STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155274	A. BUILDING 00 B. WING	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF ROCKPORT SKILLED NURSING FACILITY, THE	815 W WASHINGTON ST ROCKPORT, IN 47635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 19, 20, 21, 22, 23, 2025 Facility number: 000174 Provider number: 155274 AIM number: 100274810 Census Bed Type: SNF/NF: 30 Total: 30 Census Payor Type: Medicaid: 18 Other: 12 Total: 30 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. quality review completed on June 2, 2025.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions prepared and/or executed in compliance with State and Federal Laws. date of alleged compliance is: 6/16/2025. respectfully paper compliance for all deficiencies in this POC.	
F 0605 SS=D Bldg. 00	483.10(e)(1), 483.12(a)(2), 483.45(c)(3) Right to be Free from Chemical Restraints Based on observation, interview, and record review, the facility failed to ensure a resident's medication regimen was free from chemical restraints for 1 of 5 residents reviewed for unnecessary medications. A resident's confusion increased after initiating Zoloft (antidepressant also used to control anxiety) and Ativan (antianxiety). Staff documented administering Ativan was ineffective for controlling the resident's restlessness and anxiety, the resident	F 0605	**WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?** The DON/designee assessed resident on 6/11/2025 and no negative outcome related to the cited practice. The DON/designee notified Resident 28's family on 6/11/2025	06/13/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Natalie Walker	HFA	06/18/2025

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	was given additional doses. (Resident 28) Findings include: On 5/19/25 at 8:51 A.M., Resident 28 was observed sitting in a Broda chair (specialized seating system) in the East Hall lobby in front of the television, hands empty, and trying to pull on his blanket. On 5/20/25 at 9:51 A.M., Resident 28 was observed sitting in a Broda chair in the East Hall lobby in front of the television, hands empty, and trying to pull on his blanket. On 5/22/25 at 10:45 A.M., Resident 28 was observed asleep sitting in a Broda chair in the East Hall lobby. On 5/21/25 at 2:15 P.M., Resident 28's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with agitation, anxiety, depression, unsteadiness on feet, and generalized muscle weakness. Resident 28 was admitted to the facility on 10/2/24. The Admission Minimum Data Sheet (MDS) assessment, dated 10/7/24, indicated Resident 28's cognition was severely impaired, had not had any falls in 6 months prior, was partial to moderate assist (staff performs less than half the effort) for bed mobility and eating, substantial to maximum assist (staff performs more than half the effort) for transfers and showering, and totally dependent on staff for showering, and receiving an antianxiety and antidepressant medication. The most recent Significant Change MDS assessment, dated 3/6/25, indicated Resident 28's cognition was severely impaired, had two or more		for consent to have resident seen by psych services, family declined services on 6/11/2025. The NP evaluated resident on 6/11/2025 and documented Ativan and Zoloft effective and appropriate. **HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN?** The DON/designee completed an audit of residents receiving psychotropic medications and verified residents assessed by mental health professional on 6/11/2025. Any concerns were immediately addressed. Careplans were updated with interventions for behaviors by the MDS nurse/designee on 6/11/2025. **WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?** Nursing staff was inservices on chemical restraints and medication administration of psychotropic medication when ineffective and interventions for behaviors on 6/11/2025. Any staff who fail to comply with points of	

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	falls, one with major injury, since the last Quarterly MDS assessment, dated 12/9/24, was partial to moderate assist (staff performs less than half the effort) for bed mobility and eating, substantial to maximum assist (staff performs more than half the effort) for transfers and showering, and totally dependent on staff for showering, on hospice, and receiving an antianxiety and antidepressant medication. Physician's Orders included, but were not limited to, the following: 10/2/24 May receive counseling/medication management services as needed 10/2/24 May receive services of psychiatrist and any other specialist as deemed necessary 10/5/24 Zoloft 25 milligram (mg), give one tablet by mouth in the evening for depression 2/2/25 Behavior monitoring every shift for resisting care/medications, sleep difficulties, anxiety, depressive symptoms 10/5/24 Ativan 0.5 mg, give one tablet by mouth every 12 hours PRN (as needed) for anxiety for 14 days and discontinued 10/19/24 10/23/24 Ativan 0.5 mg, give one tablet by mouth BID (twice daily) PRN for behaviors and discontinued 3/31/25 10/24/24 Ativan 0.5 mg, give one tablet by mouth daily at 1:00 P.M. for behaviors and discontinued 3/31/25 2/22/25 Ativan 0.5 mg, give one tablet every 30 minutes as needed for anxiety or restlessness and discontinued 3/31/25 4/1/25 Ativan 0.5 mg, give one tablet by mouth every 12 hours for behaviors and discontinued 4/11/25 4/11/25 Ativan 0.5 mg, give one tablet by mouth every six hours for behaviors and discontinued 5/9/25		this inservice will be further educated and/or disciplined as indicated. **HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E. WHAT THE QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE?** DON/designee will conduct audits on interventions related to anxiety and the use of psychotropics to treat anxiety. This will be audited by observing 10 random residents weekly for 4 weeks, 5 random residents for 4 weeks, and 3 random residents weekly for 4 months. Results of the monitoring will be reviewed at monthly QAPI. Any concerns will have been addressed; any patterns identified. Any needed action plan will be written by QAPI committee and will be monitored weekly by the Administrator until resolved. If the facility is within 95% compliance at the end of 6 months, monitoring may be stopped. **BY WHAT DATE THE SYSTEMIC CHANGES FOR EACH DEFICIENCY WILL BE COMPLETED?** June 13, 2025	

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	5/9/25 Ativan 0.5 mg, give one tablet by mouth two times a day for behaviors 5/19/25 Ativan 0.5 mg, give one tablet by mouth every 30 minutes PRN for increased anxiety or terminal restlessness for 14 days A current Anxiety Care Plan, initiated and last revised 2/4/25, included, but was not limited to, the following interventions: give antianxiety medications ordered by physician, observe for side effects, refer concerns/changes to Medical Doctor (MD) PRN, and refer to psych services PRN. "The resident is taking antianxiety medications which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia, falls, broken hips and legs". The Anxiety Care Plan did not include resident specific interventions to try for anxiety, restlessness, shortness of breath, or unspecified behaviors before oral medication was administered. The clinical record lacked documentation of Resident 28 having a thorough assessment with a mental health professional. The Medication Administration Record (MAR) from 10/2/24 through 10/31/24 indicated Resident 28 received 14 PRN doses of Ativan 0.5 mg. Of those 14 doses, six doses were documented as ineffective for controlling the resident's anxiety. The MAR from 11/1/24 through 11/30/24 indicated Resident 28 received 29 doses of PRN Ativan 0.5 mg. Of those, one dose was documented as ineffective for controlling behaviors (unspecified) The MAR from 12/1/24 through 12/31/24 indicated			

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	Resident 28 received 25 doses of PRN Ativan 0.5 mg. Of those, six doses were documented as ineffective for controlling his behaviors (unspecified). The MAR from 1/1/25 through 1/31/25 indicated Resident 28 received 18 doses of PRN Ativan 0.5 mg. Of those, four doses were documented as ineffective for controlling his behaviors (unspecified). The MAR from 10/24/24 through 3/31/25 for routine Ativan 0.5 mg dose daily at 1:00 P.M. was not routinely assessed for effectiveness of the medication to control behaviors (unspecified). The MAR from 10/5/24 through the survey date Zoloft 25 mg daily at bedtime was not routinely assessed for effectiveness of the medication to control depression. Progress notes as follows: On 10/4/24 at 12:15 P.M. Physician/Practitioner Progress Note indicated the resident was sitting in the common area. Staff reported increased episodes of agitation with exit seeking behavior at times. Reviewed Veteran's Affairs (VA) Note dated August 2024. He was screened for depression, was positive, but medication was not started. Plan: Dementia with behavior/agitation: start Zoloft 25 mg at bedtime, Ativan 0.5 mg BID PRN x 14 days. On 10/8/24 at 5:24 P.M, a Medication Administration Note indicated Ativan 0.5 MG Give 1 tablet by mouth every 12 hours as needed for anxiety was ordered. "The Resident is pacing halls. Won't sit still."			

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On 10/10/24 at 11:08 A.M., Care Plan Meeting Note: A meeting was held with staff and resident's wife. The note lacked discussion on new medications ordered and about the resident's behaviors. No new interventions or recommendations were given.

On 10/11/24 at 3:13 P.M., the Nursing Progress Note indicated the resident's wife had voiced concern that resident was more tired and not having coherent conversations.

On 10/30/24 at 10:16 A.M. the Nurse Practitioner Visit Note indicated the resident had been up out of chair walking without assistance or walker and redirected multiple times by staff. Due to resident's difficulty to control impulse to get out of chair and anxiety, Ativan 0.5 mg daily at 1:00 P.M. was added to the PRN Ativan and Zoloft was continued.

On 11/1/24 at 6:55 P.M., a Nursing Progress Note indicated resident had been up and down and had received PRN and routine Ativan. The resident was with activities 1:1 until the activities employee got off work and then seated in the lobby where staff had to attend to resident standing every few seconds. The Ativan administered was ineffective.

Progress Notes from admission to 5/20/25 indicated Resident 28 mostly sat in the lobby (common area) of East Hall by the nurse's station, was very spontaneous with getting out of chair without assistance, very confused, and unable to redirect despite use of PRN antianxiety medication, requiring 1:1 staff supervision at times. He attempted to pick up things that weren't there on the floor. Unable to understand speech

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	as it was garbled most of time. Needed constant reminders but seemed unable to comprehend what was being said to him in regard to his safety. A Physical Therapy note, dated 11/22/24 (no time recorded), indicated Resident had been more unsteady on his feet and due to attempts to stand/ambulate on his own nursing had administered Ativan, 1-2 times a day. The note indicated the resident was drowsy, sedated, and presented with a recent functional decline related to adverse effects from increased administration of Ativan. During an interview on 5/23/25 at 10:25 A.M., the Therapy Services Program Manager indicated Resident 28 was on their caseload from 11/22/24 through 12/19/24, due to a fall. At that time, he was more confused and tried to get up a lot. She indicated the resident was fidgeting around and trying to get up due to what she believed was boredom, not anxiousness. On 5/23/25 at 10:00 A.M., the Director of Nursing indicated she would request any psychological consultations for the resident. She was unable to provide any requests or service notes during the duration of the survey. On 5/23/25 at 11:27 A.M., the DON indicated the Resident 28's Zoloft dosage was not adjusted due to the Ativan being adjusted instead related to the behaviors. At that time, she indicated Side effect/behavior monitoring should have been documented every shift on the Medication or Treatment Administration Record (MAR/TAR). Behavior monitoring had not been consistently completed prior to the order starting date on 2/2/25.			

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	On 5/23/25 at 10:50 A.M., a current Guidelines for Psychotropic Medication Policy, dated 6/5/23, was provided by the DON and indicated, " ... Residents will not receive psychotropic medications unless other types of interventions have been attempted to meet the resident's targeted behavioral goals and have failed. These include Behavioral Programming, by a trained Behavioral Therapist ... The objective is to ensure that the drug regimen of the residents is monitored and managed to promote and then to maintain each resident's highest practicable mental, physical and psycho-social well-being ... Psychotropic medications may be used to treat an enduring condition ... Not due to environmental stressors alone [e.g., alteration in the resident's customary location or daily routine, unfamiliar care provider] ... Not due to psychological stressors alone [e.g., loneliness], anxiety or fear stemming from misunderstanding related to his/her cognitive impairment ... " 3.1-3(w) 3.1-48(a)			
F 0641 SS=D Bldg. 00	483.20(g)(h)(i)(j) Accuracy of Assessments Based on interview and record review, the facility failed to ensure an accurate assessment of resident status for 3 of 11 residents reviewed for MDS (Minimum Data Set) assessment accuracy. Preadmission screening, antibiotic use, and UTI (urinary tract infection) diagnoses were incorrectly coded. (Resident 6, Resident 4, Resident 9) Findings include: 1. On 5/20/25 at 9:05 A.M., Resident 6's clinical	F 0641	p="" paraid="1974842216" paraeid="{35bea0ed-b5a5-4401-ba13-e7de26c91673}{45}">**WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?** MDS nurse/ designee submitted a modified MDS for resident 6 to reflect proper PASRR screening, a modified MDS for resident 4 to	06/13/2025

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	record was reviewed. The most recent Annual Minimum Data Set (MDS) assessment, dated 1/31/25, indicated a level 2 PASRR (Preadmission Screening and Resident Review) had not been completed for the resident. A level 2 PASRR was completed on 3/7/24. 2. During an interview on 5/19/25 at 10:55 A.M., Resident 9's family member indicated Resident 9 has had several urinary tract infections (UTI's) since she had been in the facility. On 5/20/25 at 11:57 A.M., Resident 9's clinical record was reviewed. Diagnoses included, but was not limited to, osteoporosis and and depression. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 5/13/25, indicated Resident 9 was cognitively impaired and did not have a UTI in the last 30 days. Physicians Orders included, but was not limited to, Macrobid 100 milligrams (mg), give 1 capsule two times a day by mouth for a UTI, completed 5/8/25. 3. On 5/21/25 at 8:11 A.M., Resident 4's clinical record was reviewed. Diagnoses included, but was not limited to, hypertension and hyperlipidemia. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 4/18/25, indicated Resident 4 was cognitively intact and received an antibiotic during the 7 day look back period. Resident 4's Physician's Orders for the 7 day look back period lacked an order for an antibiotic.		reflect proper antibiotic use, and a modified MDS for resident 9 to indicate a proper UTI diagnosis on 6/11/2025. **HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN?** The MDS nurse/designee completed a 90 day lookback for the accuracy of MDS related to PASRRs, antibiotics related to UTIs and ensuring proper coding of antibiotics on the MDS on 6/11/2025. **WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?** MDS nurse was educated on 6/11/2025 by the regional MDS consultant on the accuracy of assessments. Any staff member that fails to comply with the points of this inservice will be further educated and/or disciplined as indicated. **HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E. WHAT QUALITY**	

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	During an interview on 5/22/25 at 12:46 P.M., the MDS Coordinator indicated the order was for a UTI, but she did not code UTI on the MDS for Resident 9, the PASRR level 2 should have been indicated on the MDS for Resident 6, and the antibiotic was coded in error for Resident 4. During an interview on 5/22/25 at 12:51 P.M., the MDS Coordinator indicated she used the Resident Assessment Instrument (RAI) manual as the facility's policy.		**ASSURANCE PROGRAM WILL BE PUT INTO PLACE?** MDS nurse/designee will conduct audits on MDS assessments for accuracy of assessments. This will be audited by observing 10 random residents weekly for 4 weeks, 5 random residents for 4 weeks and 3 random residents weekly for 4 months. Results of the monitoring will be reviewed at monthly QAPI. Any concerns will have been addressed; any patterns identified. Any needed action plan will be written by the QAPI committee and will be monitored weekly by the administrator until resolved. If the facility is within 95% compliance at the end of 6 months, monitoring may be stopped. **BY WHAT DATE THE SYSTEMIC CHANGES FOR EACH DEFICIENCY WILL BE COMPLETED?** June 13, 2025.	
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to ensure the resident received adequate supervision to prevent falls for 1 of 2 residents reviewed for accidents. The plan of care was not updated, and interventions were not implemented and reviewed for effectiveness for a high risk to fall resident with severely impaired cognition. This deficient practice	F 0689	**WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?** DON/designee reviewed interventions for effectiveness and updated careplan for resident 28 on 6/11/2025.	06/13/2025

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	resulted in multiple falls, one with major injury, where the resident sustained an acute fracture to right hip/pelvis and subacute left hip fracture. (Resident 28) Findings include: On 5/19/25 at 8:51 A.M., Resident 28 was observed sitting in a Broda chair (specialized seating system) in the east lobby in front of the television, hands empty, and trying to pull on his blanket. On 5/20/25 at 9:51 A.M., Resident 28 was observed sitting in a Broda chair in the east lobby in front of the television, hands empty, and trying to pull on his blanket. On 5/20/25 at 10:00 A.M. an Indiana Department of Health (IDOH) incident report, dated 2/9/25, was reviewed. It indicated Resident 28 fell forward out of his wheelchair while attempting to pick something up off the floor, was transferred to the hospital, and the hospital nurse reported to the facility Resident 28 had bilateral hip fractures. On 5/21/25 at 2:15 P.M., Resident 28's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with agitation, unsteadiness on feet, and generalized muscle weakness. Resident 28 was admitted to the facility on 10/2/24. The most recent Quarterly MDS (Minimum Data Set) assessment prior to the fall, dated 12/9/24, indicated Resident 28's cognition was severely impaired, had no impairment of his upper or lower extremities, no pain presence, had two or more falls since admission, used a walker and wheelchair, partial to moderate assist (staff		**HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN?** The DON/designee completed an audit of resident fall careplans for interventions, effectiveness of interventions, and updated careplans as indicated on 6/11/2025. **WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?** DON/designee educated staff on fall interventions and updating careplans with new interventions after a fall on 6/11/2025. Admin/designee inserviced IDT team including the DON on the completion of the idt/root cause note to be entered after a resident fall and for monitoring effectiveness of the fall interventions on 6/11/2025. Any staff member who fails to comply with the points of this inservice will be further educated and/or disciplined as indicated. **HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT**	

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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
	performs less than half the effort) for bed mobility and eating, substantial to maximum assist (staff performs more than half the effort) for transfers and showering, and totally dependent on staff for showering. The most recent Significant Change Minimum Data Set (MDS) assessment, dated 3/6/25, indicated Resident 28's cognition was severely impaired, had two or more falls, one with major injury, since the last Quarterly MDS assessment, dated 12/9/24, was partial to moderate assist (staff performs less than half the effort) for bed mobility and eating, substantial to maximum assist (staff performs more than half the effort) for transfers and showering, and totally dependent on staff for showering, on hospice, and receiving an antianxiety and antidepressant medication. A plan of care for falls, initiated on 10/2/24 and last revised 5/20/25, indicated the resident was at risk to fall because of the following risk factors and included the following interventions: confusion/forgetfulness (intermittent or constant), frequently forgot to use assistive device for walking, history of fall(s) in the past 30 days, impaired balance with transfers with or without assistive device, incontinence, pain, required staff physical support to transfer, slow small shuffling gait, unsteady gait with or without assistive device, used assistive device for mobility, and weakness fall on 10/13/24, no injury, initiated 10/13/24 anti rollback device to wheelchair, initiated 2/21/25 and resolved on 5/20/25 bed in low position with safety mat beside bed, initiated 2/26/25 bed wheels must be locked at all times, initiated 10/2/24		**PRACTICE WILL NOT RECUR I.E. WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE?** DON/designee will conduct audits on fall intervention effectiveness and careplan accuracy related to fall interventions by observing 10 random residents weekly for 4 weeks, 5 random residents for 4 weeks, and 3 random residents weekly for 4 months. The Admin/designee will audit resident falls daily x 6 months for completion of idt/root cause notes. Results of the monitoring will be reviewed monthly at QAPI. Any concerns will have been addressed; any patterns identified. Any needed action plan will be written by QAPI committee and will be monitored weekly by the admin until resolved. If the facility is within 95% compliance at the end of 6 months, monitoring may be stopped. **BY WHAT DATE THE SYSTEMIC CHANGES FOR EACH DEFICIENCY WILL BE COMPLETED?** June 13, 2025.	

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	brake extenders with bright colored tape in place on wheelchair, initiated 2/10/25 and resolved 2/24/25 call light in reach. Explain use of it upon admission and reinforce as needed, initiated 10/2/24 check oxygen saturation frequently - utilize prn oxygen as needed, initiated 2/24/25 encourage resident to eat meals in the dining room, initiated 2/20/25 fall 2/19/25 intervention: eat all meals in dining room, initiated 2/19/25 fall 2/8/25 immediate intervention: scoop mattress on bed, initiated 2/10/25 fall 2/9/25 immediate intervention sent to Emergency Department (ED) for evaluation, initiated 2/10/25 monitor for changes in gait/positioning, initiated 10/2/24 notify Medical Doctor (MD) of changes in condition, imitated 10/2/24 notify therapy of changes in condition, initiated 10/2/24 Offer to transfer resident from wheelchair to recliner after meals, initiated 1/29/25 rear anti-tippers to wheelchair, initiated 2/21/25 remind to use walker and keep in reach, initiated 10/2/24 and resolved 2/4/25 safety mat to floor beside bed, initiated 2/4/25 and resolved 2/6/25 use overnight briefs to reduce wake times, initiated 10/2/24 Resident was observed in a Broda Chair during all days of the survey which was not included in the plan of care. The most recent "Other" Fall Risk Assessment prior to the fall, dated 2/8/25, indicated Resident 28 was a high risk to fall.			

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	An Occupational Therapy Evaluation and Plan of Treatment Note, for certification period 11/22/24 through 12/19/24, indicated resident goals were to "improve transfers/ambulation and help patient be less restless. Patient demonstrates good rehab potential as evidenced by prior level of functioning (PLOF), stable medical status, able to follow one step instructions, strong caregiver/family support, and positive results from previous physical therapy treatment", signed 11/23/24. Progress Notes from admission to present indicated the resident was admitted walking with a walker. The resident was restless, repeatedly getting up on his own to transfer from wheelchair and required 1:1 supervision of staff at times despite staff education on safety, redirection, and antianxiety medications used as needed. On 10/10/24 at 11:08 A.M., a Care Plan Meeting Note indicated there was a meeting with staff and resident's wife. The note lacked discussion about the resident's behaviors of increased confusion, restlessness, and anxiety. No new interventions or recommendations were given. Fall 1 On 10/12/24 at 4:45 P.M., the resident had a witnessed fall getting up from chair in front of nurse's station. The Interdisciplinary Team (IDT) note, dated 10/14/24, indicated immediate intervention implemented after the fall was to have the resident in recliner when in the lobby by the nurse's station, unless family or friends were visiting. The Fall Care Plan was not updated with that intervention. Fall 2 On 10/16/24 at 6:59 A.M., the nurse was called to			

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	the resident's room by Certified Nurse Aide (CNA) for fall of resident from his bed onto his buttocks on the floor, near the foot of the bed. Immediate intervention for fall was to place cushion mat on the floor next to his bed. The clinical record lacked IDT notes following the fall. Fall 3 On 10/17/24 at 8:30 A.M., Nursing Note indicated resident was anxious sitting in wheelchair in lobby and had been up and down numerous times. Attention span was "nil" and would return to what he was doing almost instantly. The nurse was in the hallway passing medications, looked up, and saw the resident standing in front of the wheelchair. The nurse tried to get the resident to sit as she walked over but when the resident tried to sit in his wheelchair, the chair rolled. The resident was able to sit on the edge of the seat. He was not falling, but slid very slowly, controlling how fast he was sliding by using his feet to slow down, finally resting on his buttocks. He then turned and was going to move the chair, but the chair turned over. The clinical record lacked IDT notes following the fall. The Fall Care Plan was not updated with a new intervention put into place at that time. Fall 4 On 10/28/24 at 12:07 P.M., witnessed fall when the resident attempted to get up from the wheelchair in the lobby without assistance. He immediately sat down on the floor on buttocks. He was assisted to the wheelchair with two persons and the resident continued to attempt to stand up from the wheelchair repeatedly. The clinical record lacked IDT notes following the fall. The Fall Care Plan was not updated with a new intervention put into place at that time.			

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	Fall 5 On 12/12/24 at 5:23 P.M., unwitnessed fall while resident was sitting in wheelchair in lobby, set up to eat dinner, and tried to stand up unassisted. He slipped and fell on his left side. Neurological checks were initiated, according to the Neurological Checks Form given, every 15 minutes for the first hour, every 30 minutes for two hours, every two hours for 12 hours, every four hours for 12 hours, every eight hours for three days, then daily for four days. These were completed for the first hour after the fall. They were not completed again until 12/13/24 at 7:50 A.M (12 hours between). They continued according to protocol until 12/17/24 but lacked the last 3 days of monitoring. The clinical record lacked IDT notes following the fall. The Fall Care Plan was not updated with a new intervention put into place at that time. Fall 6 On 1/28/25 at 11:00 A.M., resident sitting in wheelchair at nurse's station, leaned forward, and had witnessed fall to the floor hitting left elbow on the edge of the desk causing 5 centimeter (cm) "c" shaped skin tear. IDT Note, dated 1/29/24, indicated the immediate intervention was to put the resident in the recliner. IDT recommended staff transfer resident out of wheelchair following meals and assist into recliner. The plan of care was updated to Offer to transfer resident from wheelchair to recliner after meals on 1/29/25. Fall 7 On 2/8/25 at 10:30 P.M., the resident had an unwitnessed fall out of his bed in his room. CNAs found the resident on the floor, halfway on the mat and halfway off, laying on his right side, with his head on the floor. The resident had a skin tear to the right elbow. The IDT Note, dated 2/11/25,			

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	indicated a new intervention was to put raised perimeter mattress to bed and the care plan was updated. Fall 8 On 2/9/25 at 5:40 P.M., the resident had a witnessed fall, leaned over in wheelchair in the lobby to pick something up off the ground, fell onto the floor striking his head on the floor and laying on his left hip. A Skin Tear was noted to the right hand and pain noted during assessment. Received orders from the physician to send to the Emergency Department (ED) for evaluation. The resident was diagnosed with an acute fracture to right hip/pelvis and subacute left hip fracture. The resident's wife and doctor agreed resident would not have surgery due to age and would come back to the facility with pain medication. The IDT Note, dated 2/11/25, indicated a new intervention was to put brake extenders with bright colored tape to wheelchair until anti-roll back device can be obtained. Fall 9 On 2/19/25 at 5:30 P.M., a nursing note indicated the resident had an unwitnessed fall from the wheelchair in the lobby. He was found sitting on his buttocks in front of the door beside the chair. The table with half eaten food was pushed away from chair. IDT note, dated 2/20/25, indicated a new intervention was to encourage the resident to eat all meals in the dining room. Fall 10 On 2/21/25 at 12:31 P.M., the nursing note indicated the resident was found on the floor in the lobby to the left side of his wheelchair. IDT note, dated 2/24/25, indicated that the resident was found to have low oxygen saturation when assessed by the nurse after the unwitnessed fall.			

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	Anti-roll back device was delivered in the afternoon of 2/21/24 and was immediately placed on wheelchair along with anti-tippers. IDT recommends staff check oxygen saturation every four hours and utilize PRN oxygen. No further recommendations at that time. Out of the 10 falls, 8 of them occurred when the resident was sitting in his wheelchair in the lobby. The intervention after the fall 1 was to have the resident sit in the recliner when in the lobby by the nurse's station, unless family or friends were visiting. That intervention was not implemented, and the resident fell seven more times from his wheelchair in the lobby, one of them causing an acute fracture to his right hip/pelvis and a subacute left hip fracture. IDT meetings to discuss the fall and plan of care were not held after all falls, root cause analysis was not found after all falls, new interventions were not implemented after all falls, and the plan of care for Resident 28 was not revised after the falls as indicated by the facility's policy. On 2/21/25, a Nurse Practitioner's Note indicated she saw the resident for routine visit. Staff reported no new concerns. Plan: continue current care for dementia and anxiety. On 2/22/25 at 10:58 P.M., a nursing note indicated the resident was sitting in the recliner in the lobby trying to lean over to pick up things that weren't on the floor. The resident was admitted to the hospice services. On 2/23/25 at 9:56 P.M., the nursing note indicated the resident was brought back from the dining room because he wouldn't stay seated and wouldn't eat while in the dining room. The resident was sitting beside the nurse at the			

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	nurse's station. On 2/26/25 at 10:28 A.M., an IDT Note indicated the resident was reviewed for falls. Care plan interventions were in place and no new recommendations were given at that time. During an interview on 5/21/25 at 12:00 P.M., the Director of Nursing (DON) indicated after a fall, the IDT should meet the next business day to discuss the plan of care and update the care plan interventions the same day as the meeting. On 5/22/25 at 10:45 A.M., Resident 28 was asleep sitting in a Broda chair in the east lobby. During an interview on 5/23/25 at 9:25 A.M., the Therapy Services Program Manager indicated Resident 28 was on their caseload initially as a "rehab to home" resident but after repeatedly falling and increased confusion, he had remained at the facility. During an interview on 5/23/25 at 10:02 A.M., the resident's wife indicated the resident had been in a Broda chair for the last 2-3 weeks and it has worked better for him. Before that, he would see something on the floor and thought he needed to pick it up or he would stand and fall. On 5/23/25 at 10:50 A.M., a current non dated Incidents/Accidents/Falls Policy was provided by the DON and indicated, " ... residents who have an unwitnessed fall must have neuro checks started and continued per policy ... All falls will have a site investigation by appropriate staff in an effort to define the 'root cause' of the fall. This will help provide information to enable staff to roll out interventions to prevent another similar occurrence. Note: each fall needs a new			

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	intervention rolled out ... based on the results of the incident/accident/fall, the resident's care plan will be addressed to ensure that any needed points of focus have measurable goals with appropriate interventions in place ... " On 5/23/25 at 10:50 A.M., a current non dated Neuro (Neurological) Checks Policy was provided by the DON and indicated, " ... always do neuro checks if the fall was unwitnessed by a staff member ... vital signs and neurological signs are taken and recorded as follows: BP [blood pressure], pulse, and pupil checks q [every] 15 minutes x [for] 2 hours, BP, pulse, and pupil checks q 30 minutes x 2 hours, BP, pulse, and pupil checks q 60 minutes x 4 hours, complete vital signs and neurological checks q 8 hours x 16 hours, then continue vital signs and neurological checks q 8 hours until 72 hours have lapsed and resident is stable ... " On 5/23/25 at 10:50 A.M., a current Baseline Care Plan Assessment/Comprehensive Care Plans Policy, last revised 3/23/21, was provided by the DON and indicated, " ... The comprehensive Care Plan will further expand on the resident's risks, goals, and interventions using the 'Person-Centered' Plan of care approach ... the Comprehensive Care Plans will be reviewed and updated every quarter at a minimum. The facility may need to review the care plans more often based on changes in the resident's condition and/or newly developed health/psycho-social issues ... staff will attend the morning meetings where in-depth review of the 24 hour report since the prior morning meeting are reviewed and discussed as well as new or changed orders, new admissions, readmissions, falls and other pertinent circumstances regarding the residents. They will then see that the care plans for these			

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	residents are revised and updated as necessary ... " 3.1-45(a)			
F 0732 SS=C Bldg. 00	483.35(i)(1)-(4) Posted Nurse Staffing Information Based on observation, interview, and record review, the facility failed to ensure staffing sheets were posted for the correct day for 5 of 5 days during the survey. Findings include: During an observation on 5/19/25 at 5:40 A.M., the posted nurse staffing sheet by the front door was dated 5/16/25. At that time, the posted nurse staffing sheet, dated 5/18/25, was viewed on the back hallway that did not have resident's on the hall. During an observation on 5/19/25 at 7:02 A.M., the posted nurse staffing sheet by the front door was dated 5/16/25. During an observation on 5/20/25 at 8:57 A.M., the posted nurse staffing sheet by the front door was dated 5/19/25. During an observation on 5/21/25 at 8:00 A.M., the posted nurse staffing sheet by the front door was dated 5/20/25. During an observation on 5/22/25 at 8:09 A.M., the posted nurse staffing sheet by the front door was dated 5/21/25. During an observation on 5/23/25 at 8:01 A.M., the posted nurse staffing sheet was dated 5/22/25.	F 0732	**WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?** No residents found to be affected by deficient practice. **HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN?** Residents who reside in the facility have the potential to be affected by this deficient practice, therefore, this plan of correction applies to all residents that reside in the facility. **WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?** Administrator/designee inserviced the staffing coordinator on 6/9/2025 regarding the daily staffing posting policy. Daily	06/13/2025

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	During an interview on 5/19/25 at 7:03 A.M., the Director of Nursing (DON) indicated the first shift started at 6:00 A.M. During an interview on 5/23/25 at 8:19 A.M., the Scheduler Coordinator indicated posted nurse staffing is posted at 8:00 A.M. every morning at the front door and the back door. The current day should be posted. At that time, she further indicated staff does not post the posted nurse staffing sheets on the weekends. On 5/23/25 at 9:00 A.M., the DON provided a current Guidelines for Benefits Improvement Protection Act (BIPA) Staffing Posting Requirement, dated 7/24/24 that indicated, "It is the policy of the facility...to comply with the requirement of daily posting of nursing staff in the facility...must post daily, at the beginning of each shift..."		staffing signage was also moved to the front lobby at this time. Any staff member who fails to comply with the points of this inservice will be further educated and/or disciplined as indicated. **HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E. WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE?** The admin/designee will monitor the daily staffing posting 5x per week for 4 weeks, 3x per week for 4 weeks, and 1 x per week for 4 months. Results of the monitoring will be reviewed at monthly QAPI. Any concerns will have been addressed; any patterns identified. Any needed action plan will be written by the QAPI committee and will be monitored weekly by the admin until resolved. If the facility is within 95% compliance at the end of 6 months, monitoring may be stopped. **BY WHAT DATE THE SYSTEMIC CHANGES FOR EACH DEFICIENCY WILL BE COMPLETED?** June 13, 2025.	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia			

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	Based on observation, interview, and record review, the facility failed to ensure appropriate treatment and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being of 1 of 2 residents reviewed for dementia care. A resident with dementia that was a high risk to fall was not kept active resulting in increased restlessness and multiple falls. (Resident 28) Finding includes: On 5/19/25 at 8:51 A.M., Resident 28 was observed sitting in a Broda chair (specialized seating system) in the East Hall lobby in front of the television, hands empty, and trying to pull on his blanket. On 5/20/25 at 9:51 A.M., Resident 28 was observed sitting in a Broda chair in the East Hall lobby in front of the television, hands empty, and trying to pull on his blanket. On 5/22/25 at 10:45 A.M., Resident 28 was observed asleep sitting in a Broda chair in the East Hall lobby. On 5/22/25 at 11:16 A.M., Activities staff was observed notifying residents by room of activity but walked past resident seated in lobby without asking if he wanted to join. On 5/21/25 at 2:15 P.M., Resident 28's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with agitation, anxiety, depression, unsteadiness on feet, and generalized muscle weakness. Resident 28 was admitted to the facility on 10/2/24. The most recent Significant Change Minimum	F 0744	**WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?** The admin/designee updated residents preferences for activities on 6/10/2025 and updated careplans to reflect as needed. The DON/designee updated resident 28s task list with preferred activities on 6/11/2025. **HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN?** The admin/designee completed an audit of residents with dementia diagnoses for activity preferences on 6/10/2025 and updated careplans as needed. The admin/designee updated the activity calendar on 6/10/2025 to include activities for residents with dementia. The DON/designee updated resident task lists with preferred activities on 6/11/2025. **WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?** The admin/designee educated	06/13/2025

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	Data Set (MDS) assessment, dated 3/6/25, indicated Resident 28's cognition was severely impaired, had two or more falls, one with major injury, since the last Quarterly MDS assessment, dated 12/9/24, was partial to moderate assist (staff performs less than half the effort) for bed mobility and eating, substantial to maximum assist (staff performs more then half the effort) for transfers and showering, and totally dependent on staff for showering, on hospice, and receiving an antianxiety and antidepressant medication. The Activity assessment of the MDS identified his likes included music, animals, current events/news, group activities, go outside, religious services, and that doing his favorite activities was important to him. A current Dementia Care Plan, last revised 10/2/24, indicated the resident should be observed for signs and symptoms of increased confusion and complications related to dementia. A current Activities Care Plan, last revised 3/4/25, indicated the resident may be used to a different daily routine. He has a lot of interests like pet visits, exercise, playing games, keeping up with the news, watching TV and going outside. Interventions, all initiated 10/17/24, included: review the monthly calendar with the resident and ask where he/she would like it placed in their room so they may refer to it at their convenience introduce the resident to peers seated near them during activities and meals. Promote discussion and interaction by asking open-ended questions about interests, significant times in history, the old neighborhood, school days, holidays, etc assist during adjustment try to meet needs in timely manner allow to passively observe to familiarize self with activity program		staff on activities for residents with dementia and educated staff on activities preferences on the task list and providing activities for residents with dementia when the residents are having increased restlessness on 6/11/2025. Any staff member that fails to comply with the points of this inservice will be further educated and/or disciplined as indicated. **HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, IE WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE?** The administrator/designee will monitor activity calendar/programming and participation to ensure programming is meeting the needs of cognitively impaired residents and is preventing falls 5x per week for 4 weeks, 3 x per week for 4 weeks, and 1x per week for 4 months. Results of the monitoring will be reviewed at monthly QAPI. Any concerns will have been addressed; any patterns identified. Any needed action plan will be written by the QAPI committee and will be monitored weekly by the admin until resolved. If the facility is within 95% compliance at the end of 6 months, monitoring may be stopped.	

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	155274	A. BUILDING 00 B. WING	05/23/2025

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	The most recent Quarterly Activity Progress Note, dated 4/4/25, indicated Resident 28 had been very active and he really used to enjoy activities but he doesn't come much anymore. He would love going outside and he enjoyed other things. Progress Notes from admission to 5/20/25 indicated Resident 28 mostly sat in the lobby (common area) of East Hall by the nurse's station, was very spontaneous with getting out of chair without assistance, very confused, and unable to redirect despite use of PRN (as needed) antianxiety medication, requiring 1:1 staff supervision at times. He attempted to pick up things that weren't there on the floor, staff was unable to understand speech as it was garbled most of time, and the resident needed constant reminders but seemed unable to comprehend what was being said to him in regards to his safety and included, but were not limited to the following notes: On 11/18/24 at 2:45 P.M., Nursing Note indicated resident's wife was requesting physical therapy for the resident so that he can go on walks because it would wear him out. She thought that would prevent him from having to take Ativan as often as he was. Resident 28 experienced 10 falls from 10/12/2024 through 2/21/25, eight of them taking place in the lobby area on the East Hall by the nurse's station, and one resulting in resident going to the Emergency Department (ED) for evaluation. After the fall the resident was diagnosed with acute fracture to right hip/pelvis and subacute left hip fracture. A Physical Therapy Evaluation Note, dated 11/22/24, indicated "Per EMR [Electronic Medical		**BY WHAT DATE THE SYSTEMIC CHANGES FOR EACH DEFICIENCY WILL BE COMPLETED?** June 13, 2025.	

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	Record]review ... He has been more unsteady on his feet and due to his attempts to stand/amb [ambulate] on his own nsg [nursing] has administered Ativan, 1-2 times a day ... Today, during eval [evaluation], pt [patient] appeared sedated [with Ativan given last night], but he was able to follow one step instructions ... requested PT eval [physical therapy evaluation] to increase patient's activity to reduce his episodes of restlessness ... pt presents with recent functional decline, coinciding w/recent and significant wt [weight] loss and the increased administration of Ativan, with adverse side effects ... during the eval today, pt was drowsy/sedated. He tired quickly w/assessment. He was unable to tolerate gait/balance testing in standing. Significant atrophy was noted at trunk and extremities consist with inactivity ... " During an interview on 5/23/25 at 9:23 A.M., the Activities Director indicated Resident 28 participated in the ball and parachute games and liked the move and groove activity. She indicated she had been employed at the facility for approximately three weeks so she was unsure of what he did prior to that. She would like to implement more activities to engage dementia residents such as fidget blankets and sensory activities. During an interview on 5/23/25 at 9:23 A.M., the Director of Nursing (DON) indicated they were not doing anything special for dementia residents that she's aware of. During an interview on 5/23/25 at 10:00 A.M., any psychological consultations the resident had were requested from the Director of Nursing (DON). She indicated if he had any, she would bring them. These were not provided during the duration of			

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	the survey. She indicated she was unsure if the resident was able to voice that he refused activities, but he should be offered to go and/or provided with some that interested him. During an interview on 5/23/25 at 10:02 A.M., the resident's wife indicated the resident had been in a Broda chair for the last 2-3 weeks and it has worked better for him. Before that, he would see something on the floor and thought he needed to pick it up or he would stand and fall. During an interview on 5/23/25 at 10:25 A.M., the Therapy Services Program Manager indicated Resident 28 was on their caseload from 10/3/24 through 10/14/24 and was admitted as "rehab to home" so originally was on physical therapy and occupational therapy (PT/OT) caseload with end goal of going home. He was put on caseload again 11/22/24 through 12/19/24, PT only, due to a fall. At that time, he was more confused and trying to get up a lot. She did work with him personally, and indicated prior to coming to the facility, he had been a construction worker and was always busy. At the facility now, he was fidgeting around and trying to get up due to what she believed was boredom, not anxiousness because if you were talking with him or doing an activity with him 1:1, he was content. He got bored just sitting there. On 5/23/25 at 10:50 A.M., a current Guidelines for Caring for Residents with Alzheimer's and/or Dementia Policy, dated 11/20/24, was provided by the DON and indicated, " ... This need for assistance is often upsetting and frustrating to these people/residents. It is important to properly address these concerns early on ... Plan activities that the person/resident enjoys and try to these activities at approximately the same time each day ... Allow the person/resident to keep as much			

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	control of their life as possible as far as self participation in their care and making choices and having their preferences honored ... speak with them, not at them ... Finding ways to keep these people/residents active can become more challenging ... Try to do group activities. Add music to activities. videos of various activities can be entertaining ... Sitting in a room alone can be conducive to loneliness, isolation, and depression. These people/residents should be evaluated for 1:1 activities as indicated and this should be care planned ... The care plan for those with Alzheimer's or dementia must be person-centered and must address concerns associated with any diagnoses, cognitive and/or physical deficits, medication, nutrition/diet/hydration, activities, any related special programming, any psych services to include and behavioral issues or any sleep issues, ADLs [Activities of Daily Living], safety [to include fall risk], skin issues, advanced directives, and any other concerns which are discovered ... it is recommended that the care plan includes activities that help the patient/resident stay in touch with their pre-dementia lives ... " 3.1-37(a)			
F 0801 SS=E Bldg. 00	483.60(a)(1)(2) Qualified Dietary Staff Based on interview and record review, the facility failed to ensure employment of kitchen staff with appropriate competencies and skills. The kitchen manager was not certified. (Kitchen Manager) Finding includes: On 5/19/25 at 5:50 A.M., the Kitchen Manager	F 0801	**WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?** The dietary manager is scheduled to complete servsafe program on 6/20/2025. The RD will provide the	06/13/2025

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	indicated she did not have a certification in food service. On 5/22/25 at 10:24 A.M., the Regional Dietary Manager indicated she was certified withy Servsafe, but no one else in the kitchen was yet. She indicated all kitchen staff had been registered to take the certification class on 6/20/25. On 5/22/25 at 1:35 P.M., the Regional Director of Operations provided a current non-dated Dietary Manager Orientation policy that indicated "The Dietary Manager shall receive appropriate orientation and training" 3.1-20(e)		servsafe oversight daily until the dietary manager completes this course. **HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN?** No residents were found to be affected by this deficient practice, but all residents who reside in the facility have the potential to be affected by this deficient practice therefore, this plan of correction applies to all residents who reside in the facility. **WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?** The admin/designee educated the dietary manager on certifications required for dietary staff on 6/11/2025. Any staff member who fails to comply with the points of this inservice will be further educated and/or disciplined as indicated. **HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, IE WHAT QUALITY ASSURANCE**	

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			PROGRAM WILL BE PUT INTO PLACE? The admin/designee will monitor the progress of the dietary manager in her course weekly to ensure the completion in a timely manner. Results of the monitoring will be reviewed at the monthly QAPI. Any concerns will have been addressed, any patterns identified. Any needed action plan will be written by the QAPI committee and will be monitored weekly by the admin until resolved. If the facility is within 95% compliance at the end of 6 months, monitoring may be stopped. **BY WHAT DATE THE SYSTEMIC CHANGES FOR EACH DEFICIENCY WILL BE COMPLETED?** June 13, 2025.	
F 0842 SS=E Bldg. 00	483.20(f)(5), 483.70(h)(1)-(5) Resident Records - Identifiable Information Based on interview and record review, the facility failed to ensure accurate documentation for 4 of 11 residents reviewed for clinical record accuracy. Residents medications and treatments were left blank on the Medication Administration Record (MAR) and Treatment Administration Record (TAR). (Resident 136, Resident 19, Resident 30, Resident 9) Findings include: 1. On 5/10/15 at 11:56 A.M., Resident 136's clinical	F 0842	**WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?** The DON/designee assessed residents 236, 19, 30, and 9 and found no negative outcomes related to the deficient practice on 6/11/2025. **HOW OTHER RESIDENTS**	06/13/2025

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	record was reviewed. Diagnoses included, but was not limited to, encephalopathy and acute respiratory failure. The most recent Discharge Minimum Data Set (MDS) assessment, dated 5/8/25 indicated Resident 136's cognitive status was unable to be assessed and she had a tracheostomy. Current Physician's Orders included, but was not limited to: Trach: change inner cannula daily, start date 4/9/25 Trach care every shift, start date 4/9/25 The following doses of medication were marked "blank" on the April 2025 Treatment Administration Record (TAR): Inner cannula changed on dayshift on 4/16, 4/22, and 4/23 Trach care on nightshift on 4/15 and on dayshift on 4/16, 4/22, and 4/23 During an interview on 5/22/25 at 8:26 A.M., Registered Nurse (RN) 3 indicated the inner cannula and trach care should be performed every shift and documented on the TAR. 2. On 5/19/25 at 6:36 A.M., Resident 19's clinical record was reviewed. Diagnosis included, but were not limited to, anxiety, depression, and gastroesophageal reflux disease (GERD). The most recent Quarterly Minimum Data Set (MDS) assessment, dated 3/18/25, indicated a moderate cognitive impairment. Current physician orders included, but were not		**HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN?** All residents have the potential to be affected by this deficient practice, therefore, this plan of correction applies to all residents that reside in the facility. **WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?** The DON/designee educated the nurses and qmas on medication administration and signing of the EMAR/ETAR on 6/11/2025. Any staff member who fails to comply with the points of this inservice will be further educated and/or disciplined as indicated. **HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, IE WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE?** The DON/designee will audit the EMAR/ETAR 5x per week for 4 weeks, 3x per week for 4 weeks, then weekly for 4 months to ensure completion of the EMAR/ETAR. Results of the	

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	limited to: Gas-X extra strength 125mg (milligrams) twice a day, dated 4/1/25. Pantoprazole Sodium 40mg once daily for GERD, dated 4/22/24. Famotidine 40mg once daily for GERD, dated 4/22/24. Levothyroxine Sodium 25mcg (micrograms) once daily for low thyroid hormone, dated 4/22/24. Sodium Chloride 1gm (gram) three times a day for supplement, dated 4/7/25. Guaifenesin ER (extended release) 600mg twice a day for congestion, dated 4/22/25. Wellbutrin 100mg twice a day for depression, dated 4/22/25. The following doses of medication were marked "blank" on the April 2025 and May 2025 Medication Administration Record (MAR): Gas-X 125mg P.M. dose on 4/12/25. Pantaprozole Sodium 40mg on 4/12/25, 4/13/25, 4/26/25, 5/3/25, 5/5/25, and 5/9/25. Famotidine 40mg on 4/12/25, 4/13/25, 4/26/25, 5/3/25, 5/5/25, and 5/9/25. Levothyroxine Sodium 25mcg on 4/12/25, 4/13/25, 4/26/25, 5/3/25, 5/5/25, and 5/9/25. Sodium Chloride 1gm P.M. dose on 5/2/25. Guaifenesin ER 600mg P.M. dose on 5/2/25.		monitoring will be reviewed at monthly QAPI. Any concerns will have been addressed; any patterns identified. Any needed action plan will be written by the QAPI committee and will be monitored weekly by the Admin until resolved. If the facility is within 95% compliance at the end of 6 months, monitoring may be stopped. **BY WHAT DATE THE SYSTEMIC CHANGES FOR EACH DEFICIENCY WILL BE COMPLETED?** June 13, 2025.	

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	Wellbutrin 100mg P.M. dose on 5/2/25. 3. On 5/21/25 at 1:07 P.M., Resident 30's clinical record was reviewed. Diagnosis included, but were not limited to, dementia and diabetes mellitus. The most recent Quarterly MDS assessment, dated 4/11/25, indicated a severe cognitive impairment. Current physician orders included, but were not limited to: Metformin 500mg twice daily for diabetes mellitus, dated 12/3/24. Cipro 500mg twice daily for urinary tract infection, dated 5/1/25. The following doses of medication were marked "blank" on the April 2025 and May 2025 MAR: Metformin 500mg P.M. dose on 4/7/25 and 4/12/25. Cipro 500mg P.M. dose on 5/2/25. 4. On 5/20/25 at 12:57 P.M., Resident 9's clinical record was reviewed. Diagnosis included, but were not limited to, atrial fibrillation, osteoporosis, congestive hear failure, and depression. The most recent Quarterly MDS assessment, dated 5/13/25, indicated a severe cognitive impairment. Current physician orders included, but were not limited to: Amoxicillin-Pot Clavulanate 875-125mg twice daily			

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	for upper respiratory infection for 10 days, dated 1/17/25 through 1/27/25. The following doses of Amoxicillin were marked "blank" on the January 2025 MAR: 1/23/25 and 1/24/25 A.M. doses. On 5/22/25 at 10:31 A.M., Registered Nurse (RN) 3 indicated she was unsure what the blanks meant in the MAR. She indicated if a medication was not administered, there were codes to enter for the appropriate circumstance such as medication refused, progress note, in the hospital, etc. On 5/22/25 at 11:43 A.M., the Director of Nursing (DON) indicated she was unsure why the resident MARs were not marked as being administered. She indicated sometimes the computer did not save the entries in the MAR, and sometimes did not recognize the morning entries due to shift change. She indicated any number of things could have happened, but there's was no way to tell. On 5/22/25 at 1:35 P.M., the Regional Director of Operations provided a current Medication Administration policy, last revised 5/17/21, that indicated "The resident's MAR is initialed by the person administering a medication" 3.1-50(a)(1) 3.1-50(a)(2)			
F 0912 SS=E Bldg. 00	483.90(e)(1)(ii) Bedrooms Measure at Least 80 Sq Ft/Resident Based on interview and record review, the facility failed to provide at least 80 square feet (sq. ft) per resident in double occupancy rooms and 100 sq. ft. in single occupancy rooms. This was	F 0912	**WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE**	06/13/2025

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	evidenced in 14 of 43 resident rooms in the facility. (Room 3, Room 5, Room 7, Room 9, Room 13, Room 17, Room 19, Room 21, Room 22, Room 23, Room 24, Room 25, Room 10, Room 16) Findings include: During an interview on 5/22/25 10:13 A.M., the Administrator indicated the facility had room size waivers. A list of rooms and sizes was provided and were as follows: 1. Room 3: 2 beds with 154.65 total sq. ft. SNF/NF and 77.32 sq. ft. per resident. 2. Room 5: 2 beds with 154.65 total sq. ft. SNF/NF and 77.32 sq. ft. per resident. 3. Room 7: 2 beds with 154.65 total sq. ft. SNF/NF and 77.32 sq. ft. per resident. 4. Room 9: 2 beds with 154.65 total sq. ft. SNF/NF and 77.32 sq. ft. per resident. 5. Room 13: 2 beds with 154.65 total sq. ft. SNF/NF and 77.32 sq. ft. per resident. 6. Room 17: 2 beds with 154.65 total sq. ft. SNF/NF and 77.32 sq. ft. per resident. 7. Room 19: 2 beds with 154.65 total sq. ft. SNF/NF and 77.32 sq. ft. per resident. 8. Room 21: 2 beds with 154.65 total sq. ft. SNF/NF and 77.32 sq. ft. per resident. 9. Room 22: 2 beds with 154.65 total sq. ft. SNF/NF and 77.32 sq. ft. per resident. 10. Room 23: 2 beds with 154.65 total sq. ft.		**DEFICIENT PRACTICE?** The Waters of Rockport requests a continuation of the waiver for this requirement. The residents in the affected rooms have not indicated, through verbal complaints or an exacerbation in negative well being, due to the rooms being less than state requirements. **HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN?** All residents have the potential to be affected by the deficiency. Although the sq ft of the rooms cannot be adjusted, the accommodations will be kept clean and tidy to ensure the safety of each resident. **WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?** While we cannot adjust the sizes of the rooms to meet regulations, we will ensure that the residents residing in these smaller rooms do not suffer from any psychosocial distress related to room size. **HOW THE CORRECTIVE ACTIONS WILL BE MONITORED**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155274	A. BUILDING 00 B. WING	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	SNF/NF and 77.32 sq. ft. per resident. 11. Room 24: 2 beds with 154.65 total sq. ft. SNF/NF and 77.32 sq. ft. per resident. 12. Room 25: 2 beds with 154.65 total sq. ft. SNF/NF and 77.32 sq. ft. per resident. 13. Room 10: 1 bed with 90.52 sq. ft. per resident, SNF/NF. 14. Room 16: 1 bed with 90.52 sq. ft. per resident, SNF/NF. 3.1-19(l)(2)		**TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, IE WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE?** The facility will review the findings of the audit tool completed by the SSD or her designee at QAPI each month to ensure compliance. Any concerns will be addressed as found. **BY WHAT DATE THE SYSTEMIC CHANGES FOR EACH DEFICIENCY WILL BE COMPLETED?** Unfortunately, the room sizes are in relation to the structure of the building which cannot be adjusted to meet state requirements and therefore is why we request the continuation of the waiver for room sizes. SSD/her designee will monitor 10 residents weekly for 4 weeks, 5 residents weekly for 1 month, and then 1 resident weekly for 3 months for any psychosocial distress related to the rooms not meeting sq ft requirement. If facility is within 95% compliance at the end of 6 months, monitoring may be stopped.	