

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155770	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/31/2024
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NAME OF PROVIDER OR SUPPLIER WATERS OF GEORGETOWN, THE	STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00448117 and IN00447330.</p> <p>Complaint IN00448117 - Federal/State deficiencies related to the allegations are cited at F636, F677, F679, and F725.</p> <p>Complaint IN00447330 - Federal/State deficiencies related to the allegations are cited at F677, F679, and F725.</p> <p>Survey dates: December 30 and 31, 2024.</p> <p>Facility number: 011509 Provider number: 155770 AIM number: 200909280</p> <p>Census Bed Type: SNF/NF: 63 Residential: 9 Total: 72</p> <p>Census Payor Type: Medicare: 8 Medicaid: 42 Other: 13 Total: 63</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on January 9, 2025</p>	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is: February 4th, 2025. Facility is respectfully requesting paper compliance for all deficiencies in this POC.	
F 0636 SS=D Bldg. 00	<p>483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing</p> <p>Based on record review, observation, and</p>	F 0636	p="" paraid="1938680080"	02/04/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rhonda Mullins	Executive Director	01/22/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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	<p>interview, the facility failed to ensure a resident's plan of care was revised for 1 of 4 residents reviewed for behaviors and exit-seeking. (Resident E)</p> <p>Findings included:</p> <p>The record for Resident E was reviewed on 12/31/24 at 8:30 a.m. The residents' diagnoses included, but were not limited to unspecified sequelae of cerebral infarction; unspecified dementia, psychotic disturbance, mood disturbance, and anxiety; Muscle weakness (generalized); Difficulty in walking, not elsewhere classified, aphasia (a language disorder that affects a person's ability to understand and express written and spoken language); and need for assistance with personal care.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 10/10/24, indicated the resident's cognition was severely impaired. The resident's mobility was impaired on one lower extremity.</p> <p>A progress note, dated 12/01/24 at 8:08 p.m., indicated the resident was in bed yelling out "I want sex". The note indicated the nurse tried to redirect the resident and was unsuccessful.</p> <p>A progress note, dated 12/16/24 at 9:30 a.m., indicated the resident had been restless all morning, he had taken his clothes off and was yelling for help but would not let staff provide any assistance. The resident had been restless all weekend and had refused staff assistance.</p> <p>A progress note, dated 12/17/24 at 3:03 p.m., indicated the resident wandered through double doors near the kitchen toward the exit. The</p>		<p>paraeid="{19269b1c-0c02-42a8-9cd5-208cfeda2972}{138}">It is the intent of this facility to ensure residents' care plans are reviewed for behaviors and exit seeking.</p> <p>p="" paraid="640875892" paraeid="{19269b1c-0c02-42a8-9cd5-208cfeda2972}{146}"> what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>The DON/Designee reviewed and updated Resident E's care plan with behaviors, confusion, wandering and exit seeking interventions on or before 2/4/2025.</p> <p>p="" paraid="640875892" paraeid="{19269b1c-0c02-42a8-9cd5-208cfeda2972}{146}"> how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. The MDS Nurse/Designee completed a care plan audit for residents with behaviors, confusion, and wander/exit seeking behaviors and updated care plans including interventions on or before February 4th, 2025. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The DON/ Designee in-serviced the nursing staff on interventions on resident's care plans for behaviors, confusion,</p>	

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	<p>resident was able to push the double doors open. The progress note indicated therapy brought the resident back to the common area and the resident was out of sight less than two minutes.</p> <p>A progress note, dated 12/19/24 at 2:31 p.m., indicated the resident had been exit seeking and had an increase in confusion for the last several days. It showed that the resident was not combative but very unsafe to be left alone. The resident was placed in the common area with one-on-one (one staff to one resident) supervision.</p> <p>A progress note, dated 12/25/24 at 12:11 a.m., indicated the resident had been restless that night. The resident had difficulty following instructions but had no combative behaviors.</p> <p>A progress note, dated 12/28/24 at 3:11 p.m., indicated the resident was found sitting on the floor. He was unable to describe the fall or any details. The progress note showed that the resident had a motion sensor in his room, but the sensor was not on due to the resident being in the common area. The resident was then placed on one-to-one supervision in the common area.</p> <p>A care plan, with an initiated date of 10/09/24, indicated the resident used psychotropic medication related to insomnia (sleep disorder). The goal was for the resident to remain free of cognitive/behavioral impairment. The interventions included, but were not limited to, dated 10/9/24, monitor/record occurrence of target behavior symptoms such as wandering, disrobing, inappropriate responses to verbal communication and aggression towards staff.</p> <p>The resident's clinical record lacked an updated</p>		<p>wandering and exiting seeking behaviors on or before 2/4/2025. The DON/Designee in-serviced the MDS Nurse on updating residents care plans with interventions for behaviors, confusion, and wandering and exit seeking behaviors on or before 2/4/2025. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated.</p> <p>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;</p> <p>p="" paraid="640875892" paraeid="{19269b1c-0c02-42a8-9cd5-208cfeda2972}{146}"></p> <p>The DNS or Designee will audit progress notes five times for behaviors, confusion, wandering and exit seeking and check care plan for interventions x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of the 6 months, then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns been addressed. However, any patterns will be identified. Any will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.</p>				

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F 0677 SS=D Bldg. 00	<p>care plan and/or interventions related to the increased behaviors and confusion, one-on-one supervision, and wondering/exit seeking.</p> <p>During an observation on 12/30/24 at 3:15 p.m., Resident E was in a wheelchair in the common area of the Villa 5. There were no staff members in the common area or kitchen of the villa, at 3:24 p.m. two staff members walked out of a resident's room, walked past Resident E and then down towards the utility area.</p> <p>During an interview on 12/30/24 at 3:16 p.m., Resident E's family member indicated "they don't have enough people here". He had visited the villa for over two hours on another occasion and did not see a single staff member during that length of time.</p> <p>During an interview on 12/30/24 at 10:28 a.m., the Director of Nursing (DON) indicated she had just recently returned to work after being off for a few months.</p> <p>During an interview on 12/31/24 11:00 am, the Executive Director (ED) indicated there was only one secured locked unit and that unit was Villa 8.</p> <p>This citation relates to Complaint IN00448117.</p> <p>3.1-31(d)</p> <p>483.24(a)(2) ADL Care Provided for Dependent Residents</p> <p>Based on interview, record review and observation, the facility failed to ensure residents who were dependent on staff for activities of daily living received the care and services needed related to incontinence care and bathing for 2 of 4</p>	F 0677	<p>p="" paraid="41107561" paraeid="{5c83a924-0874-4518-9a06-9d5f173e1e38}{19}"> what date the systemic changes for each deficiency will be completed. The above corrective action will be completed on or before February 4th, 2025.</p> <p>It is the intent of this facility to ensure residents who are dependent on staff for activities of daily living receive the care needed for incontinence and bathing.</p>	02/04/2025

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	<p>residents reviewed for Activities of Daily Living. (Residents D and E)</p> <p>Findings include:</p> <p>1.a. The clinical record for Resident D was reviewed on 12/31/24 at 11:30 am. The resident's diagnoses included, but were not limited to, flaccid hemiplegia affecting the right dominant side, muscle weakness, transient cerebral ischemic attack, unspecified, and unspecified abnormalities of gait and mobility with lack of coordination.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 10/27/24, indicated the resident's cognition was mildly impaired. The resident's mobility was impaired on one side of his upper and lower extremities. He required maximal staff assistance with personal hygiene/bathing.</p> <p>The care plan, dated 1/22/24 and revised on 4/19/24, indicated the resident was incontinent and had impaired mobility. The interventions included, but were not limited to, staff assistance with turning, repositioning and transfers as needed, staff were to cleanse the resident's perineal area well with each incontinence episode, and keep the resident's skin clean and dry.</p> <p>The care plan, dated 1/22/24, indicated the resident had the potential for impairment to skin integrity related to frail skin. The interventions included, but were not limited to, keep skin clean and dry.</p> <p>The care plan, dated 1/22/24, indicated the resident was incontinent of bowel. The interventions included, but were not limited to, , dated 1/22/24, assist with toileting as needed; dated 11/18/24, check and change every two</p>		<p>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident D and E were assessed by the DON/Designee with no negative outcomes related to the alleged deficient practice.</p> <p>how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</p> <p>All residents that require assistance of two or more with ADL care, utilize a barrier cream, or has preventative skin measures have the potential to be affected. All residents that require ADL care with assistance of two or more, will be audited and care plans updated as appropriate.</p> <p>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The DON/Designee in-serviced the nursing staff on or before February 4th, 2025, on providing incontinence care and bathing for residents that require assistance with activities of daily living, showers per resident's preference, urinary catheter bags being drained, and two person assists.</p>	

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	<p>hours and as needed for incontinence; and dated 11/18/24, provide peri care after each incontinent episode.</p> <p>The care plan, dated 1/22/24, indicated the resident was incontinent of urine. The interventions included, but were not limited to, dated 1/22/24, assist with toileting as needed; dated 11/18/24, check and change every two hours and as needed for incontinence; and dated 11/18/24, provide peri care after each incontinent episode.</p> <p>The care plan, dated 1/22/24, indicated the resident had an activities of daily living (ADL) self-care performance deficit related to impaired cognition, weakness, and impaired mobility secondary to Hemiplegia (paralysis or weakness on one side of the body). The interventions included, but were not limited to, dated 1/24/24, the resident required one staff participation to use the toilet and one to two staff members for transfers; dated 1/22/24, one staff member for participation to reposition and turn in bed; and dated 1/22/24, the resident used a mechanical lift for transfers.</p> <p>The care plan, dated 1/22/24, indicated the resident was at risk for falls. The interventions included, but were not limited to, staff were to anticipate and meet the resident's needs; and dated 11/18/24, check and change every two hours and as needed for incontinence.</p> <p>The care plan, dated 1/22/24 and revised on 3/6/24, indicated the resident had the potential for pressure ulcer development related to impaired mobility and incontinence. The Goal was for the resident to have in-tacked skin, free of redness, blisters, or discoloration. The interventions</p>		<p>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;</p> <p>The DON/Designee will monitor showers provided per resident's preference five days a week x 4 weeks, then 3 days a week x 4 weeks, then once a week x 4 months.</p> <p>The DON/Designee will monitor catheter drainage bags being emptied daily five times a week x 4 weeks, then 3 days a week x 4 weeks, then once a week x 4 months, this audit will be completed on random shifts.</p> <p>The DON/Designee will audit 10 random incontinent residents for incontinence care weekly x 4 weeks, then 5 random resident's weekly x 4 weeks, then 5 random resident's monthly x 4 months. If the facility is within 95% compliance at the end of the 6 months, the monitoring can be stopped.</p> <p>Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.</p> <p>by what date the systemic</p>	

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	<p>included, but were not limited to, assist with turning and repositioning as needed (PRN), to off load heels (elevating the foot off the bed) for pressure reduction while in bed, the resident to be out of bed and transferred to a wheelchair as much as tolerable.</p> <p>The progress note, dated 11/18/24 at 09:36 a.m., indicated the resident attempted to go to the restroom alone due to incontinence of bowels and was found on the floor beside his bed with no apparent injury.</p> <p>During an interview on 12/30/24 at 11:17 a.m., Resident D indicated he had been sitting in the common area of the Villa since breakfast.</p> <p>During an interview and observation on 12/30/24 at 3:25 p.m., Resident D indicated that he had not been out of his wheelchair since he was interviewed that morning at 11:17 a.m. He indicated he was supposed to go to bed after lunch around 1:30 p.m. He had asked the Certified Nurse Aide (CNA) to put him in bed, but she was too busy and didn't have help. He sometimes would grow impatient if he had to wait a long time for a staff member to help him.</p> <p>During an interview on 12/30/24 at 3:30 p.m., CNA 6 indicated that her resident care sheet showed that the resident was to be assisted to bed with the mechanical lift after eating lunch every day. The CNA indicated her nurse floated to Villa 8 right after lunch and she could not safely transfer the resident until she returned. The second staff member returned from Villa 8 at 3:31 p.m., and the two staff indicated they could now lay the resident down.</p> <p>During observation on 12/30/24 at 3:35 p.m.,</p>		<p>changes for each deficiency will be completed.</p> <p>The above corrective action will be completed on or before February 4th, 2025.</p>	

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	<p>licensed Practical Nurse (LPN) 7 and CNA 6 went to lay Resident D down in bed. LPN 7 completed hand hygiene and proceeded to transfer Resident D from his wheelchair to the bed with a mechanical lift. Both the CNA and LPN removed the resident's socks, and the resident was observed to have edema (swelling) to both lower extremities. The staff turned the resident to his left side while in bed, his incontinence brief was removed, the resident's buttocks, rectum and gentile were cleaned with a disposable wipe. The resident turned with assistance to right side and the remaining stool left on the resident's perineum was cleaned with a disposable wipe. The resident had dark reddened skin to his buttocks and scrotum. There were indention marks to his buttocks from the creased brief that was removed. The two staff members offered the resident a drink of water, put the call light in his reach, and raised the head of his bed. Neither staff member offered or attempted to off load the resident's heels before leaving the room.</p> <p>During an observation and interview on 12/31/24 at 10:26 a.m., Resident D was lying in bed on his back. The resident's heels were directly lying on the bed and not off loaded. The resident indicated he wanted to get up out of bed, but had not seen a staff member since his breakfast was delivered. There was a strong urine odor in the resident's room.</p> <p>During an interview on 12/31/24 at 10:27 a.m., CNA 11 indicated she did not know the residents in that villa and since she did not know if the residents required two staff for transfer, she had not gotten anyone up out of bed at that time. The CNA indicated her nurse had now returned and she would help the resident at that time.</p>			

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	<p>During an observation and interview on 12/31/24 at 10:28 a.m., CNA 10 went into Resident D's room to check and change the resident. The resident's soiled brief was pulled back and he had stool from his back to his front lower abdomen. The resident was then rolled to his left side and the lift sheet under the resident was saturated with dark yellow urine. There was dried stool on the resident buttocks and thighs. The resident's skin on his buttocks, thighs, and scrotum areas were bright dark red. The CNA indicated the resident's skin was very red. She opened the resident's draws and found a tube of cream and started to place the cream on the resident's bottom.</p> <p>During an interview on 12/31/24 at 10:30 a.m., LPN 11 indicated Resident D did not have any orders for skin barrier cream. She did not see any progress notes or skin assessments, from 12/30/24, related to the resident's reddened skin. She indicated at that time she would look at the resident's skin.</p> <p>1.b. The care plan, dated 01/22/24, indicated the resident had an activities of daily living (ADL) self-care performance deficit related to impaired cognition, weakness, and impaired mobility secondary to Hemiplegia (paralysis or weakness on one side of the body). The interventions included, but were not limited to, dated 01/24/24, for bathing the resident required one staff participation with bathing/showering; and the resident used a mechanical lift for transfers.</p> <p>During an interview on 12/30/24 at 10:43 a.m., Qualified Medication Aide (QMA) 3 indicated the residents were supposed to have two showers a week. Sometimes it was hard to get two to three residents' daily baths done during a shift. The residents who required two staff members for</p>			

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	<p>transfers would just receive a bed bath.</p> <p>During an observation on 12/30/24 at 11:17 a.m., Resident D's hair appeared unwashed, uncombed, and pieces of hair was standing up in multiple directions.</p> <p>Review of the November 2024 task sheet indicated Resident D received 5 of 8 scheduled showers on the following dates: 11/02/24, 11/06/24, 11/20/24, 11/23/24, and 11/27/24. The resident received partial baths (the face, hands, underarms, and genital area) on 11/7/24, 11/10/24, 11/11/24, 11/19/24, and 11/24/24.</p> <p>Review of the December 2024 task sheet indicated Resident D received 4 of the 8 scheduled shower on the following dates: 12/4/24, 12/11/24, 12/21/24, 12/25/24. The resident received partial baths on two occasions: 12/17/24 and 12/29/24.</p> <p>The resident had not refused any bathing/showers for the months of November and December.</p> <p>During an interview on 12/31/24 at 11:30 a.m., the Assistant Director of Nursing (ADON) indicated Resident D only received 5 showers for the month of November. The resident has not refused any bathing. A partial bath consisted of the staff washing the residents face, hands, underarms, and genital area only.</p> <p>2. The record for Resident E was reviewed on 12/31/24 at 8:30 a.m. The residents' diagnoses included, but were not limited to unspecified sequelae of cerebral infarction; unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; Muscle weakness</p>			

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	<p>(generalized); Difficulty in walking, not elsewhere classified, aphasia (a language disorder that affects a person's ability to understand and express written and spoken language); and need for assistance with personal care.</p> <p>The Admission MDS assessment, dated 10/10/24, indicated the resident's cognition was severely impaired. The resident's bathing choice was very important. The resident's mobility was impaired on one lower extremity. He was dependent on staff for all effort of personal hygiene/bathing.</p> <p>The care plan, dated 10/11/24, indicated the resident had neurogenic bladder and needed an indwelling catheter. The interventions included, but were not limited to, catheter care every shift and as needed.</p> <p>The care plan, dated 10/09/24, indicated the resident had a Self-Care Deficit related to needing assistance with ADLs to maintain the highest possible level or functioning. The interventions included, but were not limited to, dated 10/09/24, for bathing and dressing the resident usually required the extensive assistance of one staff member with all activities of daily living.</p> <p>During an observation on 12/30/24 at 3:15 p.m., Resident E was in a wheelchair in the common area. The resident had a urine drainage bag attached to the lower portion of his left lower extremity. The drainage bag was visible attached to his ankle. The drainage bag was bulging and had a large amount of dark yellow urine. There were no staff members in the common area or kitchen of the villa during the observation. At 3:24, both the CNA and LPN came out of a resident's room and walked past the resident without addressing his catheter drainage bag.</p>			

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	<p>During an interview on 12/30/24 at 3:16 p.m., Resident E's family member indicated "they don't have enough people here". He had visited the villa for over two hours on another occasion and did not see a single staff member during that length of time.</p> <p>Review of the November 2024 task sheet indicated Resident E received 6 of 8 scheduled showers on the following dates: 11/1/24, 11/7/24, 11/15/24, 11/20/24, 11/27/24 and 11/30/24. The resident received a bed bath on 11/24/25. The resident received partial baths on the following dates: 11/2/24, 11/4/24, 11/10/24, 11/11/24, 11/13/24, 11/14/24, and 11/25/24.</p> <p>Review of the December 2024 task sheet indicated Resident E received 1 of 8 scheduled showers of the following date: 12/4/24. The resident received partial baths on the following dates: 12/5/24, 12/7/24, 12/9/24, 12/17/24, 12/21/24, and 12/29/24.</p> <p>Resident E had not refused any bathing types in the months of November and December.</p> <p>The progress note, dated 12/16/24 at 09:30 a.m., indicated the resident had been found on the floor in front of the wheelchair on his buttocks with the wheelchair locked. The resident was found to be partially dressed, and his pants were not completely pulled up. The resident tried to finish dressing himself and fell. The resident was then encouraged to stay in the common area.</p> <p>The current facility policy, dated 09/21/23 titled, "Guidelines for Bathing," which was provided by the ADON on 12/31/24, indicated the following: "Policy: To cleanse the skin and to promote circulation ...Verify bath schedule or need ...never</p>			

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F 0679 SS=E Bldg. 00	<p>leave a resident in tub or shower room unattended ..."</p> <p>The current facility policy, dated 09/21/23 titled, "Guidelines for Incontinence Care," which was provided by the ADON on 12/31/24, indicated the following: "Policy: It is the policy of the facility ... residents receive as much assistance as possible ...Frequency depends on bladder diary results or minimal every two-hour check ...reposition for comfort ...document as required ..."</p> <p>This citation relates to Complaints IN00447330 and IN00448117.</p> <p>3.1-38(a)(3)</p> <p>483.24(c)(1) Activities Meet Interest/Needs Each Resident</p> <p>Based on interview, record review, and observation, the facility failed to provide a resident-centered activities program to support residents in their choice of activities for 4 of 4 residents reviewed for activities (Residents B, C, D, and E). This had the potential to affect 63 of 63 residents that reside in the facility.</p> <p>Findings include:</p> <p>During an observation and interview on 12/30/24 at 10:40 a.m., Villa 6 was observed to have one resident in the common area and no activities present. License Practical Nurse (LPN) 6 indicated she was not a regular employee. There was one aide working with her and she did not know anything about resident scheduled activities.</p> <p>During an observation on 12/30/24 at 10:47 a.m., Villa 2 was observed with one resident in the</p>	F 0679	<p>p="" paraid="1032355885" paraeid="{74807cb2-f0a8-4f41-9191-3e86612ecd31}{106}">It is the intent of this facility to provide centered activity program to support resident choices of activities.</p> <p>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>p="" paraid="1032355885" paraeid="{74807cb2-f0a8-4f41-9191-3e86612ecd31}{106}"> Resident E, C, B, and D's activity care plan was updated with resident preferences by the Activity Director on or before 2/4/2025.</p>	02/04/2025

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	<p>common area and no activities present. During an interview with QMA 3, she indicated she was the only staff member in the Villa. There was no time for activities when you are trying to get everything done.</p> <p>During an observation and interview on 12/30/24 at 10:57 a.m., Villa 4 was observed with three residents sitting in the common area. There were no activities present. LPN 4 indicated she was covering two Villas for passing resident medications and treatments. Normally she would have to cover two Villas once or twice a week. When there were residents who require two staff assistance and the use of a mechanical lift, it was hard to get the basic care done.</p> <p>During an observation and interview on 12/30/24 at 11:10 a.m., Villa 3 was observed with no activities present. LPN 9 indicated she was covering two Villas. When she covered two Villas, each Villa had only one aide. Her aide today was new, and she was running behind on passing medications.</p> <p>During an observation and interviews on 12/30/24 at 11:16 a.m., Villa 5 was observed with one resident in the common area. LPN 7 indicated occasionally she had no aide and had to cover all care by herself. One time she had to cover three Villas, and the aides had to wait for her to help transfer residents that required two staff assistance. CNA 6 indicated her nurse today was covering two Villas. If she needed help transferring a resident she had to call another Villa, and it depended on what they were doing on how soon they could come help. There were no staff to do activities.</p> <p>During an interview on 12/30/24 11:19 a.m., LPN 7</p>		<p>p="" paraid="1032355885" paraeid="{74807cb2-f0a8-4f41-9191-3e86612ecd31}{106}">how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The facility hired a new Activity Director to start on or before 2/4/2025. The Activity Director/Designee updated residents care plans with preferences for activities on or before 2/4/2025. The Activity Calendar was posted in each villa and in resident rooms on or before 2/4/2025. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The Administrator/Designee will provide in- staff education on the Activity Calendar and providing activities per the calendar and per resident preference on or before 2/4/2025. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated.</p> <p>p="" paraid="18038746" paraeid="{74807cb2-f0a8-4f41-9191-3e86612ecd31}{242}"></p> <p>p="" paraid="18038746" paraeid="{74807cb2-f0a8-4f41-9191-3e86612ecd31}{242}">how the corrective action(s) will be monitored to ensure the deficient</p>	

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	<p>indicated she was working in two villas today for her 12-hour shift. There are no planned activity programs occurring on a regular basis due to facility not having an activities director.</p> <p>During an observation on 12/31/24 at 9:11 a.m., Villa 4 was observed with two residents in the common area. CNA 10 indicated her nurse had not arrived yet. The nurse for her Villa was covering two units today and she was not able to get the residents up until the nurse arrived.</p> <p>During an observation on 12/31/24 at 9:15 a.m., Villa 2 was observed with 4 residents sitting at the dining room table. The residents indicated the only activities were Thanksgiving and Christmas dinner.</p> <p>During an observation on 12/31/24 at 10:26 a.m., Villa 5 was observed with no activities. Resident D was lying in bed and indicated no one has been in to get him up or change him since last night.</p> <p>During an interview on 12/31/24 at 10:28 a.m., CNA 12 indicated her nurse arrived late today and she was new to the Villa. She did not have help since the nurse was late and running behind on her own work. She did not know which residents were able to get up or if they required two staff for transfer. The staff did not have time for any activities.</p> <p>During an interview on 12/31/24 11:00 a.m., the Executive Director (ED) indicated that there was no activity director, however one had been hired and will start in January. There was no structured activities program at that time. In the interim, the facility had hired a consulting company to provide activities and oversight for the facility. The company had provided an activities calendar for</p>		<p>practice will not recur, i.e., what quality assurance program will be put into place; The Activity Director/Designee will audit Activities per Activity Calendar and resident preference on 4 random Villa's at random times five times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of the 6 then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns been addressed. However, any patterns will be identified. Any will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. what date the systemic changes for each deficiency will be completed. The above corrective action will be completed on or before February 4, 2025.</p>	

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	<p>December 2024; however, the calendar was not followed. The activities calendar was not posted and no activities on the calendar were completed. The ED provided a list of Holiday activities the facility had hosted for October, November, and December as followed: Elder's Christman on December 25, 2024, Holiday Dinner's December 10, 2024 at 5:00 p.m., Trunk or Treat October 29, 2024 from 6:00 p.m. to 8:00 p.m., Haskel Gospel Singer, and Monthly Birthday Celebration for the Elder's.</p> <p>Review of the documented activity calendar for December 30, 2024, indicated the activities should have been the following: 10:00 Morning Meeting, 10:30 exercises, 11:15 word of the Day, 1:30 Christman in the Cabin -short story, 2:30 December birthdays, 4:00 balloon toss, and 6:00 daily devotions.</p> <p>Review of the documented activity calendar for December 31, 2024, indicated the activities should have been the following: 10:00 morning meeting, 10:30 dice exercises, 11:15 sorting, 11:59 countdown to noon, 1:30 cranium crunches, 2:30 bingo, 4:00 men's group, and 6:00 New Year's Eve Craft.</p> <p>No activities were observed in any of the 7 villas on December 30 and 31, 2024.</p> <p>During a telephone interview on 12/31/24 at 1:00 p.m., the Activities Consultant indicated that starting in the month of September 2024, the company had visited the facility once a week. On those visits they consisted of completing a resident's activity assessment and documentation. If time allowed, then once a week the consultant would try to visit each of the 8 villas for a 15-to-30-minute activity. There was no documentation of when, where, or what activities</p>			

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	<p>were provided by the consultant staff for the residents provided.</p> <p>The record for Resident E was reviewed on 12/31/24 at 8:30 a.m. The resident's diagnoses included, but were not limited to unspecified sequelae of cerebral infarction, and unspecified dementia, psychotic disturbance, mood disturbance, and anxiety. The Admission MDS assessment, dated 10/10/24, indicated the resident's cognition was severely impaired.</p> <p>Resident E's plan of care, dated 10/10/24, indicated the resident was new to the facility and potentially may be used to a different daily routine. The interventions included, but were not limited to, review the monthly calendar with the resident and ask where he would like it placed in his room and invite family members to join the resident in activities.</p> <p>The record for Resident C was reviewed on 12/31/24 at 9:30 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease; schizophrenia; hypertension, and unspecified mood disorder.</p> <p>Resident C's plan of care, dated 1/17/24, indicated the resident had expressed interest in reading and watching television. The activities staff would provide leisure materials PRN and provide a calendar in the resident room. The interventions included, but were not limited to, staff to provide a calendar of activities, invite the resident to groups, and provide leisure materials.</p> <p>The record for Resident B was reviewed on 12/31/24 at 10:44 a.m. The resident's diagnoses included, but were not limited to, hypertension, major depressive disorder, and vascular dementia</p>			

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F 0725 SS=E Bldg. 00	<p>with mood disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 11/23/24, indicated the resident's choice of activities was very important. The resident's cognition was severely impaired.</p> <p>Resident B's plan of care, dated 2/1/22 and revised on 2/15/22, indicated the resident will participate in activities of her choosing. The goal was for the resident to participate in activities until her next review. The interventions included, but were not limited to, provide the resident with a monthly activity calendar, and encourage and invite the resident to all activities.</p> <p>The record for Resident D was reviewed on 12/30/24 at 2:15 p.m. The resident's diagnoses included, but were not limited to, flaccid hemiplegia affecting the right dominant side; muscle weakness (generalized), unspecified abnormalities of gait and mobility; and unspecified lack of coordination.</p> <p>Resident D's plan of care, dated 01/25/24, indicated the resident had impaired cognitive function and impaired decision making. The interventions included, but were not limited to, provide a program of activities that accommodates the residents' abilities.</p> <p>No activity policy was provided by the facility.</p> <p>This citation relates to Complaints IN00447330 and IN00448117.</p> <p>3.1-33(a)</p> <p>483.35(a)(1)(2) Sufficient Nursing Staff</p>			

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	<p>Based on observation, record review, and interview, the facility failed to ensure each Villa/unit was staffed with the appropriate staff to ensure the resident received care and services in a timely manner related to bathing, toileting, behavior/supervision, and resident-centered activities. This deficient practice had the potential to affect 63 of 63 residents residing in the facility.</p> <p>Findings include:</p> <p>During an observation on 12/30/24 at 10:20 a.m., the facility had a total of 8 Villas (independent building that housed up to 10 residents in each unit). The facility was laid out like a small subdivision, with two roads and the individual Villas each had a kitchen, living room, laundry, and resident bedrooms. There was sidewalks and grass lawns between each Villa. The staff had to walk outside to get from one Villa to the other. Villa 2 had ten residents that required bathing assistance and one resident that required two staff members assistance with a mechanical lift; Villa 3 had ten residents that required bathing assistance; Villa 4 had nine residents that required bathing assistance and three that required two staff members for mobility; Villa 5 had ten residents that required bathing assistance, five to seven residents that required the assistance of two staff members for mobility, and one resident that required behavior supervision; Villa 6 had eight residents that required bathing assistance; Villa 7 had nine residents that required bathing assistance; and Villa 8 had seven residents that required bathing assistance and was a locked dementia unit. Four of the eight Villas had residents that required two staff members' physical assistance for mobility/transfer and or residents that required the use of a mechanical lift.</p>	F 0725	<p>p="" paraid="1404638109" paraeid="{912bdc31-22be-412f-bf2d-7c1597010fbe}{54}">It is the intent of this facility to ensure each Villa/Unit is staffed to ensure residents receive care and services.</p> <p>What corrective action will be accomplished by the resident found to have been affected by the deficient practice?</p> <p>p="" paraid="1404638109" paraeid="{912bdc31-22be-412f-bf2d-7c1597010fbe}{54}"></p> <p>p="" paraid="1404638109" paraeid="{912bdc31-22be-412f-bf2d-7c1597010fbe}{54}">Resident D and E were assessed by the DON/Designee on or before February 4th, 2025, and no negative outcomes related to the alleged deficient practice.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents had the potential to be affected by the deficient practice, therefore, this plan of correction applied to all residents that reside in the facility.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The ADM/DON were educated relative to Sufficient Staffing by the</p>	02/04/2025

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	<p>During an interview on 12/30/24 at 10:30 a.m., QMA 3 indicated she was working alone in the Villa today for the 12-hour shift. She would normally have to work alone once every two weeks. The facility would try to schedule one CNA and a floating nurse, but the staff would call off or no show often. The facility was using agency staff members to try to fill in the open shifts. She had one resident that required two staff assistance for transfer and sometimes the resident had to wait when she called for help. There were ten residents in the villa and all ten residents required assistance with bathing. The CNAs would have two to three baths to provide daily on day shift. The bathing tasks were hard to complete and sometimes the residents did not get their baths. There were no planned activity programs occurring on a regular basis due to facility not having an activities director. The staff working in the villas had to provide all daily care, heat up the resident's food, serve the residents, help the residents eat, check and change the residents every two hours, if possible, keep up with the laundry, clean the dishes, provide medications and treatments, and general cleaning.</p> <p>During an interview on 12/30/24 at 10:45a.m., LPN 4 indicated she was working a 12-hour shift alone. She often had to work alone, it generally occurred one to two of the three shifts she worked per week. There were ten residents in the current villa with three residents requiring the assistance of two staff members for transfers. She had to complete all the medication administration, treatments, warms up the residents' food for all three meals, do the laundry, completed resident activities of daily living, and attempted to provide minimal activities such as music or television programs. When the resident required a mechanical lift for transfers the resident would</p>		<p>RDO, including but not limited to provision of sufficient staffing based on resident acuity to meet the needs and preferences of residents. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated.</p> <p>How be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place ADM/Designee will monitor staffing levels 5 days a week for 1 month, then 3 days a week for one month, then weekly for 4 months. Any concerns noted in this audit will be addressed and corrected immediately. If the facility is within 95% compliance at the end of the 6 then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date be completed? February 4, 2025</p>	

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	<p>have to just stay in bed. When she had to go to another villa for supplies, she would have the Admissions/Marketing Director stay in the villa and monitor the residents for her. There were no planned activity programs occurring on a regular basis due to facility not having a current activities director.</p> <p>During an interview on 12/30/24 at 10:55 a.m., the Admission/Marketing Director indicated that she was not a nurse or a CNA. When the staff member working in her villa needed to leave the villa, she would be in the building to serve as a presence to monitor the residents. If a resident needed care provided, she would call for a staff member that could provide care since she was not able to provide care. This would occur two to three times a week for short periods. She did not touch the residents but could get them ice water if needed.</p> <p>During an interview on 12/30/24 11:19 a.m., LPN 7 indicated she was working in two villas today for her 12-hour shift. One of her villas had ten residents with seven of those residents requiring two-staff members' assistance for transfers. When she was alone in the building and a resident needed assistance to get up out of bed or needed to be toileted, she had to call another Villa for assistance. There were a few residents in one of her villas with behaviors and frequent falls. There are no planned activity programs occurring on a regular basis due to facility not having an activities director.</p> <p>During an interview on 12/30/24 at 11:22 a.m., CNA 6 indicated that she has worked some twelve hours shifts floating between two of the villas. When she was alone in a villa and had a resident with behaviors or an incident occur, she had to call for a nurse or another aide to come from</p>			

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	<p>another villa for assistance. The nurse or aide could only help if they were not alone in their villa.</p> <p>During an interview on 12/31/24 at 10:27 a.m., CNA 11 indicated she did not get any of the residents that required assistance out of bed yet that day. The nurse working with her was late and she did not have anyone to help her with the resident that required two staff members assistance for mobility.</p> <p>The facility assessment tool was reviewed on 12/31/24. The assessment tool indicated that the general staffing plan of the facility had a ratio of one licensed nurse to every 20 residents on dayshift for 12 hours and nightshift for 12 hours in the facility and a ratio of one direct care staff member for every 14 residents on day shift, in the evenings, and during the nightshift.</p> <p>The staffing schedule was reviewed on 12/30/24. The scheduled showed one licensed nurse was to be scheduled in each villa during the dayshift except for Villa 1 and Villa 3. Villa 1 was an assisted living group and only requiring a nurse to float between Villa 1 and Villa 3. The schedule showed a CNA to be staffed in each villa during dayshift hours and nightshift hours. The schedule indicated during the nightshift hours each licensed nurse would float between two Villas.</p> <p>The as worked schedules were reviewed for September 2024 through December 2024. The staffing schedule indicated when there was an open shift with no staff member present to work. The schedule would indicate when one staff member was floating between two or more Villas. The follow dates and time indicated when a staff member had to work more than one Villa.</p>			

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	<ul style="list-style-type: none"> - On 9/1/24, Dayshift nurse floated between Villa 2 and Villa 4, - On 9/2/24, Dayshift aide called in and was not present in Villa 5 and Nightshift nurse in Villa 6 and 7 no showed, - On 9/3/24, Dayshift nurse floated between Villa 2 and Villa 4, - On 9/4/24, Dayshift nurse floated between Villa 2 and Villa 4 and Dayshift aide in Villa 5 called in, - On 9/8/24, There was no Dayshift nurse scheduled for Villa 4, - On 9/9/24, Dayshift nurse floated between Villa 5 and Villa 8, - On 9/11/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 6 and Villa 8, - On 9/12/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 5 and Villa 8, - On 9/13/24, Dayshift nurse was vacant in Villa 4 and Villa 7, - On 9/15/24, Dayshift nurse was vacant in Villa 5 and Villa 6; and Dayshift aid was vacant in Villa 4, - On 9/16/24, Dayshift nurse floated between Villa 5 and Villa 8, - On 9/17/24, Dayshift nurse worked alone in Villa 2 without an aide, - On 9/18/24, Dayshift nurse floated between Villa 2 and Villa 4, - On 9/19/24, Dayshift nurse worked alone in Villa 2 without an aide, - On 9/20/24, Dayshift nurse floated between Villa 5 and Villa 8; and no dayshift nurse was listed for Villa 4, - On 9/25/24, Dayshift nurse floated between Villa 2 and Villa 4, - On 9/26/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 5 and Villa 8, 			

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	<ul style="list-style-type: none"> - On 9/27/24, Dayshift nurse floated between Villa 2 and Villa 4, - On 9/28/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 5 and Villa 8, - On 9/29/24, Dayshift nurse was vacant for Villa 4 and Villa 6, - On 9/30/24, Dayshift nurse floated between Villa 2 and Villa 4, - On 10/2/24, Dayshift nurse was vacant for Villa 2, Villa 4, and Villa 5, - On 10/3/24, Dayshift nurse floated between Villa 6 and Villa 8; and Dayshift nurse was vacant for Villa 2, - On 10/4/24, Dayshift nurse floated between Villa 2 and Villa 4; and Dayshift aide was vacant in Villa 5, - On 10/5/24, Dayshift nurse floated between Villa 2 and Villa 4; and Dayshift aide was vacant in Villa 7, - On 10/6/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 5 and Villa 8, - On 10/8/24, Dayshift nurse floated between Villa 5, Villa 6, and Villa 8, - On 10/9/24, Dayshift nurse floated between Villa 2 and Villa 4, - On 10/10/24, Dayshift nurse floated between Villa 2 and Villa 4, Dayshift nurse floated between Villa 7 and Villa 8, - On 10/11/24, Dayshift nurse floated between Villa 2 and Villa 4, - On 10/12/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 5 and Villa 8, - On 10/13/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 5 and Villa 8, - On 10/14/24, Dayshift aide in Villa 6 called in, - On 10/15/24, Dayshift nurse floated between 			

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	<p>Villa 5 and Villa 8,</p> <p>- On 10/16/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 6 and Villa 8,</p> <p>- On 10/17/24, Dayshift nurse floated between Villa 6 and Villa 8; and Dayshift aide was vacant for Villa 4,</p> <p>- On 10/19/24, Dayshift nurse floated between Villa 5 and Villa 8,</p> <p>- On 10/20/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 5 and Villa 8,</p> <p>- On 10/21/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 5 and Villa 8,</p> <p>- On 10/23/24, Dayshift nurse floated between Villa 2 and Villa 4,</p> <p>- On 10/24/24, Dayshift nurse floated between Villa 2 and Villa 4,</p> <p>- On 10/25/24, Dayshift nurse floated between Villa 2 and Villa 4,</p> <p>- On 10/26/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 6 and Villa 8,</p> <p>- On 10/27/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 6 and Villa 8; Dayshift aids no showed or called for Villa 5 and Villa 7,</p> <p>- On 10/28/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 5 and Villa 8,</p> <p>- On 10/29/24, Dayshift nurse floated between Villa 2 and Villa 4,</p> <p>- On 10/30/24, Dayshift nurse floated between Villa 2 and Villa 4 (from 7:00 a.m. to 3:00 p.m.) the nurse from Villa 1/3 covered Villa 2 and the nurse from Villa 5 covered Villa 4; and Dayshift nurse floated between Villa 6 and Villa 8,</p> <p>- On 11/1/24, Dayshift nurse floated between Villa 2 and Villa 4,</p>			

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	<ul style="list-style-type: none"> - On 11/2/24, Dayshift nurse floated between Villa 2 and Villa 4, - On 11/3/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 6 and Villa 8, - On 11/4/24, Dayshift nurse floated between Villa 1, Villa 2 and Villa 3, - On 11/5/24, Dayshift nurse floated between Villa 6 and Villa 8, - On 11/6/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 5 and Villa 7; and Dayshift nurse floated between Villa 6 and Villa 8, - On 11/7/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 5 and Villa 7; and Dayshift nurse floated between Villa 6 and Villa 8, - On 11/8/24, Dayshift nurse floated between Villa 2 and Villa 4, - On 11/9/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 5 and Villa 8; and Dayshift nurse floated between Villa 6 and Villa 7, - On 11/10/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 5 and Villa 7; and Dayshift nurse floated between Villa 6 and Villa 8, - On 11/11/24, Dayshift nurse floated between Villa 2 and Villa 4, Dayshift nurse floated between Villa 5 and Villa 7; and Dayshift nurse floated between Villa 6 and Villa 8, - On 11/12/24, Dayshift nurse floated between Villa 2 and Villa 4, Dayshift nurse floated between Villa 5 and Villa 7, and Dayshift nurse floated between Villa 6 and Villa 8, - On 11/13/24, Dayshift nurse was vacant for Villa 2 and Villa 4; Dayshift nurse floated between Villa 5 and Villa 7; Dayshift nurse floated between Villa 6 and Villa 8; and Dayshift aide was vacant for Villa 2, 			

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	<ul style="list-style-type: none"> - On 11/14/24, Dayshift nurse floated between Villa 2 and Villa 4, - On 11/15/24, Dayshift nurse floated between Villa 2 and Villa 4; and Dayshift nurse worked from 7:00 a.m. to 3:00 p.m. in Villa 8 (no other nurse coverage documented for Villa 8), - On 11/16/24, Dayshift nurse floated between Villa 2 and Villa 4, - On 11/17/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 6 and Villa 8, and Nightshift nurse no called no showed for Villa 3; and Nightshift aide called in for Villa 6, - On 11/18/24, Dayshift nurse was vacant for Villa 6; Nightshift nurse was vacant for Villas 5/8 and Villas 6/7, - On 11/20/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 5 and Villa 7; and Dayshift nurse floated between Villa 6 and Villa 8; and Nightshift nurse called in for Villas 2/4, - On 11/21/24, Dayshift nurse floated between Villa 2 and Villa 4, - On 11/22/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 5 and Villa 8, - On 11/23/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 5 and Villa 7; and Dayshift nurse floated between Villa 6 and Villa 8, - On 11/24/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 6 and Villa 8, - On 11/25/24, Dayshift nurse floated between Villa 5 and Villa 7; Dayshift nurse floated between Villa 6 and Villa 8, and Nightshift nurse was moved from Villas 1/3 to Villas 6/7, - On 11/26/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 6 and Villa 7; and Dayshift nurse in Villa 5 			

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	<p>worked from 7 to 9,</p> <ul style="list-style-type: none"> - On 11/27/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 6 and Villa 8, - On 11/29/24, Dayshift nurse floated between Villa 1, Villa 3, Villa 2, and Villa 4; Dayshift aide in Villa 4 and Villa 5 were vacant. - On 12/1/24, Dayshift nurse floated between Villa 2 and Villa 4, - On 12/2/24, Dayshift nurse floated between Villa 5 and Villa 8, - On 12/4/24, Dayshift aide no showed in Villa 6 and was vacant for Villa 7, - On 12/7/24, Dayshift nurse was vacant for Villa 5 and Villa 6; Dayshift aide was vacant for Villa 5, and Nightshift aide was vacant for Villa 4, - On 12/8/24, Dayshift nurse was vacant for Villa 5, Villa 6, Villa 7; Dayshift aide was vacant for Villa 5 and Villa 7, - On 12/5/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 5 and Villa 7; and Dayshift nurse floated between Villa 6 and Villa 8, - On 12/10/24, Dayshift nurse floated between Villa 5, Villa 6, and Villa 8; and Dayshift aide was vacant for Villa 5, - On 12/11/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 5, Villa 6, and Villa 8, - On 12/12/24, Dayshift nurse for Villa 5 was vacant, - On 12/13/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 6 and Villa 8, - On 12/14/24, Dayshift nurse floated between Villa 2 and Villa 4, - On 12/15/24, Dayshift nurse floated between Villa 2 and Villa 4, - On 12/16/24, Dayshift nurse floated between Villa 5 and Villa 8; Dayshift aides was vacant for 			

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	<p>Villa 2, Villa 4 and Villa 6, - On 12/20/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 6 and Villa 8, - On 12/22/24, Dayshift aides was vacant for Villa 4 and Villa 7, - On 12/24/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 5 and Villa 8; Dayshift aide was vacant for Villa 7; Nightshift nurse was vacant for Villa 3, Villa 6/7 and Nightshift aide was vacant for Villa 3, - On 12/25/24, Dayshift nurse floated between Villa 2 and Villa 4, - On 12/30/24, Dayshift nurse floated between Villa 2 and Villa 4; Dayshift nurse floated between Villa 5 and Villa 6.</p> <p>Cross Reference F679: The facility failed to provide a resident-centered activities program to support residents in their choice of activities.</p> <p>Cross Reference F677: The facility failed to ensure residents who were dependent on staff for activities of daily living received the care and services needed related to incontinence care and bathing.</p> <p>This citation relates to Complaints IN00447330 and IN00448117.</p>			