STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

(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. This visit included the Investigation of Complaint IN00434485. Complaint IN00434485- Federal/State deficiencies related to the allegations are cited at F-600. Survey dates: May 30, 31 and June 3, 4 & 5 2024 Facility number: 000135 Provider number: 155230 AIM number: 100266820 Census Bed Type: SNF/NF: 88 SNF: 7 Total: 95 Census Payor Type: Medicare: 6 Medicaid: 77 Other: 12 Total: 95 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 11, 2024	F 0000	Dear Brenda Buroker, Attached is Rosebud Village's plan of correction for annual survey completed on 6/5/24. Rosebud Village is requesting paper compliance for all deficiencies written in the 2567. Please accept the plan of correction as written. Thank you, Kari Alcorn, HFA Executive Director Rosebud Village	
F 0558 SS=E Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kari Alcorn	Executive Director	06/28/2024

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

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	or other residents. Based on interview, observation, and record review, the facility failed to ensure residents had water or beverages of choice available for 4 of 4 residents reviewed for accommodation of needs. (Resident 2, Resident 89, Resident 54, and Resident C) Findings include: 1. The clinical record for Resident 2 was reviewed on 6/3/2024 at 1:55 p.m. The clinical diagnosis included dementia. A Minimum Data Set (MDS) Assessment, dated 3/28/2024, indicated Resident 2 was cognitively impaired and needed set up assistance for eating tasks. A care plan intervention, dated 5/4/2015, indicated to encourage fluids for Resident 2. An observation and interview on 6/4/2024 at 11:30 a.m., indicated Resident 2 laying in bed at this time with her television on. Resident 2 stated she was very thirsty and hungry. No drink was available in Resident 2's room at this time. 2. During an observation on 5/30/24 at 12:53 p.m., Resident 54 was sitting in a wheelchair in his room, there were no fluids available in his room, the resident had an a empty medication cup on the bedside table. During an observation on 5/31/24 at 11:20 a.m., Resident 54 had no fluids available in room his room, the resident had an empty medication cup on the bedside table. During an observation on 6/3/24 at 10:46 a.m., Resident 54 had no fluids available in his room.	F 0558	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Residents 2, 89, 54 and C were provided with beverages of choice. • Facility will ensure that residents receive beverages of choice per policy and as needed/requested. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? • All residents have the potential to be affected by the alleged deficient practice. • An audit will be completed to ensure that all residents have water pitchers at their bedside unless otherwise contraindicated. • All nursing staff will be in-serviced on providing all residents with beverages of choice and having water pitchers at bedside by the DNS or designee by 7/12/24. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • All nursing staff will be in-serviced on providing all residents with beverages of choice and having water pitchers at bedside by the DNS or designee by 7/12/24.	07/12/2024

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	During an observation on 6/3/24 at 2:26 p.m., Resident 54 was lying in bed, there were no fluids available in his room. During an observation on 6/4/24 at 9:58 a.m., Resident 54 had no fluids available in his room. Review of the record of Resident 54 on 6/5/24 at 12:11 a.m., indicated the resident's diagnoses included, but were not limited to, osteoarthritis, cognitive communication deficit, moderate intellectual disabilities, vitamin D deficiency, hypomagnesemia, hypokalemia, gastro-esophageal reflux, and seizures. 3. During an interview with Resident C on 5/30/24 at 1:53 p.m., indicated the facility was not good to provide fresh water daily. The resident indicated she bought pop but would rather have fresh water provided. During an observation on 5/30/24 at 2:00 p.m., Resident C did not have any fluids in her room. During an observation on 5/31/24 at 11:29 a.m., Resident C did not have any fluids in her room. During an observation and interview on 6/3/24 at 10:48 a.m., Resident C had a water pitcher in her room that was half full and warm to the touch. Resident C indicated the water was from two days ago. During an observation on 6/3/24 at 12:10 p.m., Resident C had a water pitcher in her room that was half full and warm to the touch. During an observation and interview on 06/04/24 at 9:59 a.m., Resident C had a water pitcher in her room that was half full and warm to the touch.		• DNS or designee will complete rounds during GEMBA to ensure that all residents have water pitchers at bedside and receive beverages of choice. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • Ongoing compliance with this corrective action will be monitored via facility QAPI program with meetings held bi-monthly and overseen by the Executive Director. • Accommodation of Needs QAPI tool will be completed weekly x 4 weeks, monthly x 6 months. • If the threshold of 95% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed. • Completion date: 7/12/24	

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	Resident C indicated the water was from yesterday. Review of the record of Resident C on 6/4/24 at 2:15 p.m., indicated the resident's diagnoses included, but were not limited to, hemiplegia, depression, anxiety, muscle weakness and unsteady on feet. The Quarterly Minimum Data Set (MDS) for Resident C, dated 3/12/24, indicated the resident was cognitively intact for daily decision making. The resident was consistent and reasonable. 4. During an observation on 5/31/24 at 11:26 a.m., Resident 89 was lying in bed, the resident had no fluids available in her room. During an observation on 6/03/24 at 10:46 a.m., Resident 89 had no fluids available in her room. During an observation on 6/03/24 at 12:09 p.m., Resident 89 had no fluids available in her room. During an observation on 6/04/24 at 9:58 a.m., Resident 89 had no fluids available in her room. Review of the record of Resident 89 on 6/5/24 at 12:20 p.m., indicated the resident's diagnoses included, but were not limited to, diabetes, dementia, constipation, anxiety, unsteady on feet, muscle weakness and anxiety. During an interview with the Director of Nursing (DON) on 6/4/24 at 11:30 a.m., indicated the Certified Nursing Assistants (CNAs) were responsible to ensure residents were provided fresh water. The facilities protocol was fresh water would be passed to residents once a shift.			

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	The hydration management policy provided by the DON on 6/4/24 at 1:40 p.m., indicated fresh water would be passed to all residents. 3.1-3(v)(1)			
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally			

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	(meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required			

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	by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. Based on interview and record review, the facility failed to fill out a grievance regarding missing items for 1 of 2 residents interviewed for missing items. (Resident 92) Findings include: An interview conducted with Family Member 9 on 05/30/24 at 12:18 p.m., indicated Resident 92 was missing her bottom dentures since 5/28/24 and a pair of tennis shoes since 5/14/24. Family Member 9 indicated that she reported both of these missing items to the Dementia Care Director on	F 0585	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • A grievance form was completed for resident 92. • Facility will ensure that grievances are completed per policy. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action	07/12/2024

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	5/28/24. An interview conducted with Dementia Care Director on 06/03/24 at 12:14 p.m., indicated that she was made aware of the missing items for Resident 92 by Family Member 9 and she, as well as other staff, had been looking for them. She indicated that she was not sure if a grievance was filled out. She indicated that she did not fill out a grievance because she was new and did not know the policy about filling out a grievance for a resident. An interview conducted with Executive Director (ED) on 06/03/24 12:19 p.m., indicated that anyone can fill out a grievance. That included residents, family, or staff members. She indicated that once the ED looks at the form she determines whether it goes to the department manager or if she needs to handle it herself. The ED indicated that they try to address them immediately but it can take up to 72 hours. And they educate staff on how to initiate grievances for residents. The clinical record of Resident 92 was reviewed on 5/31/24 at 2:00 p.m. The diagnosis included, but was not limited to, unspecified dementia. The clinical record reviewed on 6/3/24 at 1:45 p.m., indicated that there were no progress notes entered into the resident's record for the month of May regarding any missing items reported or noted. Resident grievance reports for the month of May 2024 were reviewed on 06/03/24 at 12:03 p.m., and indicated there were no grievances filled out for Resident 92 for the month of May. A Resident Concerns and Grievance policy		will be taken? • All residents have the potential to be affected by the alleged deficient practice. • An audit will be completed to ensure that no other residents have unresolved grievances. • All staff will be in-serviced on the facility's grievance policy by ED or designee by 7/12/24. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • All staff will be in-serviced on the facility's grievance policy by ED or designee by 7/12/24. • IDT discussion during administrative meeting will be completed daily to discuss any concerns and resolutions for concerns. • Grievance forms will be located in common areas for easy access. • A letter will be mailed to all resident representatives on the facility's grievance process. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • Ongoing compliance with this corrective action will be monitored via facility QAPI program with meetings held bi-monthly and overseen by the Executive	

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	provided by the ED, on 6/03/24 at 11:12 a.m., indicated resident, representative, or family concerns/grievances occurring during the resident's stay shall be responded to promptly. The Executive Director/Grievance Official shall review all complaints and agree with the actions taken towards resolution. Responses to resident, representative, and/or family shall be made as soon as possible and preferably immediately. 3.1-7(a)(2) 3.1-7(b)		Director. • Grievance Resolution QAPI tool will be completed weekly x 4 weeks, monthly x 6 months. • If threshold of 95% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed. • Completion date: 7/12/24	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, interview and record review the facility failed to prevent sexual abuse of two residents (Resident C and Resident F) perpetrated by (Resident E) and failed to prevent verbal abuse for (Resident B) for 3 of 5 residents reviewed for abuse. Findings include:	F 0600	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Resident C and F were followed for signs and symptoms of psychosocial distress and remain free from signs or symptoms of psychosocial distress.	07/12/2024

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	1. During an observation and interview with CNA 13 on 5/30/24 at 12:57 p.m., indicated she was 1:1 with Resident E because he had touched Resident C inappropriately. Resident E was lying in bed and talked with me but was unable to be understood. During an interview with Resident C on 5/30/24 at 1:50 p.m., indicated about a month ago Resident E grabbed her right breast while she was sitting at the nursing station. It did not bother her that much because she felt like he did not know what he was doing, but it was disrespectful. The resident indicated the Executive Director and Social Services had talked with her about the incident. Review of the incident report provided by the Executive Director (ED) on 6/3/24 at 10:00 a.m., indicated Resident E extending his hand out and made contact with Resident C on 4/29/24. The residents were separated, and Resident E was placed on 1:1. During an interview with the Executive Director (ED) on 6/3/24 at 1:49 p.m., indicated Resident C had not showed any signs of psychosocial response or fearfulness from the incident with Resident E. The ED indicated in the last year Resident E had sexually inappropriate behaviors toward Resident F in March 2024. During an interview with the Social Service Director (S.S.D.) on 6/3/24 at 1:55 p.m., indicated Resident C had not showed any signs of psychosocial response or fearfulness from the incident with Resident E. Review of the record of Resident C on 6/4/24 at 2:15 p.m., indicated the resident's diagnoses		• Resident E no longer resides in the facility. • Resident B was followed for signs and symptoms of psychosocial distress and remains free from signs and symptoms of psychosocial distress. • Facility will ensure that all residents remain free from abuse. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? • All residents have the potential to be affected by the alleged deficient practice. • An audit will be completed to ensure that all residents feel safe in the facility. • All staff will be in-serviced on abuse by the ED or designee by 7/12/24. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • All staff will be in-serviced on abuse by the ED or designee by 7/12/24. • Care Companions will complete rounds weekly with residents and notify ED immediately of any voiced concerns or allegations of abuse. • IDT to complete rounds during GEMBA to ensure residents	

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	included, but were not limited to, hemiplegia, depression, anxiety, muscle weakness and unsteady on feet. The Quarterly Minimum Data Set (MDS) for Resident C, dated 3/12/24, indicated the resident was cognitively intact for daily decision making. The resident was consistent and reasonable. The progress note for Resident C, dated 4/29/24 at 10:36 a.m., (late entry recorded on 5/2/24 at 10:38 a.m.,) indicated the resident was being seen for an initial evaluation and treatment of psyche symptoms per the facility's request. Addressed staff's reports of inappropriate touching by another resident. Applied Cognitive Behavioral Therapy (CBT) (talking therapy) to her manage her anxiety about the situation. The plan was for individual therapy every 2 weeks or as needed, supportive approach, active/emphatic listening, monitor mood and behaviors, motivational interviewing, modified CBT, ongoing consultation with staff. The plan of care for Resident C, dated 4/30/24, indicated the resident was at risk for psychosocial distress related to other resident behaviors. The interventions included, follow up with resident daily for 5 days and monitor for signs and symptoms of psychosocial distress. 2. Review of the incident report provided by the ED on 6/3/24 at 10:00 a.m., indicated on 3/25/24 Resident E grabbed Resident F's breast while in the common area. During an interview with Resident F on 6/04/24 at 10:06 a.m.., indicated Resident E grabbed her breast in the hallway while they were talking. The resident reported it to the nurse because she did		remain free from abuse. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • Ongoing compliance with this corrective action will be monitored via facility QAPI program with meetings held bi-monthly and is overseen by the Executive Director. • Resident to Resident Abuse QAPI tool will be completed weekly x 4 weeks and monthly x 6 months. • Staff to Resident Abuse QAPI tool will be completed weekly x 4 weeks and monthly x 6 months. • If threshold of 95% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed. • Completion date: 7/12/24	

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	not want him to do it to anyone else. The ED and S.S.D. did talk with her about the situation. The resident indicated she was not fearful to be at the facility, that was the first time anything like had happened to her there. Resident E had not bothered her anymore, the resident had seen him in the hallway and just said hi and go on. The resident indicated she was very sensitive when someone touched her when she did not want them to. The resident indicated she did not feel like she any psychosocial harm from this incident. Review of record of Resident F on 6/4/24 at 3:40 p.m., indicated the resident's diagnoses included, but were not limited to, major depressive disorder, anxiety, lack of coordination and muscle weakness. The Quarterly MDS assessment for Resident F, dated 5/24/24, indicated the resident was cognitively intact for daily decision making. The resident was reasonable and consistent. The progress note for Resident F, dated 3/25/24 at 5:26 p.m., indicated the Executive Director (ED) met at length with resident related to the occurrence. No signs or symptoms of psychosocial distress noted. The facility would continue to observe. The progress note for Resident F, dated 4/3/24 at 8:32 p.m., indicated the Nurse Practitioner (NP) was seeing resident per staff request for recent incident taking place. The provider would be evaluating for any psychosocial distress. The resident denied any distress relating to the recent incident. 3. During an observation on 6/04/24 at 10:17 a.m., Resident E was asleep in bed remained 1:1 with			

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	staff. Review of the record of Resident E on 6/4/24 at 3:10 p.m.., indicated the resident's diagnoses included, but were not limited to, vascular dementia, psychotic disturbance, mood disturbance, depression, bipolar disorder, high risk for heterosexual behavior and sexual inappropriate behaviors. The Significant Change Minimum Data Set (MDS) for Resident E, dated 5/24/24, indicated the resident had unclear speech, rarely/never was understood. The resident had the ability to understand others. The resident was cognitively intact for daily decision making. The care plan for Resident E, dated 6/17/22, indicated the resident was observed making inappropriate contact with another resident. The resident had a history of alleged contact with other residents. The interventions included, redirect resident to a different activity if he is in close proximity to female residents, provide space between and other female resident if he was observed to be close in proximity, provide resident with at least 4 feet of distance between him and other residents, follow up with Psych Nurse Practitioner (NP), encourage resident to participate in activities, room change to different hallway, medication change per Psych NP, remove resident from area of female residents when his was within reaching distance and Speech Therapy (ST) to evaluate and collaborate with the Activity Director on activity plan. The progress note for Resident E, dated 3/26/24 at 3:00 p.m., indicated the resident had inappropriate sexual behaviors. The resident was currently taking medroxyprogesterone (hormone) 10			

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	milligrams (mg) once a day discontinue and increase to 20 mg a day for compulsive sexual behaviors. The progress note for Resident E, dated 3/26/24 at 5:22 p.m., indicated another resident alleged this resident touched her inappropriately. The residents were immediately separated and increased checks initiated. The progress note for Resident E, dated 3/28/24 at 10:19 a.m., another resident alleged that resident touched her inappropriately. The root cause was the resident had a companion most of his life and was seeking a companion. The staff increased checks on the resident. The progress note for Resident E, dated 4/4/24 at 6:24 a.m., frequent checks discontinued. The resident had been on increased dose of medication for 7 days with no other incidents noted. The progress note for Resident E, dated 4/29/24 at 12:34 p.m., the resident was started on 15-minute checks. The progress note for Resident E, dated 4/29/24 at 1:07 p.m., the resident's family and NP was notified of the resident behavior of reaching out and making contact with another resident. The resident was placed on 1:1. The progress note for Resident E, dated 4/30/24 at 9:47 a.m., the resident reached out and made contact with another resident's breast. The residents were immediately separated, the resident was placed on 1:1. The resident had a history of sexual inappropriateness. 4. The clinical record for Resident B was reviewed on 5/31/24 at 11:30 a.m.			

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	His diagnoses included, but were not limited to: Alzheimer's disease, major depressive disorder, bipolar disorder, and anxiety. The 4/24/23 care plan, last reviewed/revised 5/23/24, indicated Resident B would cry or yell at times when attention seeking. He was not aware of others' personal space and would often reach out and try to grab others as they walked by. The 4/28/23 behavioral symptoms care plan, last reviewed/revised 5/23/24, indicated Resident B would come out in the hallway in his brief to get help with re-dress; would bang on the table with a soda can to get ice for soda; and would bang on the unit door when he wanted a snack for the store at times. The 5/17/24 behavioral symptoms care plan, last reviewed/revised 5/17/24, indicated Resident B would repeat the same phrase until he got someone's attention and then would continuously move his mouth hands/arms with absence of words. The behavioral symptoms care plan, last reviewed/revised 5/23/24, indicated he exhibited signs and symptoms of attention seeking behavior such as intrusive behavior at times regarding his care as well as other residents' care. He also followed staff around at times. The investigative file into an allegation of abuse involving Resident B was provided by the Administrator on 6/3/24 at 10:00 a.m. The file included the 5/17/24 follow up incident report to the IDOH (Indiana Department of Health.) It indicated on 5/13/24 Resident B was in the activity area exhibiting behaviors towards			

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	others when AA (Activity Assistant) 3 raised her voice and used inappropriate language with Resident B. An interview was conducted with the Administrator on 6/3/24 at 1:33 p.m. She indicated it was her understanding AA 3 was in the common area of the Cottage with another resident trying to provide redirection for him. Resident B kept coming over, so she was redirecting him to the television. After several times, AA 3 got frustrated and used a curse word, not to him, but in the sentence that she said. The sentence was "Stop it [name of Resident B,] G** D***." Multiple staff witnessed it, including the DCD, who made sure Resident B was safe. CNA 4 called the Administrator who interviewed AA 3 in the DCD's office and escorted her to the time clock to punch out and leave. On 6/4/24 at 10:20 a.m., the Administrator provided a timeline of the investigation and documented Staff Abuse Questionnaires with the DCD (Dementia Care Director,) CNA (Certified Nursing Assistant) 4, LPN (Licensed Practical Nurse) 5, and OT (Occupational Therapist) 6. The 5/13/24 Staff Abuse Questionnaire for the DCD indicated she'd witnessed an employee abusing or mistreating a resident. It read, "[Name of AA 3] yelled when talking with a resident & said G.D. [G** D***] The 5/13/24 Staff Abuse Questionnaire for LPN 5 indicated she'd witnessed an employee abusing or mistreating a resident. It read, "Activities Assist raised voice at resident to get away and said G.D." The 5/13/24 Staff Abuse Questionnaire for CNA 4 indicated she'd witnessed an employee abusing or			

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	mistreating a resident. It read, "I was giving a shower, & heard [name of AA 3] raise her voice, and said a curse word! The curse word was G.D." The 5/13/24 Staff Abuse Questionnaire for OT 6 indicated she'd witnessed an employee abusing or mistreating a resident. It read, "While in the Cottage area I saw the activity aide become upset with a resident and then yelled at the resident." The timeline included the 5/13/24 interview with AA 3 conducted by the Administrator. It read, "[Name and title of AA 3] states that she raised her voice and used inappropriate language with resident. [Name and title of AA 3] states that she said D*****." The Abuse Prohibition, Reporting, and Investigation policy was provided by the Administrator on 5/30/24 at 12:25 p.m. It read, "It is the policy of [name of facility] to provide each resident with an environment that is free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to verbal abuse, sexual abuse, physical abuse, mental abuse, corporal punishment, and involuntary seclusion....Sexual Abuse - Nonconsensual sexual contact of any type with a resident. Examples may include but not be limited to fondling, touching, rubbing, exposing, licking, kissing, gestures, sharing pornography, assault, rape, harassment, seduction, coercion, photographing a resident's rectal, genital, or breast areas, and/or exhibitionism. Verbal Abuse - The use of oral, written, and/or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance, regardless of their age, ability to comprehend, or disability. This includes any episode of staff to resident, and verbal threats of			

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	harm by resident to resident. This does not include random statements of a cognitively impaired resident such as repetitive name calling or nonsensical language." This Federal tag relates to Complaint IN00434485. 3.1-27(a)(1) 3.1-27(b)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview, observation, and record review, the facility failed to ensure a resident had compression stockings in place without wrinkles for 3 of 4 observations of Resident 94's compression stockings. Findings include: The clinical record for Resident 94 was reviewed on 6/4/2024 at 11:00 a.m. The medical diagnosis included heart failure. A physician order for 94, dated 4/29/2024, indicated to place thigh high bilateral lower extremity TED hose (compression stockings) in the morning and remove them at night. A care plan intervention, dated 3/29/2024,	F 0684	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Resident 94's compression stockings were adjusted to remove wrinkles. • Facility will ensure that all compression stockings will be applied without wrinkles. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? • All residents who wear compression stockings have the	07/12/2024

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	indicated for Resident 94 to utilize bilateral thigh high TED hose in the morning and remove them at night. An observation and interview on 5/31/2024 at 11:25 a.m. indicated that Resident 94 was sitting in his wheelchair at this time. He was wearing a pair of white compression stockings. The stockings were noted to be wrinkled at the knee joints on both legs. Two additional wrinkles were noted to the left stocking at about a third of the way between the ankle and knee and halfway between the ankle and knee. An additional wrinkle was noted halfway between the ankle and knee on the right leg. Resident 94 indicated the "girls", in reference to the staff, placed his compression stockings in the morning. He stated he could "fix" the wrinkles at the top, but he is not able to straighten the ones lower in his legs. He stated these stockings typically have wrinkles. During this interview and observation, CNA 2 knocked and came into the room to remind Resident 94 that it was almost lunch time. An observation and interview with Resident 94 on 6/3/2024 at 11:47 a.m. indicated he was sitting in his wheelchair with his compression stockings in place. The stockings were noted to be wrinkled at the knee joints on both legs. Two additional wrinkles were noted to the left stocking at about a third of the way between the ankle and knee and halfway between the ankle and knee. He stated that the wrinkles do not hurt, but there are lines on his legs when they take them off at bedtime. He exhibited how he was able to smooth the tops of the stockings around the knee joints but was unable to smooth the wrinkles lower in his legs. An observation on 6/4/2024 at 9:40 a.m. indicated Resident 94 was sitting in wheelchair at this time.		potential to be affected by the alleged deficient practice. • An audit will be completed to ensure that all residents who utilize compression stockings, do so without wrinkles. • All nursing staff will be in-serviced on applying compression stockings by the DNS or designee by 7/12/24. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • All nursing staff will be in-serviced on applying compression stockings by the DNS or designee by 7/12/24. • DNS or designee will round during GEMBA to ensure compression stockings are applied correctly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • Ongoing compliance with this corrective action will be monitored via facility QAPI program with meetings held bi-monthly, and is overseen by the Executive Director. • Accommodation of Needs QAPI tool will be completed weekly x 4 weeks, monthly x 6 months. • If threshold of 95% is not met, an action plan will be developed to	

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	Resident 94 was self-propelling in his wheelchair at this time with his bilateral compression stockings wrinkled at the top. Two additional wrinkles were noted to the right stocking at about a third of the way between the ankle and knee and halfway between the ankle and knee. An additional wrinkle was noted halfway between the ankle and knee on the left leg. An interview with the Director of Nursing on 6/4/2024 at 11:40 a.m. indicated that there was not a specific policy for TED hose, but it is the expectation that TED hose would be applied when ordered and be without wrinkles due to the increased risk of developing skin impairments. 3.1-37(a)		ensure compliance. By what date the systemic changes will be completed. • Completion date: 7/12/24	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview, observation, and record review, the facility failed to implement a fall intervention of a sign in Resident 88's room to encourage the use of a call light for a resident with a moderate fall risk and recent history of a fall for 1 of 2 residents reviewed for falls. Findings include:	F 0689	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Resident 88 is no longer at the facility. • Facility will ensure that fall interventions are in place for all residents.	07/12/2024

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	The clinical record for Resident 88 was reviewed on 6/4/2024 at 1:30 p.m. The medical diagnosis included malignant neoplasm of the kidney. A Significant Change Minimum Data Set Assessment, dated 5/2/2024, indicated that Resident 88 was cognitively intact. A fall risk assessment, dated 4/25/2024, indicated that Resident 88 was at moderate risk for falls. A fall intradisciplinary note, dated 5/20/2024, indicated that Resident 88 had a fall on 5/19/2024 with an intervention put in place of a "sign in room to encourage resident to use his call light for assistance". A fall care plan intervention, dated 5/20/2024, indicated for Resident 88 to have a sign in his room to encourage resident to use a call light for assistance. An observations and interview with Resident 88, on 5/20/2024, indicated that he has a recent fall from his bed when he was trying to reach his trash can. When asked what interventions were placed after his fall, he indicated he was not sure. No sign to encourage the use of a call light was present in Resident 88's room. An observation and interview on 5/31/2024 at 12:54 p.m. indicated that no sign to encourage the use of a call light was present in Resident 88's room. Resident 88 stated that he had never seen a sign to encourage the use of his call light. An observation and interview on 6/3/2024 at 1:40 p.m. completed with LPN 1 in Resident 88's room indicated that no sign to encourage the use of a call light was present in his room. LPN 1 indicated		How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? • All residents have the potential to be affected by the alleged deficient practice. • An audit will be completed to ensure that all residents have fall interventions and/or safety interventions in place per policy and per care plan. • All managers will be in-serviced on fall interventions/safety interventions and utilization of resident profile sheets to ensure interventions are in place. • All staff will be in-serviced on fall interventions/safety interventions by the DNS or designee by 7/12/24. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • All staff will be in-serviced on fall interventions/safety interventions by the DNS or designee by 7/12/24 • All managers will be in-serviced on fall interventions/safety interventions and utilization of resident profile sheets to ensure interventions are in place. • DNS or designee will round during GEMBA to ensure fall interventions / safety interventions are added as needed.	

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	she had not ever seen that sign in his room. A policy, entitled "Fall Management Policy", was provided by the Administrator on 6/4/2024 at 10:30 a.m. The policy indicated, " ...Facilities must implement comprehensive, resident-centered fall preventions plans for each resident at risk for falls or with a history of falls ..." and "Residents who are categorized as moderate to high risk should have fall interventions implements based on resident specific risk factors ..." 3.1-45(a)(2)		• Care companions to complete rounds weekly utilizing resident profile sheets to ensure interventions remain in place. • IDT will complete Safety Rounds monthly for each resident to ensure interventions remain in place. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • Ongoing compliance with this corrective action will be monitored via facility QAPI program with meetings held bi-monthly and is overseen by the Executive Director. • Fall Management QAPI tool will be completed weekly x 4 weeks, monthly x 6 months. • If threshold of 95% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed. Completion date: 7/12/24	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the			

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	facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to provide adaptive eating equipment, fortified juice, and whole milk to 3 of 6 residents reviewed for nutrition. (Residents 6, 58, and 65) Findings include: 1. The clinical record for Resident 58 was reviewed on 5/31/24 at 11:40 a.m. Her diagnoses included, but were not limited to, dementia, severe protein calorie malnutrition, and dysphagia. The 5/23/24 Follow Up Nutrition Review indicated the current nutrition prescription was a regular diet with divided plate and cup with lid for hot beverages and fortified juice at all meals. It read, "Trending weight loss has occurred at 30, 90, and 180 days." The physician's orders indicated for her to be served a regular diet and read, "Special Instructions: Large entree at dinner. Divided plate	F 0692	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Resident 58 was provided with a divided plate and fortified juice. • Resident 6's divided plate was removed from her restorative care plan. Resident 6 did not have an order for a divided plate and does not require a divided plate. • Resident 65 was provided with whole milk. • Facility will ensure that all residents receive adaptive eating devices and supplements per physician's orders. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? • All residents who have orders for	07/12/2024

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	and cup with lid for hot beverages. Fortified juice with all meals," starting 5/24/24. The 4/16/21 nutritional status care plan indicated she had unintended weight loss and a BMI (body mass index) less than 22 due to pain with swallowing causing decreased oral intake. Approaches were fortified juice with all meals, starting 1/19/24 and divided plate, starting 12/4/23. An observation of Resident 58's lunch meal was made on 5/31/24 at 12:10 p.m. in her room. She had a sandwich, beans, and ice cream. Her food was served on a regular plate, not a divided plate. There was no fortified juice on her tray. An interview and observation of Resident 58's lunch meal was conducted with LPN (Licensed Practical Nurse) 8 on 5/31/24 at 12:14 p.m. in Resident 58's room. She indicated Resident 58 was supposed to have a divided plate and fortified juice but didn't. The Administrator provided a copy of Resident 58's 5/31/24 lunch meal ticket on 5/31/24 at 1:00 p.m. It read, "FORTIFIED JUICE - 6 OZ...DIVIDED PLATE." 2. The clinical record for Resident 6 was reviewed on 5/31/24 at 11:45 a.m. Her diagnoses included, but were not limited to, dementia and dysphagia. The 4/15/24 care plan indicated she required an eating program to maintain current functional status and prevent further weight loss. The goal was for her to feed herself at least 50% of meals daily with cues for small bites and slow rate. An approach was for her to use a divided plate, starting 4/17/24.		adaptive eating devices and supplements have the potential to be affected by the alleged deficient practice. • An audit will be completed to ensure that all residents receive adaptive eating devices and supplements as ordered. • All culinary staff will be in-serviced on adaptive eating devices and supplements by the ED or designee by 7/12/24. • All staff will be in-serviced on adaptive eating devices and supplements by the ED or designee by 7/12/24 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • All culinary staff will be in-serviced on adaptive eating devices and supplements by the ED or designee by 7/12/24 • All staff will be in-serviced on adaptive eating devices and supplements by the ED or designee by 7/12/24. • Culinary Manager or designee will complete tray audits to ensure that all residents with orders for adaptive eating devices and supplements receive them. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?	

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	An observation of Resident 6 was made on 5/31/24 at 12:00 p.m. in the dining room during the lunch meal. Her meal was served on a regular plate, not a divided plate. An interview and observation of Resident 6's meal was made with LPN (Licensed Practical Nurse) 8 on 5/31/24 at 12:16 p.m. She indicated she was unsure if Resident 6 was supposed to have a divided plate or not, so she reviewed the above 4/15/24 care plan in the electronic health record and indicated she now saw the divided plate approach. The Administrator provided a copy of Resident 6's 5/31/24 lunch meal ticket on 5/31/24 at 1:00 p.m. It did not reference a divided plate. 3. The clinical record for Resident 65 was reviewed on 5/31/24 at 11:50 a.m. Her diagnoses included, but were not limited to, dementia, severe protein calorie malnutrition, and dysphagia. The 5/17/24 Follow Up Nutrition Review indicated the current nutrition prescription was a regular diet with whole milk at meals, ice cream at lunch and dinner, regular consistency per family choice. The physician's orders indicated for her to be served a regular diet and read, "Special Instructions: Whole milk with meals, ice cream with lunch & dinner. Regular consistency, per resident/family choice," starting 3/7/24. The 8/11/20 nutritional status care plan indicated she was at risk for unintentional weight loss related to progressive dementia, dysphagia, and severe protein calorie malnutrition. The goal was for her to have a gradual weight gain towards her usual body weight of 125-130 pounds. An		• Ongoing compliance with this corrective action will be monitored via facility QAPI program with meetings held bi-monthly and is overseen by the Executive Director. • Tray Accuracy QAPI tool will be completed weekly x 4 weeks, monthly x 6 months. • If threshold of 95% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed. Completion date: 7/12/24	

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	approach was whole milk with meals. The Vitals Section of the electronic health record indicated her most recent weight was 120 pounds on 5/7/24. An observation of Resident 65's lunch meal was made on 5/31/24 at 12:08 p.m. in the dining room. She did not have whole milk. An interview and observation of Resident 65's lunch meal was conducted with LPN (Licensed Practical Nurse) 8 on 5/31/24 at 12:18 p.m. in the dining room. She reviewed the electronic health record and indicated Resident 65 was supposed to have whole milk with meals. Then she observed Resident 65's meal tray and pointed to her meal ticket which read, "WHOLE MILK - 8 OZ." The Adaptive Eating Devices policy was provided by the Administrator on 6/3/24 at 10:10 a.m. It read, "Adaptive eating devices are available for those who need them. PROCEDURE 1. Residents are reviewed on admission, and as needed for need of adaptive devices. Referrals for equipment may come from Therapy, Nursing, Physician, Registered Dietitian and/or the Culinary Manager. 2. Physician order is needed for all adaptive eating devices and the need for the adaptive equipment will be documented/care planned. 3. The type of adaptive equipment needed will be listed on the tray ticket and culinary will provide as ordered." The Supplements and Nourishments policy was provided by the Administrator on 6/3/24 at 10:10 a.m. It read, "It is the policy of this facility to ensure residents receive supplements and nourishments appropriate to their nutritional needs, physician's order, and preferences...The			

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	Nursing Department is responsible for providing the items to the residents....A physician's order: ...Is not required but is encouraged, to improve communication, for nourishments that are regular foods, i.e. ice cream, whole milk, fortified foods and shakes." 3.1-46(a)(2)			
F 0744 SS=E Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record review, the facility failed to provide their scheduled activity program on the Cottage Unit of the facility; implement and educate staff regarding a residents' individualized activity care plan; and redirect a resident with a history of wandering into other residents' rooms for 7 of 28 residents on the Cottage Unit of the facility. (Residents 6, 49, 35, 52, 60, 65, and 92) Findings include: 1. An observation of the common area of the Cottage Unit was conducted on 5/31/24 at 11:36 a.m. The common area of the unit was a very large room that consisted of a television area in the front corner with recliners around it. There was a sink and counter space in the opposite front corner of the room. It also served as the dining room with enough tables to accommodate the current census of 28 residents on the unit. Several of the tables were pushed together and served as	F 0744	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Residents 6, 49, 35, 52, 60, 65, and 92 activity preferences were reviewed. • Residents 6, 49, 35, 52, 60, 65, and 92 were provided activities based on their activity preferences and calendar. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? • All residents have the potential to be affected by the alleged deficient practice. • An audit will be completed to ensure that the activity calendar meets the needs of the current	07/12/2024

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	the group activity tables as well as dining room tables. There were couches in the back of the common area. There were 17 residents in the common area at this time, and there were no group activities occurring. Staff were passing out drinks to residents in the dining room just prior to lunch service. The group activity schedule on the wall indicated Dining Room Helpers at 11:30 a.m., but no residents were observed helping at this time. An interview was conducted with Family Member 10 in the common area of the Cottage Unit on 5/31/24 at 11:51 a.m. She was sitting at a dining room table with her husband prior to the lunch meal. She indicated she came to the facility daily around 11:00 a.m. and would stay for lunch and dinner. Group activities weren't usually going on while she was there. She'd seen bingo after lunch before, "but that's it." An observation of the common area of the Cottage Unit was made on 6/4/24 at 11:23 a.m. The group activity calendar on the wall indicated Baking as an activity at 11:00 a.m., but there was no baking or any other group activity occurring at this time. Resident 35 was sitting at the activity/dining room table with a soda. Resident 35's cognitive loss/dementia care plan, last reviewed/revised 5/16/24, indicated an approach was to encourage participation in daily activities particularly regarding orientation, socialization, and stimulation. An observation of the common area of the Cottage Unit was made on 6/4/24 at 1:36 p.m. The group activity calendar on the wall indicated Paint & Polish as an activity at 1:00 p.m. Resident 35 was observed sitting at the activity/dining room table, but there was no Paint & Polish or other		resident population. • All activity staff will be in-serviced on activity programming based on current resident population and adherence to activity calendar by the ED or designee by 7/12/24. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • All activity staff will be in-serviced on activity programming based on the current resident population and adherence to activity calendar by the ED or designee by 7/12/24 • Memory Care Support Specialist or designee will ensure that activities are carried out per calendar. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • Ongoing compliance with this corrective action will be monitored via facility QAPI program with meetings held bi-monthly and is overseen by the Executive Director. • Meaningful Day Program & Engagement QAPI tool will be completed weekly x 4 weeks, monthly x 6 months. • If threshold of 95% is not met, an action plan will be developed to	

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	group activity occurring at this time. There were 8 other residents in the area at this time, but none of them were participating in any activity. Resident 60 was sitting in a chair by the window with the back of his head against the window with his eyes closed and snoring. On 6/4/24 at 1:51 p.m., Receptionist 11 was observed standing at a dining room table in the common area with nail/polish supplies but was not currently providing nail/polish to any of the residents. An interview was conducted with her at this time. She indicated she used to work in the activity department, but now normally worked at the front desk, and was just filling in for the afternoon, because there was a shortage of activity assistants. She did nails for 2 residents today but the rest of the residents refused. This morning, AA (Activity Assistant) 12 was doing activities on the unit. An observation of Resident 35 was made on 6/4/24 at 1:54 p.m. He remained at the activity/dining room table, but now his eyes were closed. The television was on in the corner of the room, but he was not watching it, and it was quite a distance away from him. An interview was conducted with LPN (Licensed Practical Nurse) 8 on 6/4/24 at 1:48 p.m. She indicated the DCD (Dementia Care Director) was in charge of the activity program on the unit. An interview was conducted with the DCD on 6/4/24 at 2:04 p.m. She indicated she'd been in her position since December 2023, and was previously an activity assistant, mostly on other units of the facility. The activity program on the Cottage Unit was different than the rest of the facility. It was more routine and geared towards residents with		ensure compliance. By what date the systemic changes will be completed. Completion date: 7/12/24	

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	dementia. She did not believe the baking activity occurred at 11:00 a.m. earlier today, because AA 12 said she ran out of time. They lost 3 of their activity staff in the last 6 weeks. There used to be a consistent activity assistant on the Cottage Unit from 9:00 a.m. to 8:30 p.m., who conducted mostly group activities. During nail time today, they had a movie playing on the television for the rest of the residents. Of the current census, in her opinion, roughly 8-15 residents were able to participate in bingo. Some just didn't like it and some didn't come out of their room. The activity care plan for Resident 6, last reviewed/revised 6/3/24, indicated she enjoyed independent activity pursuits such as watching television, reading, listening to music, and coloring. An approach was "Offer items for room (Books, magazines, puzzles.") An observation and interview with Resident 6 in her room was made on 6/4/24 at 11:27 a.m. She was lying awake in bed. Her eyes were open. The television was on a sports channel, but the volume was not audible, and Resident 6 was facing the opposite direction of the television. She requested one grab a chair. Her request was obliged. There was a coloring book and markers in a bin on an end table near her bed. There were no puzzles, magazines, or other books. Resident 6 indicated she needed a magazine. After an attempt to exit the room, Resident 6 stated, "Don't leave." During this observation, LPN 8 entered the room to inform Resident 6 it was time for lunch. Resident 6 communicated to LPN 8 that she wanted a magazine. An observation of the common area of the Cottage Unit was made on 6/5/24 at 10:48 a.m. AA 12 was tossing a large purple ball with one			

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	resident near the television area. Eventually 2 other residents joined for a total of 3 residents participating, including Resident 52 and Resident 65. There were 3 other residents sitting on couches in the back, 2 other residents sitting in the television area, and 2 residents by the window. The activity calendar on the wall indicated Front Porch Time (GAZEBO) at 10:30 a.m. There were no residents in the outside courtyard/gazebo area of the unit, which was visible from the unit. Upon observation of the courtyard area, it was sunny, not raining, and not windy. An interview was conducted with the DCD on 6/5/24 at 10:52 a.m. She indicated AA 12 asked the residents if they wanted to go outside. The residents asked about the weather and said no. According to weather.com on 6/5/24 at 10:55 a.m. the current weather in the city where the facility was located was 76 degrees Fahrenheit and partially sunny. An interview was conducted with the Administrator and DON (Director of Nursing) on 6/5/24 at 12:25 p.m. The Administrator indicated the activity assistant who was previously assigned full time to the Cottage Unit was let go recently, and they didn't have enough CNAs (Certified Nursing Assistants) to have them do activities. They were recently hired, but still had one open position for activities. The Administrator and DON indicated they understood why the group Front Porch Time (Gazebo) activity not being done was a concern and that perhaps staff needed more education on how to approach the residents with the idea versus simply asking them if they'd like to go outside. They both agreed it was a nice day out.			

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	2. a) The clinical record for Resident 49 was reviewed on 5/30/24 at 12:35 p.m. His diagnoses included, but were not limited to, dementia. The cognitive loss/dementia care plan, last reviewed/revised 4/2/24, indicated he was severely cognitively impaired Approaches were to give him choices throughout the day regarding decisions as able and to provide him with prompts and cues as needed. The activities care plan, last reviewed/revised 4/2/24, indicated he enjoyed independent activity pursuits such as independent activity box with fidget toys, a deck of cards, a blanket, and a stuffed animal. Approaches were to offer items from activity box. Resident 49 was observed wandering throughout the Cottage Unit on 5/30/24 at 12:20 p.m., 5/30/24 at 2:31 p.m., and 6/4/24 at 1:38 p.m. He walked up and down the hallway, into the common area, and into another resident's room. An observation of Resident 49 was made on 6/4/24 at 3:15 p.m. He was standing near the nurse's desk. An observation and interview was conducted with the DCD on 6/4/24 at 3:15 p.m. Resident 49's activity box was located in the back corner of the common area, near the piano. The box had his name printed on the outside and it contained several fidget toys. There was no blanket, stuffed animal, or deck of cards inside. The DCD retrieved a new deck of cards from her office to place in the box. She was unable to locate the blue stuffed animal or blue blanket. She gave CNA 7 a description of the blue fuzzy blanket for which she			

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	was looking. On 6/4/24 at 3:19 p.m., CNA 7 indicated she thought she saw the blanket in the linen closet of Station 1, located just outside of the unit. An observation and interview was conducted with the DCD and CNA 7 on 6/4/24 at 3: 22 p.m. at the Station 1 linen closet, where a blue fuzzy blanket was retrieved. CNA 7 indicated the blanket was on the top shelf and she'd seen it there earlier this morning. She did not know it belonged to Resident 49 or belonged in his activity box. She was aware of his activity box, but not what went inside it. An interview was conducted with the DON and Administrator on 6/5/24 at 12:25 p.m. The DON indicated she remembered making Resident 49's activity box and the blanket was supposed to be in there. The ED indicated they would educate staff on this. 2. b) The clinical record for Resident 49 was reviewed on 5/30/24 at 12:35 p.m. His diagnoses included, but were not limited to, dementia. The care plan, last reviewed/revised 4/2/24, indicated he would go into others rooms/bathrooms at times. Approaches were to redirect him away from others rooms and to redirect him with a snack. An observation was made on 5/30/24 at 12:20 p.m. in Resident 92's room while conducting an interview with Family Member 9. During the interview, Resident 49 came into Resident 92's room. Resident 49 stood near the doorway and began to speak nonsensically. Family Member 9 indicated, "He pops in from time to time and it			

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	upsets her." Resident 92 was lying in bed at this time. After a few moments of Resident 49 being in her room, Resident 92 stated very loudly to Resident 49, "I said out." Resident 49 eventually left the room. Staff were not around for this observation and did not intervene to redirect him elsewhere. Resident 49 was observed wandering throughout the Cottage Unit on 5/30/24 at 2:31 p.m. and 6/4/24 at 1:38 p.m. The Activities policy was provided by the Administrator on 6/4/24 at 10:30 a.m. It read, "It is the policy of this facility to provide for an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident in accordance with the comprehensive assessment." 3.1-37(a)			