| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155400 | A. BUILDING 00<br>B. WING | 02/17/2023 |

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| CARDINAL CARE STRATEGIES | 4600 E JACKSON ST<br>MUNCIE, IN 47303 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00400820, IN00400954 and IN00401254.<br><br>Complaint IN00400820 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600.<br><br>Complaint IN00400954 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600.<br><br>Complaint IN00401254 - Substantiated. No deficiencies related to the allegations were cited.<br><br>Unrelated deficiencies are cited.<br><br>Survey dates: February 16 and 17, 2023.<br><br>Facility number: 000269<br>Provider number: 155400<br>AIM number: 100267720<br><br>Census Bed Type:<br>SNF/NF: 51<br>Total: 51<br><br>Census Payor Type:<br>Medicare: 1<br>Medicaid: 44<br>Other: 6<br>Total: 51<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed February 27, 2023. | F 0000 | Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report.<br><br>Submission of the Plan of Correction does not constitute an admission or an agreement by the provider of the truth or facts alleged or corrections set forth on the statement of deficiencies.<br><br>The Plan of Correction is prepared and submitted because of requirements under State and Federal law.<br>Please accept this Plan of Correction as our credible allegation of compliance and we respectful request paper compliance. | |

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

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| F 0600<br>SS=D<br>Bldg. 00 | 483.12(a)(1)<br>Free from Abuse and Neglect<br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>Based on observation, interview, and record review, the facility failed to provide supervision to prevent abuse for 2 of 4 residents reviewed for abuse (Resident B and Resident E).<br><br>Findings include:<br><br>1. Resident B's clinical record was reviewed on 2/16/23 at 9:27 a.m. Diagnoses included Alzheimer's disease, anxiety disorder, other recurrent depressive disorders, restlessness and agitation, dementia in other diseases classified elsewhere, severe, with agitation and dementia in other diseases classified elsewhere, severe, with anxiety.<br><br>Her medications included buspirone (treat anxiety) 10 mg (milligram) three times daily, divalproex sodium (treat mood disorders) 250 mg three times daily, and olanzapine (treat mood disorders) 10 mg twice daily. | F 0600 | F600<br><br>It is the practice of this facility to provide supervision to the residents to prevent abuse.<br>1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice.<br>a. Resident E was sent to hospital for a CT scan with negative results, placed on 15 minute checks x 72 hours displaying no sign of injury. Plan of care updated including interventions.<br>b. Resident B was sent to hospital for medical evaluation and no sign of injury. Resident was placed on 15 minute checks x 72 hours displaying no sign of injury. | 03/13/2023 |

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| | A quarterly MDS (Minimum Data Set), dated 11/17/22, indicated she was severely cognitively impaired. She required extensive assistance of one staff member for bed mobility and transfers. She required supervision of one staff member for walking in her room and locomotion on the unit. She had other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing, or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) which occurred daily.<br><br>Her current care plans included the following:<br><br>She had a peer-to-peer altercation initiated on 3/28/22. Her goal was she would not exhibit behaviors of physical altercation with peer(s) through next review. Her interventions initiated on 3/28/23 were to allow her to express her feelings and concerns and to remove her from the situation. Take her for a walk was initiated on 2/3/23.<br><br>She had a potential for psychosocial distress related to peer-to-peer altercation, initiated on 5/25/22. Her goal was she would not exhibit signs or symptoms of psychosocial distress related to incident. Her interventions, initiated on 5/25/22, were encourage her to participate in activities of interest, provide one on one as needed, offer emotional support. Her interventions initiated on 2/3/23, were to encourage/assist her to have an acceptable interaction with other residents and to remove her from the situation.<br><br>She exhibited wandering, yelling out, verbal and physical aggression, exit seeking, agitation, peer-to-peer altercation, she yelled at staff, hit | | Plan of care updated including interventions.<br>c. Resident C plan of care reviewed and change in seating proximity to resident B. Monitored every shift x 10 day no further incidents noted. Plan of care updated including interventions.<br>d. Resident D plan of care has been reviewed along with interventions. Resident D has been placed on 1/1 care until further behavioral health services can be provided. Facility is working with family as they refuse to allow resident to be sent for additional medical care. Assurance paperwork initiated but refused by family. Facility has issued a 30-day discharge notice due to the endangerment of others and family has appealed. Court hearing scheduled on March 15 with facility and facility attorney with family.<br>2. To identify other residents who have the potential to be affected by the same alleged deficient practice.<br>a. All residents that reside on the unit have the potential to be affected.<br>b. Resident D is on 1/1 care until further discharge placement. Interventions have been reviewed and plan of care updated accordingly.<br>3. Measures and systemic changes put into place to ensure that the alleged deficient practice | |

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| | staff, she was restless, resistant to care, she paced and she was self-injurious such as banging on windows and doors initiated on 6/17/22. Her goal was that she would have less than 10 episodes monthly. Her interventions initiated on 6/17/22, were approach in a calm manner, attempt to redirect with an activity of interest. She enjoyed pushing keys on the piano, and call her by her name.<br><br>Her nurses notes indicated the following:<br><br>On 2/2/23 at 8:00 p.m., staff heard her screaming, she was found in the dining room area. Resident C had her head pressed on the table by her nose. Resident C believed the resident had stolen her blanket. They were both removed from the area. She had a red area to the right side of her face, a red nose, and a small abrasion to the right side of her nose. She had no complaints of pain. Fifteen - minute checks were started.<br><br>A handwritten statement by Employee 37, dated 2/2/23, indicated she was in a resident's room and heard yelling coming from the dining room. She went to see what was going on, and Resident C had a hold of Resident B by her nose and was pulling her down. Resident C's nails were going into her nose. Resident B was screaming. She got Resident C to let go, and then she grabbed Resident B's nose again. The nurse came and got Resident C, and took her to the desk.<br><br>2. Resident E's clinical record was reviewed on 2/16/23 at 2:12 p.m. Diagnoses included Alzheimer's disease, unspecified psychosis not due to a substance or known physiological condition, dementia in other diseases classified elsewhere, moderate, with psychotic disturbance, and depression. | | does not recur.<br>a. A mandatory in-service was completed on 02/22/2023 with staff regarding aggressive resident behaviors and individualized interventions. This was re-in serviced on 3/2/2023 along with Abuse Policy.<br>b. The staff will notify Administrator and DON immediately of any altercation per reporting regulations and to ensure appropriate interventions are put into place.<br>c. The Staffing Coordinator will review the daily staffing to ensure that individuals are assigned to working areas and present to the DON and Administrator.<br>d. The DON and Administrator will review the daily staffing assignments daily.<br>e. The Social Service Director will review behaviors daily during stand-up meeting and any new identified behaviors will have interventions along with their plan of care updated.<br>4. The corrective action will be monitored to ensure the alleged deficient practice does not recur and quality assurance measures put into place are:<br>a. SSD and/or Designee will complete rounds daily to identify any new behaviors and document findings. If any issues are identified immediate action will be taken to resolve. These audits will be completed daily for 4 weeks, | |

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| | Her medications included divalproex sodium 250 mg twice daily, apixaban (blood thinner) 2.5 mg twice daily, escitalopram oxalate (treat depression) 10 mg daily, and risperidone (treat mood disorder) 0.25 mg twice daily.<br><br>An admission MDS, dated 1/23/23, indicated she was severely cognitively impaired. She required extensive assistance of one staff member for bed mobility. She required limited assistance of one staff member for transfers, walk in room or corridor, locomotion on and off the unit. She used a walker. She wandered daily and it placed her at a significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility). Her wandering significantly intruded on the privacy or activities of others.<br><br>A wandering risk assessment, dated 1/16/23, indicated she was at risk to wander.<br><br>She had a current care plan for a potential for psychosocial distress related to peer to peer altercation initiated on 2/5/23. Her goal was that she would not exhibit signs or symptoms of psychosocial distress related to incident. Her interventions were initiated on 2/5/23 and included offer emotional support, provide one on one as needed, redirect her to not enter other residents room and remove her from the situation.<br><br>Her nurses notes indicated the following:<br><br>On 2/5/23 at 5:01 p.m., she was sitting in a chair at the nurse's station. The QMA went to her room to get her walker, and when the QMA returned, she had wandered into Resident D's room. The QMA was not able to reach her in time to re-direct her out of his room. Resident D grabbed Resident | | then 3 times weekly for 60 days, then monthly for three quarters, to identify any concerns and take corrective measures.<br>b. Administrator and/or Designee will complete audit tool and document findings on daily staffing assignments. If any issues are identified immediate action will be taken to resolve. These audits will be completed daily for 4 weeks, then 3 times weekly for 60 days, then monthly for three quarters, to identify any concerns and take corrective measures. (exhibit A)<br>c. The findings from these audits and any corrective actions taken will be discussed during quarterly QA meetings and the current plan revised, as warranted. | |

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| | E her by the back of her neck, and hit her head on the bed frame. They were immediately separated, 15-minute checks were started, and a nursing assessment was completed. Her vital signs and neurological checks were with in normal limits. The psychiatric nurse practitioner was made aware. A new order was received and 911 was called to transport her to a local ER (Emergency Room) for evaluation and treatment.<br><br>On 2/5/23 at 6:00 p.m., ER staff called the facility with a report. CT (Computed Tomography) of her head was negative, her vitals were stable, and she did not complaint of pain. She would return to the facility.<br><br>The impression of the CT of her head without contrast, dated 2/5/23, indicated 1. No acute intracranial findings. 2. No significant interval change in appearance of the brain in comparison to the study from 6/20/22.<br><br>During a review of the facility's investigation, a handwritten statement by CNA 23, dated 2/5/23, indicated she was in another room with a resident. She heard her name being called and when she approached, she observed Resident E being bent over while Resident D was pushing her and QMA 27 out of the doorway. Resident D was observed bending QMA 27's fingers and cussing her out and calling her names.<br><br>A handwritten statement by QMA 27, dated 2/5/23, indicated around 3:00 p.m., Resident E started to wander around. She helped her to find a seat around nurses station while she went to get her walker down the hall in the dining room, she came back and Resident E was in Resident D's room and was being held down at her neck and bent over by Resident D. Resident D held tightly | | | |

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| | to the back of Resident E's neck, her upper body was going up and down, causing Resident E's head to hit the footboard on Resident D's bed. She immediately intervened and yelled for CNA 23 to help her. Resident D stayed standing over Resident E and cussing at her and still tried to grab Resident E. They tried to get Resident D off and away from Resident E. Resident D bent her fingers back when she tried to close his door. She stayed in doorway until they could calm Resident E down to exit away. They contacted the ADON about the altercation and started 15-minute checks on the residents.<br><br>During an interview with CNA 18, on 2/16/23 at 2:53 p.m., she indicated she tried to redirect Resident D with coffee and snacks, and they tried to keep "the little ladies" from his room. He didn't like them in his room. They had put a stop sign on his door, but it didn't work, the residents would still just go right in. They redirected the residents who tried to go into his room, with an activity or a snack. Sometimes it was scary and hard to watch all the residents. The nurse and the CNA would take turns answering call lights and toileting people. Unfortunately, there were times when they both may be in a room at the same time.<br><br>During an interview with QMA 35, on 2/17/23 at 9:18 a.m., she indicated Resident D showed verbal aggression and had displayed physical aggression. They tried to keep residents from going into his room. With the wandering residents, they tried not to let them get past the corner of the wall of the hallway that led to his room. They tried to keep someone near the nurse's station to supervise the residents. They tried to staff a nurse and two CNAs on the unit, but sometimes the CNA would get pulled to a different part of the facility. About half of a | | | |

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seven-day period, three to four days they would work with two CNAs and a nurse or a QMA. One nurse and one CNA could do it on the unit, it all depended on what type of mood Resident D was in.

During an interview with QMA 27, on 2/17/23 at 11:49 a.m., she indicated she had witnessed Resident D and Resident E. Resident D had a lot of behaviors. Sometimes if he saw her, it caused him to have behaviors and had indicated to her she lied and got him in trouble. She was scared of him. The other day, the ADON and SSD had to come to the unit to watch him so she could finish her work. He would stand by her at the medication cart and she could just tell he was getting angry at her. He would get mad just by someone walking in his room that he didn't want in there. They had tried a stop sign to his door to keep residents from wandering into his room. They had also tried a door chime to know when he was coming out of his room, or someone was going in, but he took it off and threw it. There was normally a QMA and two CNAs that worked the unit if everyone showed up. She could work with just her and a strong CNA.

A 2/1/23 revised facility policy, titled "ABUSE PREVENTION AND PROHIBITION POLICY," provided by the Administrator on 2/17/23 at 11:04 a.m., indicated the following: "...Policy...Residents residing in this facility will be treated with dignity and respect...They will not be subjected to physical, verbal, sexual and mental abuse...."

This Federal tag relates to complaint IN00400820 and IN00400954.

3.1-27(a)(1)

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| F 0609 SS=D Bldg. 00 | 483.12(b)(5)(i)(A)(B)(c)(1)(4)<br>Reporting of Alleged Violations<br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>Based on observation, interview, and record review, the facility failed to report to the State Agency a fall requiring hospital intervention for 1 of 1 resident reviewed for reporting to State Agency (Resident F).<br><br>Findings include: | F 0609 | F609<br>It is the practice of this facility to report to the State Agency timely of incident per regulations.<br>1. Corrective actions accomplished for those residents | 03/13/2023 |

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| | On 2/17/23 at 10:30 a.m., Resident F sat in her Broda (high back reclining wheelchair) in the common area. She had stitches on the right side of her forehead.<br><br>Resident F's clinical record was reviewed on 2/17/23 at 11:30 a.m. Diagnoses included chronic atrial fibrillation, Alzheimer's disease, depression, essential (primary) hypertension, combined systolic (congestive) and diastolic (congestive) heart failure, vascular dementia, unspecified severity, with other behavioral disturbance, convulsions, anxiety disorder, and muscle weakness (generalized).<br><br>Her medications included buspirone (treat anxiety) 10 mg (milligram) three times daily, carbamazepine (treat convulsions) 200 mg three times daily, midodrine 5 mg after meals, hydrocodone-acetaminophen (narcotic pain reliever) 5-325 mg twice daily, risperidone (antipsychotic) 0.5 mg twice daily, and rivaroxaban (blood thinner) 15 mg daily.<br><br>Review of a 2/7/23 at 7:13 a.m., progress note indicated she was sitting in her Broda (high back reclining wheelchair) chair in the lounge. The QMA advised the nurses she was on the floor. A complete head to toe assessment was done and there was an apparent deep open forehead wound. Her right knee was also swollen and beginning to discolor. Neurological checks were initiated but she was unable to follow directions as she had a diagnosis of severe vascular dementia and Alzheimer's disease. The NP (Nurse Practitioner) was notified, and a new order was received to send her to the ER (Emergency Room) to evaluate and treat. | | found to be affected by the alleged deficient practice.<br>a. Resident F fall was not required based on the guidance provided by the ISDH of Long-Term Care Abuse and Incident Reporting Policy effective 12/08/2022. Resident F fall was investigated as per the process of the facility. The plan of care has been reviewed for appropriate interventions and updated accordingly. EXHIBIT B<br>2. To identify other residents who have the potential to be affected by the same alleged deficient practice.<br>a. A review of incidents since survey exit has no further residents identified per reporting guidelines.<br>3. Measures and systemic changes put into place to ensure the at the alleged deficient practice does not recur.<br>a. A mandatory in-service will be completed on 3/10/2023 with all Nursing staff for Long-Term Care Abuse and Incident Reporting Policy including timelines.<br>b. All incidents will be reviewed during morning clinical review to determine for reporting procedures per regulations.<br>c. The staff will be instructed to notify nursing management of any fall with injury to determine reporting procedures per regulations. | |

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| | On 2/7/23 at 1:09 p.m., she returned to the facility with five stitches to her forehead, which measured 3.0 cm x 0.5 cm. The stitches were to be removed in seven to ten days.<br><br>During an interview with the Administrator, on 2/17/23 at 11:04 a.m., she indicated she did not know she was to report Resident F's fall.<br><br>A 7/15/15 current facility policy titled "INDIANA STATE DEPARTMENT OF HEALTH," provided by the ADON on 2/17/23 at 1:18 p.m., indicated the following: "...C. Types of incidents reportable under State rules only...5. MAJOR ACCIDENTS - unexpected or unintentional events resulting in any fracture or other outcomes that require medical treatment beyond basic first aid or ER/physician evaluation...."<br><br>3.1-28(e) | | d. The Administrator will complete audit tool to ensure for appropriate and timeliness of reporting per regulations. This will be completed daily during stand up morning meetings for the 4 weeks, then 1 time weekly for a quarter, then monthly for the next 3 quarters. Any issues identified; immediate action will be taken to resolve.<br>e. During the survey, the ADON presented the policy 7/15/15 instead of the correct policy from ISDH dated 12/08/2022. Which does not state the requirement of reporting this incident.<br>4. The corrective action will be monitored to ensure the alleged deficient practice does not recur and quality assurance measures put into place are:<br>a. The Administrator will complete audit tool to ensure for appropriate and timeliness of reporting per regulations. This will be completed daily during stand up morning meetings for the 4 weeks, then 1 time weekly for a quarter, then monthly for the next 3 quarters. Any issues identified; immediate action will be taken to resolve.<br>b. The findings from these audits and any corrective actions taken will be discussed during quarterly QA meetings and the current plan revised, as warranted. | |

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| | 155400 | A. BUILDING 00<br>B. WING | 02/17/2023 |

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

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| F 0689 SS=E Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent falls for 3 of 3 residents reviewed for falls (Resident F, Resident C and Resident E).<br><br>Findings include:<br><br>On 2/17/23 at 10:30 a.m., Resident F sat in her Broda (high back reclining wheelchair) in the common area. She had stitches on the right side of her forehead.<br><br>Resident F's clinical record was reviewed on 2/17/23 at 11:30 a.m. Diagnoses included chronic atrial fibrillation, Alzheimer's disease, depression, essential (primary) hypertension, combined systolic (congestive) and diastolic (congestive) heart failure, vascular dementia, unspecified severity, with other behavioral disturbance, convulsions, anxiety disorder, and muscle weakness (generalized).<br><br>She had admitted to the facility on 12/6/22.<br><br>Her medications included buspirone (treat anxiety) 10 mg (milligram) three times daily, carbamazepine (treat convulsions) 200 mg three times daily, | F 0689 | F689<br>It is the practice of this facility to provide adequate supervision to prevent falls.<br>1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice.<br>a. Resident F had a review completed on plan of care for appropriateness and completeness. Interventions have been reviewed for effectiveness and updated accordingly. Additional interventions are 1:1 supervision by staff or family if current interventions unsuccessful until restlessness resolves. Therapy to screen. Resident care sheets and plan of care updated to reflect changes.<br>b. Resident C had a review completed on plan of care for appropriateness and completeness. Interventions have been reviewed for effectiveness and updated accordingly. Therapy to screen. Resident care sheets | 03/13/2023 |

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| | midodrine 5 mg after meals, hydrocodone-acetaminophen (narcotic pain reliever) 5-325 mg twice daily, risperidone (antipsychotic) 0.5 mg twice daily, and rivaroxaban (blood thinner) 15 mg daily.<br><br>Her orders included floor mat next to her bed and low bed every shift for fall risk started on 12/7/22 and half siderail to bed started on 12/22/22.<br><br>An admission MDS (Minimum Data Set), dated 12/13/22, indicated she was severely cognitively impaired. She required extensive assistance of two staff members for bed mobility, transfers, and toilet use. She required extensive assistance of one staff member for locomotion on/off the unit, dressing and personal hygiene. She used a wheelchair. She had one fall with no injury.<br><br>She had a current care plan which indicated she was at risk for falls related to confusion, gait/balance problems and hypotension initiated on 12/8/22. Her interventions, initiated on 12/8/22, were assist with toileting, she was to be checked while in bed every two hours and PRN (as needed) for soilage, assist with transfers, she was to utilize footwear with non-skid soles.<br><br>A fall risk assessment, dated 12/6/22, indicated she was at a high risk for falling.<br><br>Her nurses notes indicated the following:<br><br>On 12/9/22 at 9:15 a.m., she was in her wheelchair and the CNA was making her bed. She leaned forward and slid onto the floor. She did not hit hard and did not hit her head. No injuries were noted.<br><br>A fall risk assessment, dated 12/9/22, indicated | | and plan of care updated to reflect changes.<br>c. Resident E had a review completed on plan of care for appropriateness and completeness. Interventions have been reviewed for effectiveness and updated accordingly. Therapy to screen. Resident care sheets and plan of care updated to reflect changes.<br>2. To identify other residents who have the potential to be affected by the same alleged deficient practice.<br>a. An audit of falls including interventions for the last 6 months will be completed to ensure effectiveness of interventions. If concerns are noted, then corrective action will be taken immediately, and plan of care updated as needed.<br>3. Measures and systemic changes put into place to ensure the at the alleged deficient practice does not recur.<br>a. A mandatory in-service will be completed on 3/10/23 with all Nursing staff for fall interventions.<br>b. During daily nursing rounds, the charge nurse will monitor that the fall interventions are in place. If any issues are identified, immediate action will be taken to resolve.<br>c. DON and/or Designee will complete rounds and document findings on units to ensure that fall interventions are in place. If any | |

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| | she was at a moderate risk for falling.<br><br>A late entry, IDT (Interdisciplinary Team) note, dated 12/12/22 at 10:51 a.m., indicated they met regarding her fall on 12/9/22. She had diagnosis of vascular dementia and Alzheimer's disease. She was severely cognitively impaired. She made poor decisions and was unaware of safety issues. She leaned forward in her wheelchair, slid out onto the floor and onto her bottom. She denied any complaints. She had full ROM (Range of Motion) to all extremities per her baseline. There were no areas of redness/bruising. Therapy was to provide foot pedals for her wheelchair. Her care plan was reviewed and updated as needed.<br><br>On 12/18/22 at 1:46 a.m., she was found on the floor. She had rolled out of bed. The siderail was missing off her bed and the mat was not in place. A 4 cm x 4 cm abrasion was noted to area, and on her right hip a 3 cm x 6 cm light bruise was noted. She had no pain. She was alert to self and situation and able to make wants and needs known. She was assisted to bed by three staff members.<br><br>A fall risk assessment, dated 12/18/22, indicated she was at a high risk for falling.<br><br>A late entry IDT note, dated 12/19/22 at 3:11 p.m., indicated they met regarding her fall on 12/18/22 when she was laying on the floor beside her bed. She was a poor historian and was unable to tell staff how she fell, nursing assessment was completed. The half side rail was installed on her bed to assist her with turning and repositioning, The care plan was reviewed and updated.<br><br>Her care plan was updated on 12/22/22 for half siderails. | | issues are identified, immediate action will be taken to resolve.<br>4. The corrective action will be monitored to ensure the alleged deficient practice does not recur and quality assurance measures put into place are:<br>a. DON and/or Designee will complete rounds and document findings on units to ensure that fall interventions are in place. If any issues are identified, immediate action will be taken to resolve. These audits will be completed 3 times a week for 4 weeks, then 3 times weekly for 60 days, and then monthly for three quarters, to identify any concerns and take corrective measures.<br>b. The findings from these audits and any corrective actions taken will be discussed during quarterly QA meetings and the current plan revised, as warranted. | |

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| | On 12/28/22 at 3:40 a.m., she was found on the floor by her bed with no injuries.<br><br>A fall risk assessment, dated 12/28/22, indicated she was at a high risk for falling.<br><br>A late entry, IDT note, dated 12/29/22 at 10:54 a.m., indicated they met regarding her fall on 12/28/22. She was found on the floor by her bed without injury. She was incontinent of bowel. When she was asked what happened, she stated "I know, ok." She was assessed and assisted back to bed, with bed in lowest position and with mat at the bedside. She was provided peri care and brought to common area in her wheelchair. The care plan was reviewed and updated as needed.<br><br>On 12/29/22 at 2:13 p.m., purple/yellow bruising developed around her right temple/eyebrow.<br><br>On 12/30/22 at 2:49 a.m., she was found on the floor next to her bed with no injury.<br><br>On 12/30/22 at 1:09 p.m., she has been restless and anxious, rocking back and forth in her hi-back wheelchair. She leaned forward frequently and attempted to scoot out of bed. She was given reminders to sit back in her chair and wait on staff for assistance. She was able to be re-directed momentarily. Her wants and needs were anticipated and met by staff.<br><br>A fall risk assessment, dated 12/30/22, indicated she was at a high risk for falling.<br><br>A late entry IDT note, dated 12/30/22 at 3:09 p.m., indicated they met regarding her fall on 12/30/22. She was found on floor beside her bed with no injuries. She stated, "I know," when asked what | | | |

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| | happened. She was reassessed, assisted back to bed and peri care was provided. The bedside mat was in place and her bed was in lowest position. Staff was to check her while in bed, every two hours and PRN (as needed) for soilage. Her care plan was reviewed and updated as needed.<br><br>Her care plan was updated on 12/31/22 for her bed to be used in lowest position and ensure device was in place as needed.<br><br>On 1/2/23 at 2:56 p.m., she was in her high back wheelchair in the lounge. When the QMA walked by the lounge, they witnessed her push the table forward. She bent forward and slid out of her wheelchair onto the floor on her right side. A complete head to toe assessment was done with no injuries. The witness stated she did not strike her head.<br><br>A fall risk assessment, dated 1/2/23, indicated she was at a high risk for falling.<br><br>An IDT note, dated 1/3/23 at 10:04 a.m., indicated they met regarding her fall on 1/2/23. She was up and in her high back wheelchair in the lounge when the QMA walked by the lounge and witnessed her push the table forward, she bent forward and slid out of her wheelchair onto the floor on her right side. A complete head to toe assessment was done with no injuries. The witness stated she did not strike her head. She was to sit in the common areas while in hi-back wheelchair. Her care plan was reviewed as needed.<br><br>On 1/5/23 at 1:11 p.m., she was sitting in her high back wheelchair during the shift. She continuously was sliding out of her chair or trying to get out of it. She had been yelling out at times, | | | |

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| | when staff tried to redirect her from getting out of chair, she would shout "Shut up."<br><br>On 1/5/23 at 2:05 p.m., she attempted to pull herself out of her chair. She had been moving her wheelchair down the hallway despite the wheels being locked. She was given colored pencils and a coloring book, and she threw them onto the floor.<br><br>On 1/17/23 at 7:16 a.m., she was found on the mat beside her bed with no injuries. She had on nonskid slippers and her bed was in low position.<br><br>A fall risk assessment, dated 1/17/23, indicated she was at a high risk for falling.<br><br>A late entry IDT note, dated 1/17/23 at 12:01 p.m., indicated they met regarding her fall on 1/16/23. She was found on the floor mat beside her bed with no injuries. She stated she didn't know what happened. She was assisted back to bed. Staff was to anticipate and meet her needs. Her care plan was reviewed and updated as needed.<br><br>On 1/30/23 at 6:08 a.m., she was found on floor by her bed. She was assisted to her chair by three staff members. She was moved in staff's view.<br><br>A fall risk assessment, dated 1/30/23, indicated she was at a high risk for falling.<br><br>Her care plan was updated on 1/30/23 to anticipate and meet her needs.<br><br>A late entry IDT note, dated 1/31/23 at 9:00 a.m., indicated they met to discuss her fall on 1/30/23. She was found on the floor by her bed. She was assisted to her chair by three staff members, and she was moved into staff's view. The staff was to anticipate and meet her needs. The plan of care | | | |

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| | was updated, and therapy was made aware.<br><br>On 2/7/23 at 7:13 a.m., she was sitting in her Broda (high back reclining wheelchair) chair in the lounge. The QMA informed the nurses she was on the floor. A complete head to toe assessment was done and there was an apparent deep open forehead wound. Her right knee was also swollen and beginning to discolor. Neurological checks were initiated but she was unable to follow direction as she has diagnosis of severe vascular dementia and Alzheimer's disease. The NP was notified, and a new order was received to send her to the ER (Emergency Room) to evaluate and treat.<br><br>On 2/7/23 at 1:09 p.m., she returned to the facility with five stitches to her forehead and measured 3 cm x 0.5 cm and were to be removed in seven to ten days.<br><br>The impression of the CT of her head without IV contrast, dated 2/7/23, indicated mild right parietal scalp soft tissue swelling/contusion without underlying calvarial fracture.<br><br>A fall risk assessment, dated 2/7/23, indicated she was at a high risk for falling.<br><br>A late entry, IDT note, dated 2/8/23 at 2:38 p.m. indicated they met to review her fall on 2/7/23. Per charting she was last seen sitting in Broda chair in lounge. The QMA notified the nurse that they found her laying on the floor. Intervention was when she was in her Broda chair staff was to ensure her chair was in a reclining position to keep her from falling forward.<br><br>Her care plans were updated on 2/9/23 and indicated when she was up in the high back wheelchair/Broda chair, the chair needed to be in a | | | |

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| | reclined position, she had wound management; laceration to her head with five sutures in place related to a fall and she had a skin tear to her right knee related to a fall.<br><br>During an interview with LPN 45, on 2/17/23 at 11:43 a.m., she indicated Resident F was deep into Alzheimer's dementia. She didn't really seem to know what was going on around her or able to articulate her needs. She was restless all the time. They assisted her with eating, and she was incontinent. She had no safety awareness at all. The interventions were her bed low position and mat on the floor. She was fidgety in bed. They kept her close. The only time she was out of sight was when she was in bed. They kept her Broda chair in a reclined position so she couldn't tumble forwards out of it.<br><br>2. On 2/16/23 at 9:20 a.m., Resident C sat in her wheelchair with a drink on an overbed table in front of her.<br><br>On 2/16/23 at 2:01 p.m., she sat in her wheelchair to the side of the nurses station in her wheelchair.<br><br>Resident C's clinical record was reviewed on 2/16/23 at 10:07 a.m. Diagnoses included unspecified dementia, unspecified severity, with other behavioral disturbance, muscle weakness (generalized), unsteadiness on feet, other abnormalities of gait and mobility, cognitive communication deficit, and unspecified dementia, moderate.<br><br>A quarterly MDS, dated 1/16/23, indicated she was severely cognitively impaired. She required extensive assistance of one staff member for bed mobility, transfers, locomotion on/off the unit, dressing, toilet use and personal hygiene. She | | | |

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| | required limited assistance on one staff member for walking in her room/corridor. She did not use an assistive device.<br><br>She had a care plan for risk for falls due to dementia with behaviors, impaired mobility, history of CVA (Cerebrovascular Accident), abnormal gait, mood disorders and effects of medications initiated on 10/15/22. Her interventions initiated on 10/15/22 were assist with toileting and transfers, physical therapy to evaluate and treat as ordered or PRN, she was to utilize footwear with non-skid soles. Observe her for attempting to sit down in chairs and assist as needed to prevent falls initiated on 10/28/22.<br><br>A fall risk assessment, dated 12/18/22, indicated she was at a high risk for falling.<br><br>Her nurses notes indicated she had the following falls:<br><br>On 12/28/22 at 6:44 a.m., she was found on the floor beside her bed with no injuries.<br><br>A fall risk assessment, dated 12/28/22, indicated she was at a high risk for falling.<br><br>On 12/29/22 at 7:17 p.m., IDT (Interdisciplinary Team) met regarding her fall on 12/28/22. She had a diagnosis of unspecified dementia and cerebral infarction, she made poor decisions and would wander without purpose. She was found on floor by bed without injury. She was incontinent of bowel, and stated "I don't know," peri care was provided, she was assessed and assisted to her wheelchair by the nurses station with staff. Staff was to ensure she had proper footwear on and her call light was within easy reach. Her care plan was reviewed and updated as needed. | | | |

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| | Her care plan was updated on 1/1/23 to be sure her call light was within reach and encourage her to use it for assistance as needed. She needed prompt response to all requests for assistance.<br><br>On 1/11/23 at 8:36 a.m., staff heard her calling out and entered her room to find her sitting on her bottom on the floor next to her bed. She appeared as if she had fallen out of bed or attempted to get up by herself. No injuries were found. She was weak and appeared fretful, she was on an antibiotic. She had not been ambulatory since last fall.<br><br>A fall risk assessment, dated 1/11/23, indicated she was at a high risk for falling.<br><br>Her care plan was updated on 1/11/23 to keep her in the common areas while awake.<br><br>On 1/12/23 at 12:27 p.m., IDT met regarding her fall on 1/11/23. She should not ambulate without assistance, but she had no concept of the possibility of injury. Staff heard her calling out, they entered her room to find her sitting on the floor on her bottom next to the bed. (Was in bed and fell out). She was confused per her normal and unable to articulate what happened, assessment found no apparent injuries. She was generally weak and appears fretful. She was assisted to bed and positioned for comfort. She was to remain in the common areas while awake. Her care plan was reviewed and updated as needed.<br><br>On 1/17/23 at 1:15 p.m., she was found on the floor in the unit dining room. She appeared to have landed on her left hip and possibly had hit her head. Staff was unable to move her and 911 was | | | |

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| | called for transport to ER for evaluation.<br>A fall risk assessment, dated 1/17/23, indicated she was at a high risk for falling.<br><br>Her care plan was updated on 1/17/23 to send her to ER for evaluation and treatment.<br><br>On 1/17/23 at 7:00 p.m., she returned to the facility with no new orders and was cleared of no injuries noted from fall. She was transferred to her bed, her call light was in reach.<br><br>On 1/18/23 at 9:34 p.m., IDT met regarding her fall from 1/17/23. She was noted to be on the floor in dining area of the unit. She landed on her left hip and did hit her head. She complained of pain. Staff kept her still. NP was notified and order received to send to her to ER for evaluation and treatment. She went to ER and returned to facility with no new orders received. Her plan of care was updated and therapy was made aware.<br><br>On 1/23/23 at 7:29 a.m., she was found on the floor beside her bed with no injuries noted. Her bed in lowest position and she had on appropriate footwear.<br><br>A fall risk assessment, dated 1/23/23, indicated she was at a high risk for falling.<br><br>Her care plan was updated on 1/23/23 for her bed to be in the lowest position.<br><br>On 1/23/23 at 9:50 a.m., IDT met to discuss her fall from earlier that morning. She was noted to be on floor beside bed with no apparent injury and she voiced no complaints of pain. Her plan of care was updated.<br><br>Her care plan was updated on 1/25/23 that she | | | |

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| | needed activities that minimized the potential for falls while providing diversion and distraction such as coloring, interacting with peers/staff, and getting her nails painted.<br><br>A fall risk assessment, dated 2/4/23, indicated she was at a high risk for falling.<br><br>Her care plan was updated on 2/4/23, as bright tape was added to call light as a visual cue for use.<br><br>The clinical record lacked nurses notes regarding a fall on 2/4/23.<br><br>On 2/5/23 at 6:38 a.m., she was resting in bed, no complaints of distress. Her call light was within reach and 15-minute checks continued. She had not attempted to self-transfer.<br><br>On 2/6/23 at 10:40 a.m., IDT met to discuss her fall from 2/4/23. She appeared to have slide out of bed due to attempting to self-transfer. She was sitting on the floor with her back leaned against bed. No apparent injuries with no signs of discomfort. Therapy was made aware. Her plan of care was updated.<br><br>On 2/6/23 at 10:44 a.m. IDT note indicated the intervention for her fall was bright tape added to call light as a visual cue for use.<br><br>3. On 2/16/23 at 9:20 a.m., Resident E sat in front of the nurses station in a facility chair, drinking from a foam cup.<br><br>On 2/16/23 at 2:01 p.m., she sat in a recliner in the room across from the nurses station, with her legs elevated as she was looking at a book | | | |

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| | Resident E's clinical record was reviewed on 2/16/23 at 2:12 p.m. Diagnoses included Alzheimer's disease, unspecified psychosis not due to a substance or known physiological condition, dementia in other diseases classified elsewhere, moderate, with psychotic disturbance, depression, epilepsy, essential (primary) hypertension, age-related osteoporosis without current pathological fracture, muscle weakness (generalized), and other abnormalities of gait and mobility.<br><br>Her medications included divalproex sodium 250 mg twice daily, apixaban (blood thinner) 2.5 mg twice daily, escitalopram oxalate (treat depression) 10 mg daily, and risperidone (treat mood disorder) 0.25 mg twice daily.<br><br>An admission MDS, dated 1/23/23, indicated she was severely cognitively impaired. She required extensive assistance of one staff member for bed mobility, dressing, toilet use, and personal hygiene. She required limited assistance of one staff member for transfers, walk in room/corridor, locomotion on/off unit. She used a walker. She wandered daily and it placed her at a significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility).<br><br>She had a care plan for risk for falls related to Alzheimer's, dementia, seizures, impaired mobility, psychosis and effects of medications, initiated on 1/14/23. Her interventions initiated on 1/14/23 were assist with toileting and transfers, assistive device was a walker, ensure another resident's mat was put up when he was not in bed. She was to utilize non-skid footwear initiated on 1/15/23.<br><br>A fall risk assessment, dated 1/13/23, indicated she was at a high risk for falling. | | | |

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Her nurses notes indicated the following:

On 1/14/23 at 11:47 a.m., she had fallen in another resident's room. She didn't know why she fell, but stated she bumped the left side of her head. The resident other resident stated, "she fell over the mat." No other injuries were noted.

A fall risk assessment, dated 1/14/23, indicated she was at a high risk for falling.

On 1/15/23 at 9:00 a.m., IDT met to discuss her fall on 1/14/23. She was on the floor in another resident's room. The other resident stated she fell over his mat. She had no apparent injury and denied pain. Staff was to ensure the other resident's bedside mat was put up when he was not in bed. Her plan of care was updated and therapy was made aware.

On 1/15/23 at 12:21 p.m., she was found on the floor by the nurses station. She was laying on her back. She had a hematoma to her left forehead. She was an extensive assistance of two staff members to her feet. No rotation noted to her hips.

On 1/16/23 at 9:22 a.m., IDT met to discuss her fall from 1/15/23. She was on floor by the nurses station on her hall. She sustained a hematoma to her left forehead. She had no signs of pain. First aid was provided. She was to utilize non-skid footwear when up. Her plan of care was updated and therapy was made aware.

On 1/16/23 at 3:06 p.m., she continued to have an unsteady gait and wandered without her rolling walker.

On 1/21/23 at 4:33 p.m., she stood in the hall/near

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| | nurse station and was witnessed falling onto her right side. She bumped her head as she slid to the floor. Staff was nearby although not close enough to catch her. She was assessed for injuries. She had a small skin tear on her right elbow. The nurse was able to approximate it with steri-strips.<br><br>A fall risk assessment, dated 1/21/23, indicated she was at a high risk for falling.<br><br>Her care plan was updated on 1/21/23 to assist/encourage her to use her walker.<br><br>On 1/22/23 at 3:46 a.m., she was found on floor at her bedside, no injuries were noted.<br><br>A fall risk assessment, dated 1/22/23, indicated she was at a high risk for falling.<br><br>Her care plan was updated on 1/22/23 for her bed to be in the lowest position.<br><br>A care plan for a skin tear to her right elbow related to a fall was initiated on 1/22/23.<br><br>On 1/22/23 at 9:25 p.m., IDT met to discuss her fall on 1/21/23. She stood in the hall near the nurses station without her walker and fell to her right side, without notice. She sustained a skin tear to her right elbow. Staff were to encourage/assist her to utilize her walker. Her plan of care was updated and therapy was made aware.<br><br>On 1/22/23 at 9:36 a.m., IDT met to discuss her fall from earlier this a.m. Staff walked by the room and she was on the floor by her bed. She could not state what she was doing. No apparent injury was noted. Her plan of care was updated and therapy was made aware. | | | |

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| | On 1/22/23 at 10:56 a.m., when collecting her vital signs, she indicated her hand was sore. She had a significant swelling on top of right wrist. She squeezed with both hands and she squeezed harder with her left hand.<br><br>On 1/22/23 at 12:09 p.m., a soft nodule observed on her right hand. She was able to move it freely without difficulty. Does not articulate pain well although she denied it hurting with movement. No bruising was on surface of her skin, her grasps were within normal limits. She was placed on the NP list for further assessment.<br><br>On 1/23/23 at 8:24 a.m., she complained of pain in her right hand, she unable to squeeze with her hand and she was tearful with movement. Tylenol (pain reliever) was given per order. Her hand had a hard nodule on top with swelling to whole hand and wrist.<br><br>On 1/24/23 at 5:51 a.m., she was in bed resting with her eyes closed at prior bed check. She stated she was getting up to come check on staff and she fell. She was found on buttocks near doorway.<br><br>A fall risk assessment, dated 1/24/23, indicated she was at a high risk for falling.<br><br>Her care plan was updated on 1/24/23 for a urinary analysis and culture and sensitivity.<br><br>On 1/24/23 at 9:38 a.m., IDT met to discuss her fall from earlier that morning. She was on her buttocks near her doorway. She had gotten out of bed per herself and stated, "checking on staff." She had no apparent injury. NP notified with new order received to do a urinary analysis and culture and sensitivity due to her increased confusion. Her | | | |

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| | plan of care was updated and therapy was made aware.<br><br>On 1/24/23 at 5:00 p.m., a new order was received per NP to send her to the ER for evaluation and treatment. She had increased confusion, attempting to walk through walls, and picking up furniture. .<br><br>On 1/26/23 at 8:28 a.m., she continued on an antibiotic for UTI (Urinary Tract Infection).<br><br>On 2/1/23 at 12:04 p.m., she was walking around with an unsteady gait. She was educated on using a walker with no comprehension. Staff tried to assist her to dining room to sit and she kicked staff and started to throw herself backwards, staff caught her and walked her to nurses station to sit in a chair. She was toileted and fluids were offered.<br><br>Her care plan was updated on 2/2/23 to anticipate and meet her needs.<br><br>During an interview with LPN 7, on 2/16/23 at 9:25 a.m., she indicated there were eleven residents on the unit. Typically, there was one aide and one nurse on duty on the unit, and the same was on the evening shift and night shift. Although sometimes there was just a QMA in the unit on night shift.<br><br>During an interview with QMA 35, on 2/17/23 at 9:18 a.m., she indicated they tried to keep someone near the nurse's station to supervise the residents. They tried to staff a nurse and two CNAs on the unit, but sometimes the CNA would get pulled to a different part of the facility. About half of a seven-day period, three to four days they would work with two CNAs and a nurse or a | | | |

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| | QMA.<br><br>During an interview with QMA 27, on 2/17/23 at 11:49 a.m., she indicated Resident E was persistent she was going walk. She was unsteady on her and needed reminders to keep her walker with her. She liked to be on the go, and she was the resident who wandered the most. Resident C would kick her feet over the edge of her bed and come to the nurses station and say "see - I'm up". There was normally a QMA and two CNAs that worked the unit if everyone showed up. She could work with just her and a strong CNA.<br><br>A 10/14 policy, titled "FALL PREVENTIONS PROGRAM," provided by the ADON on 2/17/23 at 1:18 p.m., indicated the following: "...POLICY...Identified residents shall be monitored by the IDT in an effort to implement prevention interventions that minimize occurrence of falls thereby minimizing resident risk of injury...."<br><br>3.1-45(a) | | | |