STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155655	A. Building B. Wing	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peabody Retirement Community	400 W Seventh St North Manchester, IN 46962

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35283 Based on observation, interview, and record review, the facility failed to provide supervision and immediate individualized interventions to prevent falls. This deficient practice resulted in 4 of 8 residents reviewed for falls sustaining fractures (Residents 79, 179, 125, and 18). The immediate jeopardy began on 1/24/22, when Resident 79 fell and sustained a right femur fracture and immediate interventions to prevent falls were not put into place, resulting in additional falls. The Administrator and DON were notified of the immediate jeopardy on 3/15/22 at 11:04 a.m. Findings include: 1. On 3/8/22 at 2:16 p.m., Resident 79 was seated in her wheelchair at a table in the unit common area. Activity Aide 31 was seated next to her. On 3/8/22 at 2:30 p.m., she was saying she wanted to get up; Activity Aide 31 was encouraging her to sit still. On 3/9/22 at 9:14 a.m., she was sitting up on the side of her bed, with her feet on the floor. CNA 34 entered the room and asked if she was ready to get up for the day. On 3/9/22 at 9:33 a.m., she was up walking alone in her darkened room, partially dressed, standing near her armoire. She then walked to her recliner chair, sat down, and began putting on socks. During an interview, on 3/9/22 at 9:35 a.m., LPN 51 indicated staff tried to keep her from being up by herself. At 9:42 a.m., she was assisted to the common area via wheelchair. On 3/9/22 at 10:43 a.m., she was up walking away from the activity group in the common area. LPN 51 went to assist her and asked her to sit in a chair near the fireplace sitting area. On 3/9/22 at 1:10 p.m., she was seated at a table in the common area with a baby doll during a small group activity. On 3/10/22 at 8:51 a.m., she was seated in her wheelchair in the common area with her head in her hands. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/10/22 at 9:20 a.m., she remained in her wheelchair near an activity group, holding her head up with her fingers in her eyes. On 3/10/22 at 11:18 a.m., the resident's wheelchair sat in the common area, with the cushion tilted forward. There was no anti-slip mat observed in the seat. CNA 52 assisted the resident from a chair into her wheelchair for lunch in the dining room. On 3/10/22 at 3:06 p.m., the resident left her wheelchair in the common area and began walking. CNA 53 assisted her to a chair in the lounge area near the fireplace. The CNA walked away and then the resident got up and walked to a chair across the lounge area and sat down with two other residents. On 3/11/22 at 8:35 a.m., she was up walking around the unit with CNA 39, looking for her family member. On 3/11/22 at 9:32 a.m., she was up walking toward the medication carts. LPN 37 assisted her back to her wheelchair near a small group of residents and walked away. On 3/14/22 at 9:59 a.m., she was in bed, laying facing the wall. Her bed was elevated to approximately knee height. During an interview, at the time of the observation, CNA 52 indicated the bed was at knee height, but there were no current interventions for the resident's bed to be kept low. On 3/15/22 at 9:36 a.m., she was seated in a recliner in the common area, asleep, with a pillow on her lap. Resident 79's clinical record was reviewed on 3/8/22 at 9:50 a.m. Diagnoses included, but were not limited to, (1/27/22) fracture of unspecified part of neck of right femur, major depressive disorder, transient ischemic attack (TIA), restlessness and agitation, psychotic disorder with delusions, dysphagia, unsteadiness on feet, age-related physical debility, and Alzheimer's disease. She had current physician orders for, but not limited to, sertraline (anti-depressant) 50 mg daily, nortriptyline (anti-depressant) 25 mg at HS for insomnia and neuropathic pain secondary to hip fracture, tramadol (opiate pain medication) 50 mg every six hours as needed for pain, acetaminophen (analgesic) 325 mg two tablets three times daily, quetiapine (anti-psychotic) 25 mg 0.5 tablet (12.5 mg) at bedtime, and alprazolam (anti-anxiety) 1 mg twice daily. A 12/17/21, annual, Minimum Data Set (MDS) assessment indicated she was severely cognitively impaired and required supervision for ADLs and mobility. A 1/31/22, 5 day, MDS assessment indicated she was severely cognitively impaired and required extensive assistance for ADLs and supervision for mobility. She had a current, 2/10/22, care plan problem of confusion/distress as evidenced by calling her family members and them asking about her husband, wanting to go home, stating husband has given her money, and being unable to find her husband. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	She had a current, 3/4/22, care plan problem of risk for falls related to confusion, wandering, and behaviors. She had impaired safety awareness and attempted to transfer and ambulate without assistance. She had a walker, but at times would not use it, stating she did not need it. Interventions included, but were not limited to, the following: a. anti- rollbacks to wheelchair (1/28/22) b. encourage to sit in common area if awake during high risk walking rounds (1/28/22) c. hipsters to be worn at all times (1/31/22) d. be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. (2/2/22) e. anti-slip mat to wheelchair (2/7/22) f. keep footrest to recliner down while resident is sitting in recliner (2/7/22) g. remove exercise equipment from across the nook area (2/7/22) h. encourage to sit in common area while awake, offer activity and/or conversation (2/14/22) i. staff to get resident up and ready for breakfast between 6-7 am and assist to common area. (2/17/22) j. keep bed at appropriate height (2/18/22) k. staff to encourage resident to wear glasses appropriately (2/22/22) l. non-skid strips in and out of bathroom doorway (2/23/22) m. high risk walking rounds-if awake during rounds, encourage to sit in common area. If awake during sleep hours, offer/assist to toilet (2/24/22) n. offer/encourage to rest in recliner in common area (2/24/22) o. obtain urinalysis sample (3/4/22) p. assist to common area when finished eating meals (3/8/22) q. assist to toilet before and after meals (3/8/22) Review of progress notes and assessments indicated the following: On 1/11/21, she was started on buspirone 5 mg at bedtime and a one time dose of 15 mg. On 1/13/22, a Nurse Practitioner note indicated she had a shuffling gait; the resident didn't realize she was walking any differently. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/18/22, the facility's secured unit and it's residents were moved to another area of the facility. On 1/20/22, a Nurse Practitioner note indicated an acute visit, per staff request, for an aggressive episode towards another resident, throwing belongings out the window, and continued delusions. She was started on quetiapine 12.5 mg daily. Review of a 1/24/22 at 6:30 p.m. fall risk assessment indicated score of 6, low fall risk. On 1/24/22 at 11:01 p.m., the resident was standing next to another resident in the common area, when she turned around and then fell on the ground, landing on her right hip. She was unable to move her right leg and complained of severe pain when attempting to sit up. She was sent to the emergency department for evaluation. A 1/25/22 Interdisciplinary Team (IDT) note indicated therapy was to evaluate her when returned from the hospital. On 1/27/22 at 3:40 p.m., she returned from the hospital following a surgical repair of a right hip fracture. On 1/27/22 at 8:23 p.m., she was found sitting on her bottom in front of the fireplace, with her legs bent at the knee and feet flat on floor. Staff were to continue high risk walking rounds. Staff was in the back cluster of the unit, and the resident had been seen in the common area talking with another resident 5 minutes before the fall. No immediate intervention was implemented to prevent further falls. On 1/27/22 at 10:08 p.m., she was found lying on her right side in front of her room, facing the hallway. She stated she was just going for a walk and fell . She had a 2-centimeter (cm) bruise to her right shoulder and swelling to her right outer hip area and appeared inwardly rotated. She was transferred to the Emergency Department for evaluation. She returned to the facility on [DATE] at 2:40 a.m. and was to be placed on 1:1 supervision. A 1/28/22 IDT note indicated she was currently using a wheelchair and an intervention would be added for an anti-rollback device to her wheelchair. A 1/28/22 IDT note indicated she had dementia and poor safety awareness and continued to attempt to walk. An intervention was added to encourage her to be in the commons area if awake during walking rounds. Review of a 1/28/22 Nurse Practitioner note indicated she had fallen twice since return to the facility and was now unable to ambulate and had an obvious deformity to her right hip. Staff report she fell out of bed and onto her right side. She had a large abrasion and hematoma to her right shoulder and redness and swelling to her right hip. A progress note dated 1/28/22 at 2:41 p.m. indicated she had an unwitnessed fall requiring a further evaluation. No new fractures were identified, and the resident was expected to return to the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/28/22, new orders were received to discontinue the buspirone, wean the sertraline, and start nortriptyline for mood, sleep, and neuropathic pain secondary to falls and hip fracture. On 1/29/22 at 7:20 a.m., she had an unwitnessed fall in the common area. She had last been seen 15 minutes prior, sitting in a chair in the common area. Resident stated she got tripped up on her own feet and was lying on her left side, with her right leg at an awkward angle, bent inward; she complained of pain when moved. She was transferred to the emergency department for evaluation. No interventions were implemented upon her return to the facility on [DATE]. A 1/31/21 IDT note indicated she had experienced increased anxiety and was unable to understand she couldn't get up on her own. An intervention was added to wear hipsters at all times. A 2/1/22 IDT note indicated a review of staff monitoring of the fall interventions from 1/24/22, 1/27/22, 1/27/22, and 1/29/22. The IDT found the interventions remained effective and continued to follow care plan. On 2/2/22 at 11:25 p.m., she was found sitting on her bed with an abrasion to her right lower arm posteriorly, measuring 1.1 cm long x 4.9 cm wide. She was unable to state what had occurred. On 2/3/22 at 2:55 p.m., she was in the common area, near the fireplace, visiting with another resident, when staff heard the other resident asking her to wait for help as she slid out of her wheelchair and onto the floor. No injuries were noted. No immediate intervention was implemented to prevent further falls. On 2/4/22 at 12:10 p.m., she was propelling herself in the common area, stood up to ambulate and fell backwards, hitting her head on exercise equipment. She was conscious but moaning and wanting to hold the back of her head; her pupils were dilated. A laceration of at least 4 cm in length and unknown depth was noted to the back of her head. She was transferred to the emergency department for evaluation. On 2/4/22 at 5:10 p.m., report was received from the hospital of the resident having six sutures to her head and a possible compression fracture. She was to be transferred back to the facility. Review of a 2/4/22 Emergency Department visit summary indicated diagnoses of compression fracture, closed head injury, and stitches. No immediate intervention was implemented to prevent further falls. On 2/5/22 at 7:55 p.m., she was observed sitting in front of her recliner. She stated she was going walking and was unable to remember to not get up on her own. She was assisted into her wheelchair and to bed. There was no immediate intervention implemented to prevent further falls. A 2/7/22 IDT note indicated an anti-slip mat would be placed on her wheelchair seat due to the her having slid from her wheelchair on 2/3/22. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A 2/7/22 IDT note indicated the unit's exercise equipment would be removed due to her striking her head on it on 2/4/22. A 2/7/22 IDT note indicated an intervention was added to ensure the footrest was down on her recliner when she was sitting in it. A 2/11/22 IDT note indicated a review of staff monitoring of the fall interventions from 2/2/22, 2/3/22, 2/4/22, and 2/5/22. The IDT found the interventions remained effective and continue to follow care plan. On 2/12/22 at 4:24 p.m., a yell then a thud was heard in the hallway off the side of the nurses station. The resident was found on the floor, laying on her back, crying. She complained of pain, but no injury was noted. No immediate intervention was implemented to prevent further falls. On 2/13/22 at 4:09 p.m., the nurse was informed the resident was on the floor again, and went to the unit to assess her. An x-ray of her hip was ordered. No immediate intervention was implemented to prevent further falls. A 2/14/22 IDT note indicated she was not injured in the 2/13/22 fall. An intervention was added to encourage her to stay in the common area when awake and offer her a snack. On 2/14/22 at 8:04 p.m. staff heard an oomph and turned and found the resident sitting in the middle of the hallway in front of her wheelchair. No injuries were noted. She was kept in staff's line of sight. A 2/15/22 IDT note indicated an intervention was added to keep her walker within reach at all times. On 2/16/22 at 7:00 a.m., she came out of her room earlier in the morning, tearful, and stated I woke up to use the bathroom and just broke my self all up. She had been in bed sleeping approximately 15 minutes prior. She had a 2 cm linear skin tear under her chin and complained of a headache. High risk walking rounds continued due to high fall risk. No immediate intervention was implemented to prevent further falls. A 2/16/22 IDT note indicated a review of staff's monitoring of the fall on 2/12/22 intervention. The IDT found the intervention remained effective and continued to follow the care plan. A 2/17/22 IDT note indicated she had been going to the bathroom on 2/16/22 broke herself all up. She had a laceration to her chin. A new intervention was added to assist her with getting up in the morning between 6:00 and 7:00 a.m., then to the common area. On 2/18/22 at 1:37 a.m., she was heard by staff, calling out for help, and was found sitting on the floor at the end of her bed. She stated she was trying to get up to use the bathroom. The bed was in the lowest position. No injuries were noted. She was assisted to the bathroom. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	No immediate intervention was implemented to prevent further falls. A 2/18/22 IDT note indicated an intervention was added to keep bed at an appropriate height. The appropriate bed height was not defined by the facility. On 2/19/22 at 7:24 p.m., she was seen in front of the chair on one knee, halfway into getting up. She claimed she did not fall she just sat down; other residents in the area said she sat too far forward on the chair and slipped out and down to ground. She was assisted to her room and then was resting. No immediate intervention was implemented to prevent further falls. A 2/21/22 IDT note indicated she had missed the chair on 2/19/22 and fell to her left side, due to not wearing her glasses appropriately. A new intervention was added to encourage her to wear her eye glasses appropriately. On 2/23/22 at 12:42 a.m., she was found lying on her back on the floor in her room at the bathroom entrance. She had a light red 2 cm long x 2 cm wide abrasion to her left buttock. She complained of back pain and had no visible injuries noted. She was assisted to the bathroom, then back to bed. No immediate intervention was implemented to prevent further falls. A 2/23/22 IDT note indicated she had lost her balance while ambulating, causing her last fall. An intervention was added for non-skid strips to the floor in front of her bathroom and inside of her bathroom. On 2/23/22 at 11:06 a.m., she was found laying on the floor, on her left side, in front of the recliner in her room. She was assisted to her wheelchair and transported to the bathroom for ADL care. She denied any pain or discomfort and no new injury was noted. No immediate intervention was implemented to prevent further falls. On 2/24/22 at 1:35 a.m., she was found sitting in front of her wheelchair beside her bed. She said she was on the way to the bathroom and she slipped. She grimaced slightly when she stood and then took off walking on her own. She was assisted to the bathroom. No pain indicators were noted. No immediate intervention was implemented to prevent further falls. A 2/24/22 IDT note indicated on 2/23/22, she had attempted to transfer by herself and lost balance. An intervention was added to offer her to rest in recliner in common area during day. A 2/24/22 IDT note indicated an intervention was added to offer to assist to toilet if awake during high-risk walking rounds. A 2/25/22 IDT note indicated a review of staff's monitoring of the fall interventions from 2/14/22, 2/16/22, 2/18/22, 2/19/22. The IDT found the interventions remained effective and continued to follow the care plan. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A 3/1/22 IDT note indicated a review of staff's monitoring of the fall interventions from 2/22/22, 2/23/22, and 2/24/22. The IDT found the interventions remained effective and continued to follow the care plan. On 3/3/22 at 3:05 p.m., she was sitting in the common area during an activity. When the activity staff went to attend to another resident, Resident 79 got up and fell beside her wheelchair. No injury was noted. No immediate intervention was implemented to prevent further falls. On 3/3/22 at 7:51 p.m., she was found on the floor in the common area with her wheelchair behind her. No injuries were noted. The nurse observed her wheelchair and the cushion seemed to be slanted, with the anti-rollback system was pushing it up into the chair, causing the cushion to slant forward. A maintenance request was made for the cushion to be evaluated. A 3/4/22 IDT note indicated an intervention of risk versus benefit, and she continued to be a fall risk related to her dementia and poor safety awareness. A 3/4/22 IDT note indicated the resident had been experiencing increased urinary frequency and a urinalysis order would be requested of the Nurse Practitioner. On 3/6/22 at 5:16 p.m., she was found on her knees in front of her wheelchair in the common area. Staff had reported leaving her to sit in a chair while they assisted another resident. When they returned 10 minutes later, she was on the floor. No injuries were noted. No immediate intervention was implemented to prevent further falls. On 3/7/22 at 6:45 p.m., staff was assisting another resident out of the dining room, and observed Resident 79 walking, while holding on to the tray line rails. She went down and sat on her buttocks and then laid back on the floor. Her wheelchair was still sitting at the table where she had been seated. No injuries were noted and she was assisted back into her wheelchair. The nightshift QMA was to keep the resident close while passing medications to prevent repeated fall. A 3/8/22 IDT note indicated a new intervention of toileting before and after meals. A 3/8/22 IDT note indicated a new intervention of assist out of dining room after finished eating. Review of a 3/10/22 Nurse Practitioner note indicated she was seen at 9:05 a.m. due to a fall earlier in the morning and hitting her head on a filing cabinet. She complained of a headache right after the fall but denied one at the time of the exam. A 3/10/22 at 5:04 p.m. progress note indicated the nurse had been at the medication cart and the resident was inside the nurses station, organizing her purse, when she lost balance and fell backward, hitting her head against the filing cabinet. Pain medication was administered for head pain. No immediate intervention was implemented to prevent further falls. A 3/11/22 IDT note indicated a new intervention to wear tennis shoes when awake. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A 3/15/22 at 11:36 a.m. progress note indicated she had sustained an ulna (lower arm bone) fracture and was to be transferred to the orthopedic urgent care facility. A 3/15/22 Nurse Practitioner note indicated she had sustained a fracture to her distal ulna and would likely need a hard cast placed. On 3/15/22 at 7:13 p.m., the facility had been unable to transport her to the orthopedic facility due to a staff shortage. Transportation was set up for the next day at 8:00 a.m. During an interview, on 3/11/22 at 10:22 a.m., CNA 30 indicated she did not know where fall interventions were located but could go ask. She was not sure what Resident 79's specific interventions were, but knew she fell a lot. During an interview, on 3/11/22 at 10:40 a.m., the DON indicated all fall information and investigations were noted in the clinical record. During an interview, on 3/11/22 at 1:22 p.m., RN 33 indicated following a resident fall, she would be expected to develop and add an appropriate intervention to the resident's plan of care. During an interview, on 3/14/22 at 9:59 a.m., CNA 52 indicated the nurses would post any new fall interventions at the nurses station. They attempted to keep Resident 79 in a chair and to keep her busy and in activities. She was frustrated she couldn't walk. During an interview, on 3/14/22 at 12:12 p.m., the DON indicated the resident got up frequently, even if someone was standing right next to her. The DON would expect the nurses to implement immediate interventions to prevent further falls, but it does not always get done. The IDT looked at fall specifics afterward and placed interventions as well. The interventions were added to the care plan and at times, added to the kiosk to have the CNAs look at them. They try to keep her within sight. They have discussed her falls with the Nurse Practitioner and asked to have her medications adjusted; her family thought it may be related to anxiety. 2. On 3/9/22 at 9:07 a.m., Resident 179 was in bed, being assisted with breakfast. Resident 179's clinical record was reviewed on 3/9/22 at 1:55 p.m. Diagnoses included, but were not limited to, fracture of left upper end of humerus, hypertensive heart disease, and COVID-19. She had a current, 2/25/22 care plan for risk for falls. Interventions included, but were not limited to, non-skid strips on floor (3/8/22). A 2/25/22 admission assessment indicated she was independent with ADLs and mobility. A 2/28/22 Nurse Practitioner note indicated she had viral pneumonia and a slight increase in cough and malaise. A 3/5/22 at 11:45 a.m. progress note indicated she was found at 7:15 a.m., sitting on the floor, scared and crying. She indicated she had fallen and couldn't get back up. She did have a disfigured left shoulder area, and was transferred to the emergency department. She remained on the floor until EMS arrived and helped get her off the floor. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	There was no immediate intervention implemented to prevent further falls. Review of a 3/6/22 Nurse Practitioner note indicated she a left humerus fracture and had been sent to the emergency department due to a head injury and use of Eliquis (a blood thinner). Review of a 3/7/22 Nurse Practitioner note indicated her pain was poorly controlled. A new order was placed for Fentanyl patch (opioid pain medication). A 3/8/22 IDT note indicated non-skid strips would be placed on the floor beside her bed due to having loss of balance when she fell . During an interview, on 3/7/22 at 10:21 a.m., LPN 30 indicated Resident 179 had not been doing well due to a recent decline and recent fall. She had required total assistance since her decline. 40241 3. On 3/8/22 at 2:05 p.m., Resident 125's door was closed. On 3/9/22 at 9:13 a.m. her door was slightly ajar, unable to see resident from the doorway. On 3/11/22 at 2:08 p.m., Resident 125 was lying on her back in bed, her bed was at thigh height, fall mat in place. Her overbed table was on top of the floor mat and over the resident's lap, her head was elevated. On 3/15/22 at 9:55 a.m. she was in her wheelchair at a table in the common area. Resident 125's clinical record was reviewed on 3/8/22 at 3:05 p.m. Diagnoses included, but were not limited to, hypertensive heart disease with heart failure, age-related osteoporosis without current pathological fracture, generalized anxiety disorder, weakness, altered mental status, repeated falls, dizziness and giddiness, cognitive communication deficit, muscle wasting and atrophy, not elsewhere classified, unspecified lower leg, unsteadiness on feet, need for assistance with personal care, muscle weakness (generalized), difficulty in walking, not elsewhere classified, encounter for other orthopedic aftercare, displaced intertrochanteric fracture of right femur, and subsequent encounter for closed fracture with routine healing, Her orders included, but were not limited to, hydrocodone-acetaminophen (narcotic pain reliever) 5-325 mg (milligram) twice daily, mirtazapine (treat depression) 7.5 mg daily, furosemide (diuretic) 20 mg every other day, citalopram hydrobromide (treat depression) 20 mg daily, buspirone (treat anxiety) 10 mg three times daily and high-risk walking rounds. A quarterly MDS (Minimum Data Set), dated 11/21/21, indicated she was severely cognitively impaired. She required limited assistance of one staff member for bed mobility, transfers, walk in room/corridor, locomotion on/off unit. She required extensive assistance of one staff member for dressing, toilet use and personal hygiene. She used a walker and a wheelchair. She was occasionally incontinent of bladder and continent of bowel. She had one fall with injury. A Fall Risk Assessment, dated 11/19/21, indicated she was a low risk for falls. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	She had a care plan that indicated she was at high risk for fall related to history of falls and she attempted to put herself on the floor to pray initiated on 2/15/21 and revised on 11/26/21. Her goal was she would be free of fall with injury through the review date. Her interventions included, but were not limited to, anti-roll back bars to her wheelchair initiated on 7/27/21, anticipate and meet the resident's needs initiated on 2/15/21, be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance initiated on 2/15/21, dycem to recliner and wheelchair initiated on 2/17/21, encourage to keep door open to room initiated on 5/17/21, ensure recliner foot rest are not up initiated on 2/17/21, ensure that she was wearing appropriate footwear (non-skid socks/shoes) when ambulating or mobilizing in wheelchair, initiated on 2/15/21, fall mat beside her bed initiated on 2/15/21, follow facility fall protocol initiated on 2/15/21, gait belt to be used for all transfers initiated on 10/7/21, high risk walking rounds initiated on 2/15/21, keep transfer wheelchair folded up and out of sight initiated 7/27/21, offer prayer visitation services per Catholic Priest initiated on 5/17/21, evaluate and treat per falls initiated on 2/15/21, review information on past falls and attempt to determine cause of falls. Record possible root causes, alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes initiated 2/15/21, the resident needs a safe environment with: (even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, personal items within reach) initiated on 2/15/21. Her nurses notes and care plan interventions indicated the following: On 12/3/21 at 4:29 a.m., resident called for help at 2:00 a.m., she was lying on her back between her bed and the entrance to her room. She was swaddled in her bed linen and some blood was noted to the linen. She reported that she had rolled from the bed, the low air loss bed was noted to be half deflate, the connection from the foot blow up and mattress had failed. To attempt the use of standard pressure reduction mattress to promote sleep. She had a frequent history of wandering from her bed during the night hours, possibly, her bed caused sleep disturbances. to She stated mild discomfort to left hip during the assessment. She had no signs or symptoms of pain or injury with AROM (Active Range of Motion) or weight bearing. Discomfort was resolved with position change. Her gait was at her baseline when she walked to the restroom post fall. She was noted to be incontinent. Staff reported, she was toileted an hour prior and she was seen resting in bed 15-20 minutes before fall. A 6 cm x 3 cm skin tear was noted to her right [TRUNCATED]

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40461 Based on observation, interview and record review, the facility failed to ensure staffing levels were adequate related to falls, abuse prevention, meal timing and call lights for 12 of 46 residents reviewed for staffing, (Residents 179, 125, 18, 93, 117, 65, 108, 14, 86, 91 and Resident B). The immediate jeopardy began on 12/3/21, when the facility failed to ensure staffing levels were adequate to allow supervision of residents to prevent frequent falls resulting in major injury of cognitively impaired residents and resident to resident abuse and altercations. The Administrator and DON were notified of the immediate jeopardy on 3/15/22 at 11:04 a.m. Findings include: During a confidential interview, on 3/9/22, Employee 8 indicated the facility had been working short of staff, especially lately, it had been hard to get everything done and be able to spend time talking to any of the residents. During an interview, on 3/9/22 at 3:05 p.m., Resident 38 indicated sometimes it took the staff an hour to answer his call light, he knew it had been an hour because he had two clocks in his room. He had fallen five times and had a whistle to alert staff. During a confidential interview, on 3/11/22, Employee 2 indicated she didn't always have time to look for interventions due to not having enough staff. During an interview, on 3/14/22 at 12:20 p.m., the Scheduler for the Nursing Department indicated ideally she would schedule one CNA per eight bed cluster of residents, had recently tried having two CNAs per unit with an additional float between the two units, this would have been about 9.5 residents per CNA. Tried to do this will all Healthcare units. Tried to schedule one nurse and one QMA per unit, there had been a nurse that called off today so there was only one nurse and one QMA to work that unit. The facility had six different agencies they used to supplement staffing. She did not consider acuity of residents with scheduling. During a confidential interview, on 3/15/22, Employee 10 indicated they had tried to give residents showers but the nurse would have had to watch the floor for them while they were in a resident's room. Cross reference F689. During a confidential interview, on 3/11/22, Employee 4 indicated they didn't have enough staff a lot of the time and the residents aren't able to the time and care they deserved. During a confidential interview, on 3/11/22, Employee 6 indicated they didn't have enough help to what needed to be done. They didn't have enough time to do anything, sometimes they only had one CNA for a whole unit. They had gotten so stressed they cried and had been yelled at for not being able to get everything done. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview, on 3/11/22 at 11:18 a.m., QMA 44 indicated they sometimes had enough help to do what needed to be done. During an interview, on 3/14/22 at 12:12 p.m., the DON indicated they had not been able to do 1:1 with residents due to not having the staffing available. Cross reference F600. Cross reference F744 . During an observation of meal service on Cedar Ridge, on 3/9/22 from 9:10 a.m. to 10:04 a.m., residents were sitting in the small dining room across from the nurses' station, a dietary staff member was picking up trays from resident rooms that were finished eating, a covered breakfast tray was sitting on the ledge outside of the Nurses' Station. The meal tray also included a glass of apple juice and a covered breakfast tray sitting on a table in the small dining room across from the Nurses' Station. This tray included a glass of milk and a glass of orange juice. During an interview, on 3/9/22 at 9:19 a.m., CNA 21 had picked up the tray from the ledge and started to place in the open serving rack. She indicated it was Resident 14's breakfast, she was trying figure out what to do next, she needed to get a resident up for breakfast, Resident 14 needed to be assisted with her meal. Immediately after the interview she went into another resident's room to check on her. 3/9/22 at 9:22 a.m., CNA 21 entered Resident 86's room with a mechanical lift, then exited the room. On 3/9/22 at 9:24 a.m., CNA 21 entered room [ROOM NUMBER], a resident exited from the bathroom, CNA 21 assisted her to sit on the side of her bed and prepared her meal tray that was sitting on the over-bed table. She brought out the other resident's meal tray. On 3/9/22 at 9:27 a.m., CNA 21 pulled Resident 14's meal tray out from the open serving rack and sat it on the ledge outside of the Nurses' Station. On 3/9/22 at 9:28 a.m., CNA 21 entered Resident 86's room and closed the door. On 3/9/22 at 9:34 a.m., CNA 21 exited Resident 86's room and let the dietary staff member know to not pick up Resident 14 and Resident 86's meal trays yet, then re-enter the room. On 3/9/22 at 9:42 a.m., CNA 21 exited Resident 86's room with the mechanical lift and re-entered the room. On 3/9/22 at 9:46 a.m., CNA 21 assisted Resident 86 to the dining room, removed the cover, took the plate to the kitchenette and placed it in the microwave, the milk and orange juice remained on the resident's tray. On 3/9/22 at 9:49 a.m., CNA 21 brought Resident 86 a cup of coffee then retrieved the plate from the microwave and took to the resident, cut up the pancakes and poured syrup over them. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/9/22 at 9:51 a.m., CNA 21 picked Resident 14's meal tray off the ledge, warmed the food in the microwave, the apple juice remained on the tray, then took the tray to the resident's room. Resident 14's clinical record was reviewed on 3/11/22 at 11:56 a.m. Diagnoses included, but were not limited to, dementia, major depressive disorder and anxiety disorder. Current physician orders included, but were not limited to the following: a. Med Pass (nutritional supplement), 90 ml (milliliters) three times a day for weight loss, the order date was 7/19/21. b. Mirtazapine (antidepressant), 7.5 mg (milligram), one tablet at bedtime for weight loss, the order date was 7/21/21. c. Regular diet, pureed texture, liquids at pudding consistency. A 3/9/22 quarterly MDS (Minimum Data Set) assessment indicated she had severe cognitive impairment and required extensive assistance with eating. A current care plan, with a revised date of 1/19/22, indicated she was at risk for potential alteration of her nutrition and/or weight status related to diagnoses dementia, major depressive disorder, anxiety, atrila-fibrillation and abnormal weight loss. She received mirtazapine to stimulate her appetitive, her meal intakes were inadequate to meet her nutritional needs and she required supplementation. A review of her weights indicated, on 10/7/21 she weighed 84.7 lbs (pounds) and on 3/1/22 she weighed 78. 2 lbs, a 7.67% weight loss. Resident 86's clinical record was reviewed on 3/16/22 at 3:13 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, anxiety disorder and major depressive disorder. Current physician orders included, but were not limited to, regular diet with regular texture. A 2/5/22 quarterly MDS assessment indicated she had severe cognitive impairment and required extensive assistance with eating. A current care plan, with a revised date of 2/18/22, indicated she had the potential for alteration of her nutritional and weight status related to dementia, dysphagia, anxiety and depression. Interventions included, but were not limited to, she needed assistance with eating and drinking, date initiated was 11/6/21. A review of her weights indicated, on 11/2/21 she weighed 159.8 lbs and on 3/1/22 she weighed 153.3 lbs, a 4.07% weight loss. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Facility Assessment, dated 2/21/22 and scheduled to be reviewed with QAA/QAPI on 3/9/22, indicated their staffing plan indicated their general approach was to maintain a PPD (Per Patient Day) of 4.2 based on a budgeted census of 173, staff adjusted accordingly as acuity and census fluctuated, up with increased census/acuity or down with decline in census/acuity. The staff training/education and competencies section indicated to see staff development list. The section for policies and procedures for provision of care indicated the Medical Director reviews with the DON, Pharmacy, QAPI, QAA, and Administration all policies and procedures reviewed and instituted on a quarterly basis. The section identified to describe how you determine and review individual staff assignments for coordination and continuity of care for residents within and across these staff assignments did not include a response. A staffing formula included in the Facility Assessment indicated the number of CNA's X 8 hours X 7 days would equal 2,072 hours. A review of the facility's working schedules indicated the following: On 3/6/22, there had been 228 CNA hours worked. On 3/7/22, there had been 252.5 CNA hours worked. On 3/8/22, there had been 212.5 CNA hours worked. On 3/9/22, there had been 277 CNA hours worked. On 3/10/22, there had been 293 CNA hours worked. On 3/11/22, there had been 208.5 CNA hours worked. On 3/12/22, there had been 212.5 CNA hours worked. The total of the above hours was 1,684 hours. The difference between the number indicated on the Facility Assessment and the number from the working schedule indicated 48.5 less hours had been worked. The immediate jeopardy that began on 10/23/21 was removed on 3/17/22 when the facility began education and interventions for staffing, but the noncompliance remained at the lower scope and severity level of actual harm that is not immediate jeopardy because the facility had not completed education with all staff and had not completed monitoring to ensure staff was following the plan. This Federal Tag relates to Complaint IN00371468. 3.1-17(a)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 40461 Based on interview and record review, the facility did not ensure dietary staff had the appropriate cooking abilities to provide meals in a palatable manner, for 6 of 6 residents that attended the Resident Council meeting, (Residents 17, 115, 38, 94, 51, and 53). Findings Include: During a tour of the kitchen, on 3/7/22 at 9:40 a.m., accompanied by the Production Manager, the grease vat had black/dark brown grease, burnt debris was visible in the grease as well as on the surface leading into the grease vat. He indicated the grease was changed every Tuesday and hash browns had been made for breakfast. During an interview, on 3/7/22 at 11:36 a.m., Resident 38 indicated residents could no longer receive onion rings because dietary staff always burnt them and the facility had stopped serving macaroni and cheese because the staff didn't know how to fix them. During an interview, on 3/8/22 at 9:41 a.m., Resident 94 indicated his food was burnt a lot, especially shrimp and meatballs. He never received his food warm from the kitchen. 1/3 of his meals were either brought in by family or staff that worked at the facility. During a Resident Council meeting, on 3/9/22 at 3:05 p.m., the residents that were present had indicated food was burnt, macaroni and cheese was no longer available, and meals were not served at a consistent time. During an interview, on 3/10/22 at 11:57 a.m., the Dietary Inventory Manager indicated it was hard to get macaroni and cheese and onion rings in on the supply trucks. Sometimes they had to make macaroni and cheese from scratch for the assisted living portion of the facility, the staff cooking in healthcare didn't have a cook that knew how to make it, and the onion rings were getting burnt too often. During an interview, on 3/11/22 at 9:21 a.m., the Dietary Manager indicated staff were younger, there was less staff, and they had different skill sets that didn't include cooking. Review of a Position Description for a cook, with an effective date of 1/2014 and provided by the Dietary Manager on 3/16/22 at 2:09 p.m., indicated .DUTIES AND RESPONSIBILITIES To perform this job successfully, an individual must be able to perform each essential duty satisfactorily .2. Insures meals are palpable and attractive when served 3. Follows time schedule for coordination of meal preparation and service This Federal Tag relates to Complaint IN00371468. 3.1-21(h)