STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155827	A. BUILDING 00 B. WING	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAGE BLUFF HEALTH & REHAB CENTER	4180 SAGE BLUFF CROSSING FORT WAYNE, IN 46804

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: December 5, 6, 7, 8, and 11, 2023 Facility number: 013293 Provider number: 155827 AIM number: 200395060 Census Bed Type: SNF/NF:35 SNF:11 Total:46 Census Payor Type: Medicare:7 Medicaid:29 Other:10 Total:46 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review complated December 12, 2023	F 0000	We respectfully request paper compliance due to low scope and severity of citations.	
F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Isaac Lenon | Administrator | 01/02/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, record review, and interview the facility failed to schedule staff adequately to prevent intrusive behavior affecting 7 of 22 residents reviewed. (Resident 147, Resident 6, Resident 31, Resident 2, Resident 21, Resident 42, and Resident 3). Findings include: 1. In an observation and interview on 12/5/23 at 9:26AM Resident 147 was making inarticulate loud noises. The SSD (Social Services Director) indicated she was not crying, moaning, nor in pain. He indicated she was new, and this was just what she did. During an observation on 12/5/23 at 11:16AM indicated Resident 147 could be heard at the end of the hall, making the loud vocalizations. No staff were available to check on the resident or attempt interventions with her behavior.	F 0725	Element 1 Resident # 147 no longer resides at the facility. Residents # 2, 6, 31, 21, 3, 42 were assessed by the Psych Nurse Practitioner on 12/20/2023 and suffered no lasting effects from the noted behavior. Element 2 Residents residing at the facility have the potential to be affected by staffing patterns. Current residents who reside in the facility will be reviewed by the Social Worker to identify current residents with behaviors and	01/05/2024

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	Resident 147's records review began on 12/5/23 at 1:38PM. Resident 147's diagnoses were epilepsy, developmental disorder, chronic pain, hypertension, constipation, muscle weakness, low oxygen levels in her blood, schizophrenia, and obstructive sleep apnea. She had abnormalities of gait and needs for assistance with personal care. Resident 147's care plan indicated a problem of psychotropic drug use created on 12/7/23. An intervention was to assess if the resident's behavioral/mood symptoms presented a danger to the resident and/or others. Intervene as needed. There was no indication of the interventions to attempt. A problem of psychosocial well-being indicated a goal of resident will have their mental health and/or specialized services/needs met daily through next review period. The interventions were: Ensure specific recommendations (specify) are followed as needed. Follow regulations relating to any significant change assessments needed and to closely supervise the resident. A problem of Cognitive loss/Dementia created 11/16/23 by LPN 8. The interventions included avoid use of restraints, remove resident from other resident's rooms and unsafe situations. A problem of at risk for falls related to epilepsy, history of falls, muscle weakness, and developmental disorder. Many of the interventions were to monitor frequently; while in bed, toilet frequently, and observe frequently. A review of progress notes from 11/15/23 to 12/7/23 indicated the following behaviors and observations of mood were documented: 11/30/23 at 2:23PM Nursing staff reported resident		ensure they have effective interventions in place to address and manage the identified behavior. Utilizing the Behavior Management Audit Tool (Attachment A) this audit along with identified corrections will be completed on or before 1/5/2024. Element 3 To prevent recurrence, systemic change implemented to promote, protect and improve the health and safety of residents, a staffing meeting (consisting of the Administrator, Director of Nursing, Staffing Coordinator and Director of HR) will be conducted Monday through Friday, reviewing daily staffing to assure that there is adequate staffing to meet the needs of all residents with special focus on behavioral needs. The Regional Vice President of Operations or Regional Director of Clinical Services will educate the Administrator and Director of Nursing on the regulatory requirements of F725 sufficient staff with a focus on ensuring the facility has enough staff to adequately prevent intrusive behaviors from affecting residents who reside in the facility. This education will be completed on or before 1/5/2024.	

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	continued to wander throughout the building in her wheelchair and did not follow commands. 12/1/23 at 2:08PM staff reported resident was on her floor with blood and feces smeared around her. 12/2/23 at 1:41PM Resident was up most of the night. Resident was assisted to bed and was resting comfortably. 12/3/23 at 2:23PM anxiety medication was given as resident continued to yell out and roam facility. Redirection and other interventions were not effective. 12/5/23 at 5:03AM she was yelling and continuously going into other residents' rooms violating their privacy. Redirection, favorite activities, and one on one were attempted. None of the interventions were effective. 12/5/23 at 5:23AM she attempted to leave the building out of an employee only door while the 2 employees on the hall were checking on other residents. 12/5/23 at 1:22PM a progress note from the NP indicated her mood was stable. During an observation on 12/6/23 at 9:31AM Resident 147 was making loud demands. She repeated simple phrases. This behavior was not documented in progress notes by staff. During an observation on 12/7/23 at 1:35PM Resident 147 was making loud vocalizations, Resident 2 began to scream repeatedly, "shut up". The staff had difficulty calming Resident 2 as Resident 147 continued to be heard in the hallway. These behaviors were not documented. During a meeting with residents on 12/7/23 at 1:53PM, 4 of 6 residents in attendance indicated Resident 147 had entered their rooms without permission. Resident 31, Resident 21, Resident 42,		Element 4 To monitor and maintain ongoing compliance the Administrator or Designee will complete weekly audits for 2 months then monthly audits for 4 months utilizing the Daily Staffing Audit Tool to ensure adequate staffing is available. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	

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	and Resident 3 indicated they were troubled by the intrusive behavior. Resident 21, and Resident 3 indicated they were afraid of Resident 147. In an interview on 12/7/23 at 2:00PM, Resident 42 indicated Resident 147 was noisy all day long and this kept her on edge. Resident 42 indicated Resident 147 had come into her room at night on multiple occasions and wheeled herself right up to her face. Resident 42 indicated she was afraid of Resident 147 because Resident 147 was unable to be redirected by staff. The feeling staff were unable to deter Resident 147 increased Resident 42's fear. When asked where staff were when Resident 147 came into her room, Resident 42 indicated they were in other rooms giving care. Resident 42 did not blame staff for Resident 147's behaviors because there were not enough staff to intervene with her. When asked if she informed staff of her fear she indicated if her frightened screaming did not tell them mere words would not either. An interview on 12/7/23 at 2:06PM Resident 6 indicated Resident 147 had entered her room on several occasions. Resident 6 further indicated she was woken up by Resident 147 across the hall yelling out in the middle of the night. Resident 6 indicated she no longer walked with her walker in the hallway due to unease of what Resident 147 might do and there was not enough staff to intervene. Resident 6 indicated she did not feel Resident 147 would purposefully hurt anyone but could easily do so not knowing any better. In an interview on 12/7/23 at approximately 2:15PM with the IDT (Inter Disciplinary Team) they indicated Resident 147's acclimation to facility and behaviors; they have attempted redirection, changing anxiety medications from as			

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	needed to routine, stuffed animals, activities, orienting, and reorienting her to her room. The IDT indicated none of the approaches have been successful and they were questioning the appropriateness of placement. The DON (Director of Nursing) indicated they were going to assign one staff to directly care for Resident 147 due to knowledge of peers' fear and lack of effectiveness with other interventions. In an observation on 12/8/23 at 04:03AM, Resident 147 was talking more quietly than previous days. She responded differently to a male CNA 5 (Certified Nursing Aid) than the female CNA 7 on third shift. CNA 5 was able to tell her shush, and she would quiet down. CNA 7 was unable to deter her behaviors without physically standing between her and the exit door, a peer's room, or the nurses station. Resident 147's chair had a wander guard and set off an alarm due to staff's inability to keep her from the door. The alarm was unable to be reset for over 30 minutes because there were not staff able to reset it. In an interview on 12/8/23 at 4:23AM CNA 5 he indicated Resident 147 had dementia so she wandered and at times went into other resident's rooms. He indicated she never troubled anyone. Resident 147 did not have a diagnosis of dementia. In an interview on 12/8/23 at 4:38AM LPN 6 (Licensed Practical Nurse) indicated she was aware Resident 6, and 2 other residents were afraid of Resident 147. She indicated they expressed they were afraid of Resident 147. LPN 6 indicated she offered to file grievances and encouraged them to talk to administration. LPN 6 indicated herself and multiple staff have removed Resident 147 from peers' rooms on multiple			

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	occasions. LPN 6 indicated third shift especially was not staffed to have her awake all night moving throughout the facility while they were trying to turn and change other residents. She indicated it was impossible to always keep an eye on her. During an observation on 12/08/23 at 05:14 AM, Resident 147 with her wheelchair brakes locked as she was in the hallway near a sitting area becoming more and more loud making noises rather than using words. Resident 147 was unable to move in chair due to brakes being locked. CNA 5 came out of another resident's room with CNA 7 and was able to calm Resident 147 down and released the brakes on her wheelchair. CAN 7 indicated the staff had to lock the wheelchair brakes to get their work done. In an interview on 12/11/23 at 8:36AM, Resident 3 indicated she was afraid of Resident 147 due to her frequently entering her room. She also was afraid to leave her room at times due to uncertainty of Resident 147 entering while she was away. Resident 147 had come into her room more than one occasion and rummaged through her belongings. Many of those times were during the day and some were at night. Resident 3 felt Resident 147 was unable to be cared for at the facility due to lack of sufficient staff. In an interview with SSD on 12/11/23 at 10:26AM he indicated the care plan for psychosocial wellbeing he created on 12/5/23 was a baseline care plan. He indicated the care plan was not person centered and would need to be redone to give staff direction on how to best assist Resident 147. Record reviews for the residents affected by			

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	Resident 147's behaviors began on 12/8/23 at 5:30AM and were as follows: 2. Resident 6 was admitted with diagnosis included stroke, anxiety, depression, cognitive impairment, and repeated falls. Her BIMS (Brief Interview of Mental Status was 14. A score of 14 indicated only slight cognitive impairment. Resident 6 care plan included a focus on behavior with an intervention to encourage resident to express feelings. Establish and maintain a trusting relationship. Provide reassurance and comfort measures. Resident care plan indicated she was at risk for falls related to history of falls and impaired mobility. 3. Resident 31 was admitted with diagnosis included kidney disease, dementia, hypertension, and abnormalities of gait. Her BIMS score was 14 on 11/2/23. Her care plan indicated she was at risk for falls related to her lack of mobility. Resident had focus of altered cognitive function with one of the interventions were to provide a calm and relaxing environment. 4. Resident 2 was admitted with diagnosis included respiratory disease, heart failure, kidney disease, muscle weakness, difficulty walking, and dementia. Her BIMS score was a 5 on 11/22/23. A score of 5 indicated severe impairment. Resident 2 did not have a care plan for behavioral issues. 5. Resident 21 was admitted with diagnosis included end stage heart failure, respiratory failure, anxiety, and depression. Resident 21's BIM score was 14 on 10/3/23. Resident 21's care plan included a focus on risk for falls and self-care deficit. 6. Resident 42 was admitted with diagnosis			

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	included anxiety, depression, lung disease, abnormalities of gait, and muscle weakness. Resident 42's BIMS score was 15 on 11/22/23. A score of 15 indicated no cognitive impairment. Resident 42's care plan had no focus on behaviors. 7. Resident 3 was admitted with diagnosis included lung disease, diabetes, stroke, anxiety, depression, and cognitive impairment. Resident 3's BIM score was 11 on 11/3/23. A score of 11 indicated moderately impaired cognitive function. Resident 3's care plan indicated she had self-care deficit problem. A risk of falls. A focus of hoarding items in her room. This focus had no goal or interventions listed. No policy and procedure was provided at time of exit. 3.1-17(a)			
F 0732 SS=D Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides.			

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	(iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, and interview, the facility failed to ensure the daily report of nursing staff directly responsible for resident care was accurately posted during 2of 3 observations. Findings included: An observation on 12/5/2023 at 8:58 AM, of the daily staffing post was located on the wall next to the front desk lobby. The single sheet had a date of 12/1/2023. In an observation on 12/6/2023 at 9:00 AM the daily staffing post had a date of 12/5/2023. In an interview on 12/7/2023 at 9:04 AM, Receptionist 9 indicated the staff scheduler does	F 0732	Element 1 It is the policy of this facility to post the daily staffing data in a prominent place readily accessible to residents and visitors. On 12/6/23 the daily staffing positing was updated by the staffing coordinator. Element 2 Daily staffing posting has the	01/05/2024

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	the changing of the staffing post. In an interview on 12/7/2023 at 9:14 AM, Scheduler 3 indicated she had the posting on her desk but just had not posted it yet. Scheduler 3 indicated no one changes the posting on the weekends. A current facility policy titled Daily Nurse staffing posting policy, was provided by the Director of Nursing on 12/7/2023 at 11:35 AM. The facility policy indicated..." daily nursing staffing will be posted per state/federal regulations...The facility will post the following information on a daily basis, at the beginning of each state: facility name, the current date, resident census, the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift...."		potential to affect those residing in the facility. No negative outcomes were identified by lack of the daily posting of nursing hours. Element 3 The current facility policy titled "Daily Nursing Staffing Posting" was reviewed and remains appropriate. The Nursing Scheduler and Front Desk Receptionist will be educated by the Administrator by 1/5/2024. (Attachment D) Element 4 Administrator or designee will audit for appropriate posting 3 X per week times 4 weeks, then weekly times 4 weeks then monthly times 2. Results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. To monitor and maintain ongoing compliance the Administrator or Designee will complete weekly audits for 2 months then monthly audits for 4 months utilizing the Daily Staffing Audit Tool to ensure Daily Staff Posting is kept current. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	

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F 0743 SS=D Bldg. 00	483.40(b)(2) No Behavior Difficulties Unless Unavoidable §483.40(b)(2) A resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma and/or post- traumatic stress disorder does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that development of such a pattern was unavoidable; Based on observation, interview, and record review the facility failed to implement person centered interventions to prevent intrusive behaviors for 1 of 7 residents reviewed. Resident 147 Findings include: In an observation and interview on 12/5/23 at 9:26AM Resident 147 was making inarticulate loud noises. The SSD (Social Services Director) indicated she was not crying, moaning, nor in pain. He indicated she was new, and this was just what she did. In an observation on 12/5/23 at 11:16AM Resident 147 could be heard at the end of the hall, making the loud vocalizations, even with the door shut in a peer's room. Resident 147's records review began on 12/5/23 at 1:38PM. Her diagnoses were epilepsy, developmental disorder, chronic pain, hypertension, constipation, muscle weakness, low	F 0743	Element 1 Resident #147 no longer resides in the facility Residents # 2, 6, 31, 21, 3, 42 were assessed by the Psych NP on 12/20/2023 and suffered no lasting effects from the noted behavior. Element 2 Residents residing at the facility have the potential to be affected by residents behaviors. Current residents who reside in the facility will be reviewed by the Social Worker to identify current residents with behaviors and ensure they have effective interventions in place to address and manage the identified behavior. Utilizing the Behavior Management Audit Tool (Attachment A) this audit along with identified corrections will be	01/05/2024

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	oxygen levels in her blood, schizophrenia, and obstructive sleep apnea. She had abnormalities of gait and needs for assistance with personal care. No behaviors were documented on 12/5/23. Resident 147's physician orders indicated a change in her medications from admission as follows: *Discontinue trazodone 50mg at bedtime for sleeplessness 11/15/23 to 11/28/23 * Discontinue mirtazapine 15mg at bedtime 11/15/23 to 11/28/23, a medication known to help with sleep and appetite. *Discontinue melatonin 5mg as needed 11/15/23-11/28/23, a sleep aid *Ativan 0.5mg three times a day as needed 11/17/23 to 11/29/23 to Ativan 0.5mg every 8 hours, 8 am, 4pm, and midnight on 11/29/23 *Discontinue lacosamide 200mg twice a day and lacosamide 50mg twice a day equals 500mg daily 11/15/23 to 11/28/23. A controlled substance used for seizures. The medication was a controlled substance due to its potential to be misused or lead to dependency. It was possible to have withdraw from discontinuing lacosamide. *Discontinue clobazam 20 mg twice a day 11/15/23 to 11/28/23 a-controlled substance used for seizure disorder. A controlled substance due to risk of abuse and addiction. *Discontinue Aptiom 200mg daily 11/15/23 to 11/28/23 a seizure medication. *Discontinue levetiracetam 1000mg twice a day 11/15/23 to 11/28/23 a seizure medication Resident 147 was not on any medications for seizures at time of record review. Resident 147's admission assessment was scheduled on 11/15/23 and completed on 11/20/23 by an LPN (Licensed Practical Nurse) 5 days after		completed on or before 1/5/2024. Element 3 Front Line Behavior Meeting to be put in place on a weekly basis. Meeting will be led by Social Service Director or designee and will include the staff who are working on the floor. The content of the Front Line Behavior Meeting will then be brought to the Interdisciplinary Team to ensure appropriate interventions are implemented. Staff will be educated by the Social Services Director or Designee on recognizing, managing and documenting resident behaviors (Attachment B). This education will be completed on or before 1/5/2024 Element 4 Utilizing the Behavior Management Audit Tool the Social Services Director or Designee will audit residents with behaviors to ensure they have effective interventions in place to address and manage the identified behavior. To monitor and maintain ongoing compliance the Administrator or Designee will complete weekly audits for 2 months then monthly audits for 4 months utilizing the Daily Staffing Audit Tool to ensure Daily Staff Posting is kept current.	

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	155827	A. BUILDING 00 B. WING	12/11/2023

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	admission. The section of cognition indicated her thinking was impaired by a diagnosis of dementia. A readmission assessment scheduled 11/28/23 was completed on 12/8/23 by an RN (Registered Nurse). The area of neuropsychological problems indicated Resident 147 had mild dementia. Resident 147's care plan indicated a problem of psychotropic drug use created on 12/7/23. An interventions were to assess if the resident's behavioral/mood symptoms presented a danger to the resident and/or others, Intervene as needed. No direction was given to how to intervene. A problem of psychosocial well-being created by the SSD (Social Services Director) indicated a goal of resident will have their mental health and/or specialized services/needs met daily through next review period. Created on 12/5/23. The interventions were: Ensure specific recommendations (specify) are followed as needed. Follow regulations relating to any significant change assessments needed. Identify any level 2 recommendations. Make any referrals and/or follow up relating to level 2 recommendations, if applicable. There were no specific recommendations listed. A problem of Cognitive loss/Dementia created 11/16/23 by LPN 8 without interventions or referral to Resident 147's vocalizations, or intrusive wandering. Progress notes dated 11/15/23 to 12/7/23 indicated the following behaviors and observations of mood were documented: 11/30/23 at 2:23PM Nursing staff reported resident continued to wander throughout the building in her wheelchair and did not follow commands. By NP (Nurse Practitioner) 12/2/23 at 1:41PM Resident was up most of the			

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	night according to report. Resident was assisted to bed and was resting comfortably. 12/3/23 at 2:23PM anxiety medication was given as resident continued to yell out and roam facility. 12/5/23 at 5:03AM she was yelling and continuously going into other residents' rooms violating their privacy. Redirection, favorite activities, and one on one were attempted. None of the interventions were effective. 12/5/23 at 5:23AM she attempted to leave the building out of an employee only door while the 2 employees on the hall were checking on other residents. 12/5/23 at 1:22PM a progress note from the NP indicated her mood was stable. In an observation on 12/6/23 at 9:31AM Resident 147 was making loud demands. She repeated simple phrases. I want to go back to my room. I want to eat. This behavior was not documented. In an observation on 12.7.23 at 1:35PM Resident 147 was making loud vocalizations. Resident 2 began to scream repeatedly, "shut up". The staff had difficulty quieting Resident 2 as Resident 147 continued to be heard in the hallway. These behaviors were not documented. During a meeting with residents on 12/7/23 at 1:53PM, 6 of 6 residents in attendance indicated Resident 147 had entered their rooms without permission. Resident 8, Resident 31, Resident 21, Resident 42, and Resident 3 indicated they were troubled by the intrusive behavior. Resident 8, Resident 21, and Resident 3 indicated they were afraid of Resident 147. In an interview on 12/7/23 at 2:00PM, Resident 8 indicated Resident 147 was noisy all day long and the noise kept her on edge. Resident 8 indicated			

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	Resident 147 had come into her room at night on multiple occasions and wheeled herself right up to the bed and into her face. Resident 8 indicated she was afraid of Resident 147 becasue Resident 147 was unable to be redirected by staff. The feeling staff were unable to deter Resident 147 increased Resident 8's fear. When asked about staffing when Resident 147 came into her room, Resident 8's response was giving care to others who also require it. Resident 8 did not blame staff for Resident 147's behaviors yet expressed being troubled by being awoken with a stranger so near her face or in her room rummaging through her belongings. When asked if she informed staff of her fear she indicated if her frightened screaming did not tell them mere words would not either. In an interview on 12/7/23 at 2:06PM, Resident 6 indicated Resident 147 had entered her room on several occasions. Resident 6 further indicated she was woken up by resident 147 yelling out in the middle of the night in response to Resident 147 being in her room. Resident 6 indicated she no longer walked with her walker in the hallway due to unease of what Resident 147 might do. Resident 6 indicated she did not feel Resident 147 would purposefully hurt anyone but could easily do so not knowing any better. In an interview on 12/7/23 at approximately 2:15PM with the IDT (Inter Disciplinary Team) indicated for Resident 147 acclimation to facility and behaviors; they have attempted redirection, changing anxiety medications from as needed to routine, stuffed animals, activities, orienting, and reorienting her to her room. The IDT indicated none of the approaches have been successful and they were questioning the appropriateness of placement. The DON (Director of Nursing) indicated they were going to assign one staff to			

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	directly care for Resident 147 due to knowledge of peers' fear and lack of effectiveness with other interventions. During an observation on 12/8/23 at 04:03AM Resident 147 was talking more quietly. She responded differently to a male CNA 5 (Certified Nursing Aid) than the female CNA 7 on third shift. CNA 5 was able to tell her shush, and she would quiet down. CNA 7 was unable to deter her behaviors without physically standing between her and the exit door, a peer's room, or the nurses station. Resident 147's chair had a wander guard and set off an alarm due to inability to keep from the door. The alarm was unable to be reset for over 30 minutes. In an interview on 12/8/23 at 4:23AM CNA 5 he indicated Resident 147 had dementia so she wandered and at times went into other resident's rooms. He indicated she never troubled anyone. Resident 147 did not have a diagnosis of dementia. In an interview on 12/8/23 at 4:38AM with LPN 6 (Licensed Practical Nurse) indicated she was aware Resident 8, Resident 6, and 2 other residents were afraid of Resident 147. She indicated they expressed they were afraid of Resident 147. LPN 6 indicated she offered to file grievances and encouraged them to talk to administration. LPN 6 indicated herself and all staff have removed Resident 147 from peers' rooms on multiple occasions. LPN 6 indicated third shift especially was not staffed to have her awake all night moving throughout the facility while they were trying to turn and change other residents. She indicated it was impossible to always keep an eye on her.			

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	During an observation on 12/08/23 at 05:14 AM, Resident 147 with her wheelchair brakes locked as she was in the hallway near a sitting area becoming more and more loud noises. Resident 147 was unable to move in the chair due to brakes being locked. CNA 5 came out of another resident's room with CNA 7 and was able to calm Resident 147 down and released the brakes on her wheelchair. In an interview on 12/11/23 at 8:36AM, Resident 3 indicated she was afraid of Resident 147 due to her frequently entering her room. She also was afraid to leave her room at times due to uncertainty of Resident 147 entering while she was away. Resident 147 had come into her room more than one occasion and rummaged through her belongings. Resident 3 felt Resident 147 was unable to be cared for at the facility due to lack of sufficient staff. In an interview on 12/11/23 at 9:42AM LPN 8 indicated her care plan of cognitive loss/dementia was unable to be changed to not include the word dementia as to not confuse the staff doing direct care for Resident 147. In an interview on 12/11/23 at 9:46AM the DON (Director or Nursing) indicated she expected all assessments to be done timely and thoroughly. The DON indicated she was unsure where the dementia diagnosis was assigned to Resident 147 as she was developmental disorder not dementia. In an interview with SSD on 12/11/23 at 10:26AM he indicated the care plan for psychosocial well being he created on 12/5/23 was a baseline care plan. He indicated the care plan was not person centered and would need to be redone to give staff direction on how to best assist Resident 147.			

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	No policy or procedure was provided by time of exit. 3.1-43(a)(2)			