He has had no further falls and is making safe decisions while in his wheelchair. 2. Any resident who has had multiple falls and also has poor cognition (confirmed per BIMS) has the potential to be affected. All falls for the past 30 days will be reviewed to determine any resident with frequent fall pattern and poor cognition. Any resident exhibiting multiple falls in a short period of time and having poor cognition will be provided increased staff supervision for safety. 3. Nursing staff were educated to ensure that any resident who is having frequent falls will have increased supervision when required. The resident will be assisted to a common area or nurse's station to be supervised closely as tolerated. Staff were educated that such actions should be in the resident's care plan and documented in the resident's chart. When a resident is identified to be a frequent fall situation, staff working directly with that resident will be educated on how to increase the amount of supervision that the resident is receiving.	02/10/2025

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	mood (affective) disorder, and altered mental status. Current physician orders included the following: divalproex 125 milligrams (mg) twice a day for mood stabilization (12/23/24), hydrocodone-acetaminophen 10-325 mg every six hours as needed for pain (12/12/24), check function and placement of silent pressure alarm to bed and chair/wheelchair every shift for safety (12/17/24), and keep splint clean and dry until follow up with orthopedic physician and check skin each shift to monitor for break down for radial fracture (12/23/24). An admission Minimum Data Set (MDS) assessment, dated 12/14/24, indicated Resident 129 was severely cognitively impaired. He had hallucinations and rejected care one to three days of the assessment period. He had limitations of his functional range of motion to his upper and lower extremities on both sides. He required substantial to maximal assistance with toileting, bathing, dressing, putting on and taking off footwear, rolling left and right in bed, moving from sitting to lying, moving from lying to sitting, moving from sitting to standing, transferring from chair to bed and bed to chair, and transferring to the toilet. He was short of breath with exertion and when lying flat. He had fallen the month prior to admission. He had fallen two or more times with no injuries and one time with injury since he was admitted. A bed alarm was used daily. A current care plan for falls indicated the resident was at risk for falls related to history of falls, syncope, and decrease in safety awareness (initiated 12/17/24 and revised on 1/8/24). Interventions included the following: A silent pressure chair/bed alarm was to be used to alert		Any new admissions with a recent history of multiple falls will be considered as requiring increased supervision. Any resident determined to need increased supervision will be re-evaluated every 2 weeks to determine if necessity remains. 4. DON/designee will review falls 5 times weekly to determine residents found to have a pattern of frequent falls in a short amount of time with a BIMS indicating cognitive impairment requiring increased supervision. Audits will be completed 5 times weekly for 8 weeks then monthly for 4 months. This will be monitored through QA quarterly until 100% compliance is achieved. Audit results will be reviewed in the monthly Quality Assurance (QA) meetings. Any identified issues will be addressed immediately, and corrective actions will be documented.	

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	staff that the resident needed staff assistance with transfers (initiated 12/17/24 and revised 1/8/25); The resident was to wear proper footwear or non-slip footwear when he is up (initiated 12/17/24); The resident will have a non-slip mat in his wheelchair to decrease the resident from sliding out of his wheelchair (initiated 12/17/24); The resident will sleep/rest in a floor bed that is low to the floor with a mat on the floor to assist in decreasing the risk of the resident injuring himself when he rolls out of bed (initiated 12/17/24); The resident will be toileted at 7:00 p.m. as he allows (initiated 12/18/24); and The resident will be reminded to change position slowly (initiated 12/22/24). An admission evaluation, dated 12/12/24 at 7:34 p.m., indicated the resident had fallen in the last month and two to six months prior to admission. He had a fracture related to a fall in the six months prior to admission. A fall risk assessment, dated 12/12/24 at 7:37 p.m., indicated the resident had intermittent confusion. He had three or more falls in the past three months. He was chair bound and/or required assistance with elimination. He received three to four medications which increased the risk of falling. He had three or more predisposing conditions which increased the risk of falling. He was a high fall risk. A Hospital Emergency Department Progress Note, dated 12/22/24 at 6:58 a.m., indicated the resident presented to the emergency department by ambulance. The resident reported he was sitting in a chair and was asleep. He was unsure what had happened. The staff reported he fell forward out of his chair and hit his head. He sustained a large laceration to his forehead. His right forearm had			

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	tenderness with flexion and extension of the wrist. On the right side of the forehead just below the hairline was an approximately 2.5 centimeter (cm) irregular laceration that was y-shaped with an additional linear portion extending from the center gaping, bleeding controlled. The laceration was repaired with five sutures. The x-ray showed a distal radius (bone in the forearm) fracture and possible scaphoid (small bone in the wrist) fracture. The orthopedic physician was consulted about the x-ray findings and a follow-up was advised. A splint was applied to the right upper extremity. The resident was discharged back to the facility. An x-ray of the right wrist, dated 12/22/24 at 8:48 a.m., indicated an avulsion (a break in a small piece of bone in the wrist that's attached to a ligament or tendon) fracture arising from the volar (palm side) aspect of the wrist and a lucency (darker area on the X-ray) through the scaphoid which may represent a nondisplaced fracture. The resident's fall events and immediate interventions were as follows: A Nurses Note and Fall Investigation Worksheet, dated 12/13/24 for the fall at 5:40 a.m., indicated the resident was found lying on his right side on the floor next to his bed with his head near the foot of the bed. The resident's feet were bare. The call light was not sounding. The resident complained of some soreness to back and leg. No obvious injuries were noted. The immediate intervention was the placement of a bed alarm. A Nurses Note and Fall Investigation Worksheet, dated 12/13/24 for the fall at 8:00 p.m., indicated the resident was found on both knees on the floor in his room. The resident had appeared to attempt			

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	to self-transfer from wheelchair. He wore gripper socks. His call light was sounding. An alarm was being used at the time of the fall and was working properly. No new injuries were noted. The immediate intervention was the placement of a chair alarm pad underneath the resident. The resident was assisted into the wheelchair, and the call light was clipped to his shirt. He was reminded to use the call light if he wished to move. A Nurses Note and Fall Investigation Worksheet, dated 12/14/24 at 7:00 a.m., indicated the resident was found sitting on the floor at the side of the bed with his back resting against the bed and his legs extended in front of him. The resident indicated he was sitting on the bed at the time of the fall. The bed was in low position. The resident had one gripper sock on and one was off on the floor beside him. The bed alarm was in place and sounded. The call light was not sounding. No new injuries were noted. The immediate intervention was the placement of the bed in a low position with a mat at the side of the bed. The resident was also assisted back to bed, and his gripper socks were reapplied. A Nurses Note and Fall Investigation Worksheet, dated 12/14/24 at 9:00 p.m., indicated the resident was sitting in a wheelchair at the nurses station. The resident leaned forward and grabbed at the floor. He fell out of the chair onto his side. The wheelchair brakes were locked. The resident had gripper socks on both feet. The chair alarm was in place and sounded after the fall. A skin tear to the resident's right hand was measured at 1.8 cm by 0.2 cm. The immediate intervention was the placement of the nonslip mat in the wheelchair under the cushion. The skin tear was cleansed and dressed.			

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	A Nurses Note and Fall Investigation Worksheet, dated 12/18/24 for the fall at 7:30 p.m., indicated the resident attempted to stand up and fell onto his left side in front of the nurses station. An alarm was in place and working. The immediate intervention was the toileting of the resident and assisting him to bed. A Nurses Note and Fall Investigation Worksheet, dated 12/22/24 at 5:50 a.m., indicated the nurse was standing at the medication cart when the resident fell forward without warning and hit his head on the floor. Pressure was applied to his wound, and his neck was stabilized. He transferred to the hospital. He had a one-inch laceration on his forehead. The resident wore gripper socks. The chair alarm was in place and working properly. A Nurses Note, dated 12/22/24 at 3:15 p.m., indicated the resident returned from the hospital with a laceration to his forehead, an abrasion of his right arm, a distal radius fracture, and lumbar radiculopathy (condition where a nerve in the spine is damaged or irritated). Sutures were intact to his forehead and open to air. A Fall IDT (interdisciplinary team) Note, dated 12/24/24 at 1:16 p.m., indicated Resident 129 was seated in a wheelchair at the nurses station when staff witnessed the resident falling forward from the wheelchair. Staff was unable to intervene. The immediate intervention for the fall on 12/22/24 at 5:50 a.m., was to remind the resident to change positions slowly. During an interview, on 1/14/25 at 11:52 a.m., QMA 13 indicated the interventions to prevent falls for the resident were his chair alarm, a bed alarm, a mat beside his bed, and he was taken to			

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	the bathroom every two hours even though he had a catheter. The resident was generally up and about in the sight of staff. During an interview, on 1/14/25 at 12:28 p.m., LPN 19 indicated interventions to prevent falls for the resident included his bedside mat. She indicated she needed to access his care plan. Then, she indicated bed and chair pads that alarmed at the nurses station were used. He also did not stand well and required nonskid footwear. He had a nonslip mat in his wheelchair. He was to be toileted at 7:00 p.m. The staff also monitored him. She indicated whenever she went up and down the hall she looked in every room. During an interview, on 1/14/25 at 12:41 p.m., CNA 20 indicated interventions to prevent falls for the resident included a tall mat beside his bed, a bed alarm, a chair alarm in his wheelchair, gripper socks or shoes on, and his call light should be in reach. She could look at the Kardex (list of care strategies in the clinical record) if she needed more information. During an interview, on 1/14/25 at 3:08 p.m., the DON indicated they tried to do all kinds of things to prevent the resident from falling like bringing him to the nurses station. Since one of his resident representatives had returned to town and visited frequently, he had been doing much better. During an interview, on 1/14/25 at 4:17 p.m., the DON indicated the pressure alarms should not be used in place of supervision for the residents. She did not have documentation of increased supervision or additional interventions that would show increased supervision for the resident. A current facility policy, revised 10/8/24, titled			

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(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
	"Accidents and Supervision," provided by the DON on 1/13/25 at 4:28 p.m., indicated the following: "Policy: The resident environment will remain free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazards(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring for effectiveness and modifying interventions when necessary...." 3.1-45(a)(2)			
F 0710 SS=D Bldg. 00	483.30(a)(1)(2) Resident's Care Supervised by a Physician Based on interview and record review, facility failed to ensure the physician was notified of a resident's significant weight loss for 1 of 3 residents reviewed for nutrition. (Resident 72) Findings include: Resident 72's clinical record was reviewed on 1/10/25 at 8:56 a.m. Diagnoses included Alzheimer's disease, dysphagia, oropharyngeal phase (swallowing difficulty that occurs in the mouth and throat), and other recurrent depressive disorders. Current physician's orders included regular diet, mechanical soft texture with ground meat and thin consistency liquids (7/31/24), super cereal (fortified food supplement) at breakfast (8/13/24), and magic cup (vitamin and mineral rich food supplement) at lunch (9/3/24). A Minimum Data Set (MDS) assessment on 12/14/24 indicated the resident was severely	F 0710	1. Weight comparisons and alerts for resident 72 for significant change were reviewed for a 6 month lookback period. The weights without notification were reported to the physician and family and notification was documented. 2.Weight exception report reviewed for past 30 days for all residents. Any noted significant changes in weight were reviewed to ensure MD and family were notified. Any alerts or changes without documented notification were reported to MD and family and notification was entered into resident’s charts. 3. Nursing staff were educated to ensure that weights entered into the resident’s charts with	02/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155432	A. BUILDING 00 B. WING	01/14/2025

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	cognitively impaired. The staff assessment of her mood indicated the resident had poor appetite or overeating for two to six days of the assessment period. She required partial to moderate assistance with eating. The resident's weights were as follows: 7/30/24 - 107.4 pounds 11/25/24 - 99.2 pounds 12/16/24 - 101.6 pounds 12/23/24 - 101.3 pounds 12/30/24 - 92.5 pounds 1/6/25 - 95.7 pounds 1/13/25 - 96.3 pounds The resident experienced an 8.69% weight loss in one week from 12/23/24 to 12/30/24. She experienced a 6.75% weight loss in one month from 11/25/24 to 12/30/24. From 7/30/24 to 1/13/25, nearly a six-month span, she experienced a 10.24% weight loss. The clinical record lacked notification of the physician or the resident representative of the resident's significant weight loss. During an interview, on 1/14/25 at 11:20 a.m., LPN 17, the charge nurse on the resident's unit, indicated when a resident had a significant weight loss or gain, the physician and family were notified. Notifications were documented in the progress notes. The staff, typically, reweighed a resident when a significant change in weight occurs to ensure the weight was correct. The aides reported to the nurses when they obtained the residents' weights. She thought the resident might have been followed by the nutritional at risk (NAR) team. The aides had not told LPN 17 of the resident's weight loss, and she indicated they		significant change or alerts are reviewed and reported to the doctor or nurse practitioner and family timely with documentation of notification. 4. DON/designee will perform an audit in which the weights exception report will be reviewed daily for new significant changes or alerts requiring family and physician notification and ensure such documentation is in the resident's chart. Audits will be completed daily for 4 weeks, 2 times weekly for 8 weeks, monthly for 3 months, then quarterly for a minimum 6 months. Audit results will be reviewed in the monthly Quality Assurance (QA) meetings. Any identified issues will be addressed immediately, and corrective actions will be documented.	

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	most likely told the NAR team. She had been unaware of the resident's weight loss. During an interview, on 1/14/25 at 11:29 a.m., RN 18 who was the unit manager and part of the NAR team, indicated the resident was not currently on the NAR list. She did not know the resident had experienced significant weight loss. She indicated the dietician should have notified the NAR team when the weight was put into the electronic medical record as the software triggered an alert with a significant weight loss or gain. She found where the weight loss had triggered the alert. She was unable to find where the physician had been notified. During an interview, on 1/14/25 at 12:00 p.m., the DON indicated the physician should have been notified of the resident's significant weight loss. A current facility policy, revised on 2/2022, titled "PHYSICIAN/CLINICAN/FAMILY/RESPONSIBL E PARTY NOTIFICATION FOR CHANGE IN CONDITION", provided by the DON on 1/14/25 at 12:08 p.m., indicated the following: " ...The facility must immediately inform the resident; consult with the resident's physician/clinician; and notify, consistent with his or her authority, the resident representative when there is ...a significant change in the resident's physical, mental, or psychosocial status ...." 3.1-22(b)(1)			