STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435100	A. BUILDING ______ B. WING ______	C 09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET MANOR AVERA HEALTH	129 E CLAY ST IRENE, SD 57037

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/24/24 through 9/25/24. Areas surveyed included allegations of abuse and neglect and quality of care regarding repositioning, incontinent care and resident observation. Sunset Manor Avera Health was found not in compliance with the following requirements: F600 and F684.	F 000		
F 600 SS=H	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §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; This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) complaint review, record review, interview, video review, and policy review, the provider failed to protect six of eight sampled residents (1, 2, 3, 5, 7, and 8) from neglect by licensed practical nurse (E) who did not offer or provide repositioning or toileting assistance as directed in their plans of care. Findings include:	F 600	F 600 Correct to the Individual: DON and Admin reviewed all TBI residents' care plans and met with Care plan team on 10/11/24. We discussed items that needed to be corrected for all TBI residents' care plans in order to make them more accurate and individualized. These will all be updated by 10/22/24. All care plans moving forward will be individualized to each resident. Education was provided at an all staff meeting on 10/15/24 about the complaint survey. We also re-educated all staff on being mandatory reporters and if they have any concerns about resident cares tehy need to report it immediately to their supervisor, Social Services, DON or Admin. Inservice/training for all CNAs was completed on 10/15/24 about their roles and responsibilities to ensure residents receive necessary cares and services and are not neglected or ignored. Education was also completed with the CNAs about the updated Hall Sheets (pocket care plans/report sheets). DON educated on the purpose of the hall sheets, where they will get them at the beginning of their shift, use for notes, times for toileting, any behaviors or other aspects of their shift with each one of their residents for more accurate documentation. CNAs will turn these into the charge nurse at the end of their shift and charge nurse to turn them into the DON at the end of their shift. Education on tasks that CNAs will chart on in EMR and that PRN toileting has been addedand how they will access this and chart for every toileting event. Inservice/training for all nurses was completed on 10/15/24 about their roles and responsibilities as charge nurses to ensure residents receive necessary cares and services and are not neglected or ignored. This includes monitoring and making sure the CNAs are following through on their duties and to assist them with duties and resident care as needed. Nurses were educated on the updated Hall Sheets, their use, how CNAs will be using throughout their shifts and the need for CNAs to turn these into the charge nurses at the end of their shifts. They should use these to help with nursing documentation. Before the nurses leave for the day they will need to turn the hall sheets into the DON. We also went over the complaint survey and reminded nurses that they are mandatory reporters - report immediately if concerns. (continued on next page)	10/22/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robin R. Stockland	Administrator	10/29/24

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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F 600	Continued From page 1 1. Review of the 9/12/24 SD DOH complaint revealed: *The complainant wanted to remain anonymous. *There was concern regarding neglect for all residents in the Traumatic Brain Injury (TBI) unit. *From 9/7/24 at 10:00 p.m. to 9/8/24 at 6:00 a.m. -Resident 5 was left in the same clothes he was dressed in on 9/7/24. -He was curled up in a ball on the floor with no blanket. -He was cold to the touch. -He was covered in feces. -His bed was still made from the previous day. *Residents (1, 2, 3, 7, and 8) were identified as being incontinent of both bowel and bladder in the complaint. *Complainant requested a review of the video footage of the unit. 2. Review of resident 1's electronic medical record (EMR) revealed: *His diagnoses included: -Traumatic subdural hemorrhage with loss of consciousness. (blood pooling between the brain and the outer layer of the brain-protective membrane). -Urinary incontinence. -Major depressive disorder. -Cognitive communication deficit. -Restlessness and agitation. -Impulse disorder. *His Brief Interview for Mental Status (BIMS) score was 4 which indicated he had severe cognitive impairment. *He required the assistance of one to two staff with all mobility, toileting, personal hygiene, and dressing. *He was to be checked (for incontinence needs)	F 600	F 600 Continued from page 1 System correction - the facility has found the following ways to identify other residents that have potential to be affected by the same deficient practice and how to ensure the deficient practice will not recur. Hall sheets have been updated for all residents in the facility to identify what care level they are, what type of rounding needs to be completed on each resident. All are standardized with the following: bathing, meals, dressing, transferring, assistive devices and behaviors. This also includes if they are continent of bowel and bladder, or incontinent and type and size of brief they wear. CNAs will pick these up at the front desk at the beginning of their shift, use throughout their shift and turn into the charge nurse at the end of their shift. The charge nurse will turn into the DON at the end of their shift so they can be reviewed. Tasks were updated in the EMR to include PRN toileting. CNAs will document every encounter of toileting at the time of toileting. If they are unable to document at the actual time of care they will put it down on their hall sheet and document at another time during their shift. Care plans will include rounding necessity for all residents, to include their preferences or family/POA preferences. Care plans have been updated and individualized on the TBI and will be individualized for all residents in the facility going forward. ADL sheets will be implemented by 10/22/24 for all residents in the facility and will be kept in the top drawer of each resident's dresser. These mirror the hall sheets. Monintoring of system: audits will be completed on the following to ensure that the deficient practice will not occur again and these audits will be reported to the QAPI team at our monthly QAPI meetings. Video footage will be audited by DON/ADMIN or designee of 2-3 random shifts/units weekly x 4 weeks, then every other week x 2 months, then monthly x 3 months to ensure all duties are being completed and residents are being cared for by all staff properly. Hall sheets and ADL sheets will be audited for accuracy by HIM/IP, DON or designee weekly x 4 weeks, every other week x 2 months, then monthly x 3 months to ensure all care levels are up to date. (Continued on next page)	

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F 600	Continued From page 2 and changed every 2 hours. 3. Review of resident 2's EMR revealed: *His diagnoses included: -Traumatic subdural hemorrhage with loss of consciousness. -Fracture of base of skull. -Mental disorder due to known physiological condition. -Psychotic disorder. -Anxiety disorder. -Cerebral infarction due to thrombosis (stroke due to a blood clot). -Hemiplegia and hemiparesis (paralysis) following a cerebral vascular disease (conditions that affect blood flow to the brain). *His BIMS score was 99 which indicated he chose or could not participate. *He had incontinence and was to be checked and changed every 2 hours. *He was dependent on two staff to assist him with all activities of daily living (ADLs). *He was dependent on staff for assistance with all his toileting, hygiene, dressing and personal hygiene needs. *He required the use of a total body mechanical lift for all transfers. *He was known to hit staff. *He had a gastrostomy tube (G-tube) for nutrition and medication administration and is nothing by mouth. 4. Review of resident 3's EMR revealed: *His diagnoses included: -Vascular dementia. -Major depressive disorder. -Hemiplegia (paralysis) following nontraumatic intracerebral hemorrhage (bleeding in brain). -Psychosis (disconnection from reality).	F 600	F 600 continued from page 2 Hall sheets will be turned into the DON and audited by DON, Unit Coordinator or Designee reviewing 100% of the TBI and random sampling (up to 5) from the Manor and CBU weekly x 4 weeks, every other week x 2 months, then monthly x 3 months to ensure they are being completed and cares are being documented properly. Care plans will be audited for individualization and completeness by DON/ADMIN or designee by 10/22/24 for all TBI care plans and then 2 care plans weekly until all care plans have been reviewed and revised as needed throughout the facility. Corrective action will be completed by 10/22/24 for the following items: TBI Care plans will all be updated, hall sheets and ADL sheets will be uupdated and implemented, training will be completed with all CNAs and nursing staff that were unable to attend training on 10/15/24 and staff will begin charting all toileting encounters on the EMR beginning10/22/24 using the PRN tasks that have been added for all residents.	

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*His BIMS score was 7 indicated he had severe cognitive impairment.
*He had incontinence and was to be checked and changed every 2 hours.
*He requires one to two staff to assist him with his bed mobility, bathing, toileting, and personal hygiene needs.
*He required the use of a sit-to-stand lift for transfers.

5. Review of resident 5's EMR revealed:
*His diagnoses included :
-Dementia with behavioral disturbances.
-Nontraumatic intracranial hemorrhage (stroke that occurs from a blood pooling in brain).
-Anoxic brain damage (lack of oxygen to the brain).
-Sleep disorder.
*His BIMS score is 99 and he had inattention that would fluctuate.
*He had incontinence of his bowel and bladder.
-He used incontinence products.
-He needed the assistance of one staff with his toileting needs every 2 hours.

6. Review of resident 7's EMR revealed:
*His diagnoses included:
-Traumatic subarachnoid hemorrhage with loss of consciousness.
-Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.
-Dementia, severe with behavioral disturbances.
-Major depressive disorder, recurrent, severe with psychotic symptoms.
*His BIMS score was 1 which indicated he had severe cognitive impairment.
*He had incontinence of his bowel and bladder.
-He required "substantial/maximal" staff assistance for his transfers and ADLs.

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-He required the use of a total mechanical lift at times with the assistance of two staff.
*He had a history of physical outbursts, verbal aggression, resistance with care, and social and sexually
inappropriateness.

7. Review of resident 8's EMR revealed:
*Her diagnoses included:
-Dementia without behavioral disturbances.
-Nontraumatic intracerebral hemorrhage (stroke that occurs from a blood pooling in brain).
-Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis following a stroke).
-Neuromuscular dysfunction of the bladder (muscles in the bladder do not work properly) with stress incontinence.
*BIMS score of 99, and indicated she was unable to participate.
*She required substantial to maximal assistance of two staff with all of her ADLs and mobility.
*She had incontinence of her bowel and bladder.
-She required to be checked and changed every two hours, and staff were to assist her with her incontinent care needs at each episode.

8. Interview on 9/24/24 at 4:45 p.m. with certified nursing assistant (CNA) F revealed:
*She had worked on the TBI unit 9/8/24 and at 6:00 a.m. that day:
*Resident 1 was incontinent of both bowel and bladder and his bedding was soaked through.
*Resident 2 was soaked in urine from head to toe and bedding was soaked through.
*She found resident 5 lying on the floor, in the living room area of his room.
-His body was curled up in a ball, and his skin was cold to the touch.

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-He had feces on him and was incontinent of urine.
*She stated he should have been assisted with toileting every two hours and that he would at times lay on the floor, but would stay in bed if staff placed him in his bed.
-He had on the same clothes she had dressed him in on the 9/7/24 morning shift.
*Resident 6 was incontinent, and his bed was soaked with urine.
*Resident 8 was incontinent of bladder and bedding was soaked through.
*She stated all of those residents required staff assistance with their toileting needs every two hours.

9. Interview on 9/25/24 at 8:02 a.m. with licensed practical nurse (LPN) E revealed:
*He had worked on 9/7/24 from 6:00 p.m. to 9/8/24 at 6:00 a.m. and was assigned to be the nurse in the TBI and CBU (challenging behaviors unit) from 6:00 p.m. to 10:00 p.m. that night.
*He said he went to the TBI unit on 9/7/24 at 10:00 p.m. to work only on TBI unit till 9/8/24 at 6:00 a.m.
*He was unsure why a CNA was not assigned to the TBI unit.
*He completed toileting and personal cares for the TBI unit residents from 10:00 p.m. on 9/7/24 until 6:00 a.m. on 9/8/24.
*He did not know which residents needed to get up in the morning.
*He completed all point click care (PCC) EMR charting.
*He stated resident 5 would lie on the floor at times.
*He said typically, there were three CNAs and two nurses in the building from 10:00 pm to 6:00 a.m.
*He had not been trained to perform the CNA

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F 600	Continued From page 6 tasks. 10. Interview on 9/25/24 at 9:20 a.m. with LPN D revealed: *She was the nurse for the TBI and CBU on 9/8/24 at 6:00 a.m. *She had been told resident 5 had been up all night and had not slept from a report with LPN E. *Resident 2 had been spitting and kicking at LPN E and he needed assistance to change him. *CNA F had told her resident 2 was soaked. *She stated the CNAs working that morning never contacted her regarding complaints about residents' care. *On 9/8/24 at 6:30 a.m. she had washed up resident 2 and changed his bedding, because he had soaked through the incontinence soaker pad and all of his bedding. *She stated, resident 7 did not like male staff. 11. Interview on 9/25/24 at 9:50 a.m. with director of nursing (DON) B revealed: *Tasks are automated in the PCC EMR system with assessments when completed. *Tasks can be added independently. *Registered nurse (RN)/Minimum Data Set (MDS) H was in charge of reviewing tasks and updating them when needed. *Social worker (SW) C was in charge of updating resident care plans. 12. Interview on 9/25/24 at 10:42 a.m. with RN/MDS H revealed: *She did not enter the tasks for residents in PCC. *She thought DON B or medical records (MR) I entered the tasks. *She did not know who updated the resident "pocket care plans" for staff.	F 600		

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13. Interview on 9/25/24 at 10:50 a.m. with MR I revealed:
*She did not enter tasks in PCC.
*She did not update the pocket care plans.

14. Interview on 9/25/24 at 10:52 a.m. with DON B revealed:
*Everyone in management had access to update the pocket care plans.
*Pocket care plans were kept at the front desk for staff.
*DON B would update the pocket care plans for the main floor residents.
*MR I printed them off and placed them at the front desk for staff.

15. Interview on 9/25/24 at 12:05 p.m. with Administrator A and DON B revealed:
*LPN E had training completed on 9/6/24 with LPN M.
*All nurses would have received CNA training in nursing school.
*The standard nursing care for incontinent residents was to check and change or toilet them every two hours.
*They had checked with other facilities and they did not put toileting tasks in PCC for every two hours.
*There had been no communication to management that there was a problem on the 9/7/24 and 9/8/24 weekend from the TBI nursing staff.
*DON B had contacted LPN E employment agency in regards to him needing to improve on his required tasks while working in the facility before she had learned of the complaint.

16. Interview on 9/25/24 at 1:20 p.m. with DON B revealed:

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*She completed the schedule for nursing staff.
*Usual staffing for a 10:00 p.m. to 6:00 a.m. shift included is two nurses and three CNAs in the building.
*She stated one of the CNAs scheduled to work had called in on 9/7/24.
*Her expectation for residents who needed two staff for assistance with their care needs was that staff would be assisted by staff from another unit.

17. Interview on 9/25/24 at 1:41 p.m. with CNA G revealed:
*She worked 9/7/24 at 6:00 p.m. until 9/8/24 at 6:00 a.m.
*Pocket care plans are available at the front desk where report was given.
*She was on the CBU for her shift that day.
*She did not know who called in.
*She had given LPN E a list of what needed to be completed for the residents on the TBI unit that included:
-Who was to be checked and changed every two hours.
-Who needed to have morning cares completed on 9/8/24. She stated that included residents 1, 5, and 8.
*When she needed help she would call for assistance.

18. Review of the provider's video footage of TBI unit for 9/7/24 10:00 p.m. through 9/8/24 at 6:00 a.m. revealed:
*Resident 2 was in a wheelchair in the dining area.
*LPN E arrived at 10:05 p.m. on the TBI unit.
*LPN E attempted to give resident 2's medications to him through his G-tube at 10:23 p.m.
*LPN E called for assistance, at 10:25 p.m.

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F 600	Continued From page 9 Medication aide J and LPN K arrived and assist with that medication administration then they exited the TBI unit. *LPN E entered resident 3's room at 10:38 p.m. and exited that room at 10:49 p.m. *LPN E and CNA L entered TBI unit and entered to resident 1's room at 11:02 p.m. *LPN E and CNA L remained in resident 1's room till 11:22 p.m. *CNA L and LPN E repositioned resident 2 from his wheelchair with a total mechanical lift to his room at 11:26 p.m. and exited his room at 11:31 p.m. *CNA L and LPN E entered resident 7's room till 11:36 p.m. then CNA L exited the TBI unit. *LPN E was at a desk in the TBI unit from 11:38 p.m. until 12:40 a.m. when he got up, went and goes to the laundry room and then returned to the desk. *CNA L entered the TBI unit at 1:00 a.m. and entered resident 1's room, he exited that room at 1:08 a.m. with a garbage bag and left the TBI unit. *LPN E sat at a desk from 1:10 a.m. until 2:01 a.m. *CNA G entered the TBI unit checked on resident 1 in his room and then exited the TBI unit. *LPN E returns to a desk from 2:03 a.m. to 2:41 a.m. he then stood, peeks into resident 1 room and returned to a desk. *CNA L entered TBI unit at 2:45 a.m. LPN E exited TBI unit at 2:48 a.m. CNA L walked up and down both hallways and entered resident 5 room at 2:56 a.m. and then exited the room a minute later. *LPN E returned to the TBI unit at 3:08 a.m. and CNA L exited the TBI unit LPN E remained at a desk until 4:25 a.m *LPN E entered resident 6's room and exited at	F 600		

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4:28 a.m. with no garbage bag in hand, LPN E entered laundry room.
*LPN E sat at a desk from 4:29 a.m. until 5:34 a.m. when LPN D entered the TBI unit.
-LPN E gives report to LPN D.
-Observed LPN E and LPN D counting narcotics in the medication cart.
*CNA F and CNA L entered TBI unit at 5:51 a.m. CNA L leaves the TBI unit after one minute.
*CNA F entered resident 3's room at 6:01 a.m. and then returned to the dining room area.
*CNA N entered the TBI unit at 6:04 a.m. for her shift.
*CNA N and CNA F entered resident 5's room at 6:10 a.m.
*LPN E exited the TBI unit at 6:12 a.m.
*CNA N and CNA F are observed talking with LPN D at the desk at 6:23 a.m.

19. Follow-up interview on 9/25/24 at 2:47 p.m. with DON B revealed:
*Last rounds were to be completed before 10:00 p.m.
*Check and change for incontinence needs would then start approximately at midnight and every two hours after that.
*She confirmed residents 1, 2, 3, 5, 7 and 8 had incontinence and needed to be checked and changed every two hours.

20. Follow-up interview on 9/25/24 at 3:43 p.m. regarding the above observations of the video recording with administrator A and DON B revealed:
*LPN E was not in resident rooms when he was expected to be.
*Cares for residents were not completed as required by staff on the night of 9/7/24 at 10:00 p.m. to 9/8/24 at 6:00 a.m. and according to the

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SUNSET MANOR AVERA HEALTH	**129 E CLAY ST IRENE, SD 57037**

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F 600	Continued From page 11 residents' care plans. 21. Review of the provider's 1/20/24 LTC Abuse Prohibition Policy revealed: *"Neglect the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress." *"Neglect occurs when the facility is aware of or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s) ..." *"Neglect includes cases where the facility's indifference or disregard for resident care, comfort, or safety, results in or may result in physical harm, pain, mental anguish, or emotional distress." *"Neglect may be the result of a pattern of failures or may be the result of one or more failures involving one resident and one staff person."	F 600		
F 684 SS=H	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) complaint review, record review, interview, and video review, the provider failed to	F 684	F 684 Correct to the Individual: DON and Admin reviewed all TBI residents' care plans and met with care plan team on 10/11/24. We discussed items that needed to be corrected for all TBI residents' care plans in order to make them more accurate and individualized. These will be updated by 10/22/24. All care plans moving forward will be individualized for each resident. Education was provided at an all staff meeting on 10/15/24 about the complaint survey. We also re-educated all staff on being mandatory reporters and if they have any concerns about resident cares they need to report it immediately to their supervisor, Social Services, DON and/or Admin. Inservice/training for all CNAs was completed on 10/15/24 about their roles and responsibilities to ensure residents receive necessary and quality cares and services and that residents are not neglected or ignored. (Continued on next page)	10/22/2024

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F 684

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ensure eight of eight sampled residents (1, 2, 3, 4, 5, 6, 7, and 8) who were dependent on staff for their care needs, received those cares as directed on their care plans. Findings include:
1. Review of the 9/12/24 SD DOH complaint revealed:
*The complainant wanted to remain anonymous.
*There was concern regarding neglect for all residents in the Traumatic Brain Injury (TBI) unit.
*From 9/7/24 at 10:00 p.m. to 9/8/24 at 6:00 a.m.
-Resident 5 was left in the same clothes he was dressed in on 9/7/24.
-He was curled up in a ball on the floor with no blanket.
-He was cold to the touch.
-He was covered in feces.
-His bed was still made from the previous day.
*Residents (1, 2, 3, 7, and 8) were identified as being incontinent of both bowel and bladder in the complaint.
*Complainant requested a review of the video footage of the unit.

2. Review of resident 4's electronic medical record (EMR) and pocket care plan revealed:
*His diagnoses included:
-Cerebral Infarction (stroke) affecting right dominant side.
-Aphasia (language disorder).
-Atherosclerotic heart disease.
*His Brief Interview for Mental Status (BIMS) score was 00 which indicated he had severe cognitive impairment.
*He needed 24-hour supervision.
*He was at risk for elopement.
*He lacked safety awareness.
*He could not express his needs at times due to his speech.
*Staff were to anticipate his needs.

F 684

F 684 Continued from page 12
Education was also completed with the CNAs about the updated hall sheets (pocket care plans/report sheets). DON educated on the purpose of the hall sheets, where they will get them at the beginning of their shift, use for notes, times for toileting, any behaviors or other aspects of their shift for each one of their residents for more accurate documentation. CNAs will turn these into the charge nurse at end of their shift. Education on tasks that CNAs will chart on in EMR and that PRN toileting has been added and how they will access and chart for every toileting event.

Inservice/training for all nurses was completed on 10/15/24 about their roles and responsibilities as charge nurses to ensure residents receive necessary and quality cares and services and are not neglected or ignored. This includes monitoring and making sure CNAs are following through on their duties and to assist them with duties and resident cares as needed. Nurses were educated on the updated hall sheets, their use, how CNAs will be using throughout their shifts and the need for CNAs to turn these into the charge nurse at the end of their shifts. The nurses should use these to help with accurate nursing documentation. Before the nurses leave for the day they will need to turn the hall sheets into the DON. We also went over the complaint survey and reminded nurses that they are mandatory reporters - report immediately if you have concerns about resident cares or a staff member not performing their duties.

System correction: the facility has found the following ways to identify other residents that have potential to be affected by the same deficient practice and how to ensure the deficient practice will not recur.

Hall sheets have been updated for all residents in the facility to identify what care level they are, what type of rounding needs to be completed on each resident. All have been standardized with the following: bathing, meals, dressing, transferring, assistive devices and behaviors. They also include if the resident is continent of bowel and bladder or incontinent and the type and size of brief they wear. CNAs will pick these up at the front desk at the beginning of their shift, use throughout their shift and turn itno the charge nurse at the end of their shift. The charge nurse will turn them into the DON at the end of their shift so they can be reviewed.

Tasks were updated in the EMR to include PRN toileting. CNAs will document every encounter of toileting at the time of toileting. If they are unable to document at the actual time of care, they will put it down on their hall sheet and document at a later time during their shift.

Care plans will include rounding necessity for all residents, to include their preferences or family/POA preferences.
Care plans have been updated and individualized on the TBI and will be individualized for all residents in the facility going forward.

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F 684	Continued From page 13 *He was independent with emotional, intellectual, physical and social needs. *He was continent of bowel and bladder. *He was a full code. 3. Review of resident 6's EMR and pocket care plan revealed: *His diagnoses included: -Cerebral infarction (stroke). -Incontinent of bowel. -Aphasia (language disorder). -Heart disease. *He required the assistance of one staff for most of his activities of daily living (ADLs). *His BIMS score was 9 which indicated he had moderate cognitive impairment. *Staff were to anticipate his needs, due to him rarely expressing his needs, even though he was able to. *He required partial/moderate assistance of one staff with bed mobility, toileting needs, and ADLs. *He was a full code. 4. Interview on 9/25/24 at 8:45 a.m. with administrator A revealed: *Tasks are used for ADL charting. *Provider does not have an ADL Policy. 5. Review of the provider's video footage of TBI unit for 9/7/24 10:00 p.m. through 9/8/24 at 6:00 a.m. revealed: *Resident 2 was in a wheelchair in the dining area. *LPN E arrived at 10:05 p.m. on the TBI unit. *LPN E attempted to give resident 2's medications to him through his G-tube at 10:23 p.m. *LPN E called for assistance, at 10:25 p.m. Medication aide J and LPN K arrived and assist with that medication administration then they	F 684	F 684 continued from page 13 ADL sheets will be implemented by 10/22/24 for all residents in the facility and will be kept in the top drawer of each resident's dresser. These mirror the hall sheets and will make it easier for staff to provide the appropriate cares to all residents. Monitoring of system: audits will be completed on the following to ensure that the deficient practice will not occur again and these audits will be reported to the QAPI team at the monthly QAPI meetings. Video footage will be audited by DON/ADMIN or designee of 2-3 random shifts/units weekly x 4 weeks, then every other week x 2 months, then monthly x 3 months to ensure all duties are being completed and residents are being cared for by all staff properly. Hall sheets and ADL sheets will be audited for accuracy by HIM/IP, DON or designee weekly x 4 weeks, then every other week x 2 months, then monthly x 3 months to ensure all care levels are up to date. Hall sheets will be audited by DON/Unit Coordinator or designee to ensure they are being completed and cares are being documented properly. 100% of the TBI hall sheets and random sampling (up to 5) from the Manor and CBU will be audited weekly x 4 weeks, then every other week x 2 months, then monthly x 3 months. Care plans will be audited for individualization and completeness by DON/Admin or designee by 10/22/24 for all TBI care plans and then 2 care plans per week until all have been reviewed and revised as needed throughout the facility. Corrective action will be completed by 10/22/24 for the following items: TBI care plans will be updated, hall sheets and ADL sheets updated and implemented, training will be completed for all CNAs and nurses not able to attend training on 10/15/24 and staff will begin charting all toileting encounters on the EMR beginning 10/22/24 using the PRN tasks that have been added for all residents on the EMR.	

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F 684	Continued From page 14 exited the TBI unit. *LPN E entered resident 3's room at 10:38 p.m. and exited that room at 10:49 p.m. *LPN E and CNA L entered TBI unit and entered to resident 1's room at 11:02 p.m. *LPN E and CNA L remained in resident 1's room till 11:22 p.m. *CNA L and LPN E repositioned resident 2 from his wheelchair with a total mechanical lift to his room at 11:26 p.m. and exited his room at 11:31 p.m. *CNA L and LPN E entered resident 7's room till 11:36 p.m. then CNA L exited the TBI unit. *LPN E was at a desk in the TBI unit from 11:38 p.m. until 12:40 a.m. when he got up, went into the laundry room and then returned to the desk. *CNA L entered the TBI unit at 1:00 a.m. and entered resident 1's room, he exited that room at 1:08 a.m. with a garbage bag and left the TBI unit. *LPN E sat at a desk from 1:10 a.m. until 2:01 a.m. *CNA G entered the TBI unit checked on resident 1 in his room and then exited the TBI unit. *LPN E returns to a desk from 2:03 a.m. to 2:41 a.m. he then stood, peeks into resident 1 room and returned to a desk. *CNA L entered TBI unit at 2:45 a.m. LPN E exited TBI unit at 2:48 a.m. CNA L walked up and down both hallways and entered resident 5 room at 2:56 a.m. and then exited the room a minute later. *LPN E returned to the TBI unit at 3:08 a.m. and CNA L exited the TBI unit LPN E remained at a desk until 4:25 a.m *LPN E entered resident 6's room and exited at 4:28 a.m. with no garbage bag in hand, LPN E entered laundry room. *LPN E sat at a desk from 4:29 a.m. until 5:34	F 684		

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F 684	Continued From page 15 a.m. when LPN D entered the TBI unit. -LPN E gives report to LPN D. -Observed LPN E and LPN D counting narcotics in the medication cart. *CNA F and CNA L entered TBI unit at 5:51 a.m. CNA L leaves the TBI unit after one minute. *CNA F entered resident 3's room at 6:01 a.m. and then returned to the dining room area. *CNA N entered the TBI unit at 6:04 a.m. for her shift. *CNA N and CNA F entered resident 5's room at 6:10 a.m. *LPN E exited the TBI unit at 6:12 a.m. *CNA N and CNA F are observed talking with LPN D at the desk at 6:23 a.m. *Residents 1, 2, 3, 4, 5, 6, 7, and 8 were not provided care according to their individual care needs. Refer to F600 findings 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, and 20.	F 684		