DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VITA OF MARION	4211 S ADAMS STREET MARION, IN 46953

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00417206. Complaint IN00417206 - State deficiencies related to the allegations are cited at R0053 and R0116. Unrelated deficiencies are cited. Survey date: October 27, 30, and 31, 2023. Facility number: 015081 Residential Census: 73 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed November 6, 2023.	R 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the plan of correction be considered the letter of credible allegation of compliance and request for a desk review (compliance) by 12/01/2023.	
R 0053 Bldg. 00	410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse. Based on interview and record review, the facility failed to protect resident rights to be free from verbal abuse by staff for 2 of 3 residents reviewed for abuse (QMA 16 and Resident B, LPN 6 and Resident C). Findings include: 1. Resident B's clinical record was reviewed on 10/27/23 at 10:29 a.m. Diagnoses included anxiety disorder and dementia in other diseases classified elsewhere, moderate, with anxiety. A BIMS (Brief Interview for Mental Status)	R 0053	It is the policy of Priority Life Care that all residents remain free from verbal abuse. Both allegations for resident B and C were investigated thoroughly. Both staff members involved in these incidents were terminated. Both residents continue to reside at the community and have no ongoing issues related to the allegations. All residents have the potential to be affected. Through the investigation process no other	12/01/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
James M. Combs MBA HFA	Executive Director	11/19/2023

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

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	assessment, dated 9/11/23, indicated she was severely cognitively impaired. Her medications included sertraline (treat anxiety) 50 mg daily. A physician's progress note, dated 9/11/23 at 11:00 a.m., indicated the nurse practitioner was asked to meet with Resident B by the DON and ADON to assess her level of distress after an interaction with a staff member. She was interviewed in her room, and when asked if she had had an unpleasant or upsetting interaction with a staff member, she denied that anything had happened. The note indicated it should be noted that in July, 2023 she had a BIMS of 10 and her recent recall was a four out of six points. Therefore, after talking generally with her, it was not sensed that she had much memory and she appeared to exhibit no sign or symptoms of distress. She was seen later in the lounge with a family member and continued to be stable without distress. A review of the facility investigation, on 10/30/23 at 10:26 a.m., indicated a personal action notice for the termination for QMA 23, due to verbal abuse towards residents. The incident was witnessed and reported to Indiana Department of Health. She had previously been counseled many times verbally about complaints of a negative attitude. She was inserviced on abuse. A handwritten statement by Dietary Aide 3, dated 9/11/23, indicated while she was in the Memory Care Unit, a little after 6:00 a.m., QMA 23 was yelling at Resident B and said she was about to catch a f---ing charge. During an interview with Resident B's daughter,		residents identified as affected. All staff were educated on abuse policy on or before 12/01/2023. Education consisted of what constitutes abuse and procedures to be followed for any allegations of abuse. A new grievance procedure has also been implemented and staff have been trained to help identify any further issues that could be considered abuse. To ensure ongoing compliance the facility will initiate ongoing monthly reviews with all residents/POAs. This will be completed by the facility QA Team. Concerns will be addressed immediately by the facility. All concerns/grievances and actions taken will be reviewed in the monthly QA meeting. A QAPI plan has been initiated and will be followed/reviewed and revised in the monthly QA meeting. Date of compliance: 12/01/2023	

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on 10/27/23 at 12:13 p.m., she indicated she was not aware that her mother had ever been treated badly, or anyone had ever used vulgar language toward her.

2. Resident C's clinical record was reviewed on 10/27/23 at 11:15 a.m. Diagnoses included unspecified dementia, unspecified severity, personal history of traumatic brain injury and adjustment disorder.

A BIMS assessment, dated 10/16/23, indicated she was moderately cognitively impaired.

She had a care plan for alleging staff was mean to her and she was scared of them (9/1/23). Her interventions included monitor for emotional distress and provide emotional support as needed (9/1/23).

A nurse practitioner note, dated 8/31/23 at 4:20 p.m., indicated she reported having crying episodes overnight.

A review of the facility investigation, on 10/30/23 at 10:45 a.m., indicated Resident C reported an incident, on 8/31/23, to the home health aide and staff that the nurse last evening was verbally rude to her. She was scared, and afraid of the nurse. Resident C indicated she stayed in her room and was very upset until this morning after breakfast when she told staff what happened. The Administrative team was notified and Resident C was interviewed to verify the findings concerning the incident. She described the nurse in detail with characteristic features.

During an interview with Resident C, on 10/27/23 at 11:22 a.m., she indicated a nurse made her feel afraid. The nurse said to her that she didn't want

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to talk to her and told her to shut up. The nurse was always on her cell phone. This happened a while back, they fired the nurse and she was not afraid anymore.

During an interview with Resident C's sister, on 10/27/23 at 12:21 p.m., she indicated a staff member said something to Resident C, but the DON took care of it right away and thought they had gotten rid of that staff member. She was not sure what was said, but it made her cry and upset her.

During an interview with Resident C's home health aide, on 10/30/23 at 2:33 p.m., she indicated Resident C told her a staff member told her that she, and her room, stunk.

During an interview with the Administrator, on 10/31/23 at 10:29 a.m., he indicated when he went to talk with Resident C, she was visibly upset. She was crying and it may had been the way she felt, the way the nurse spoke to her, not that the nurse said anything derogatory to her. With Resident B, she kept getting up and QMA 23 muttered under her breath. Although it was not a direct comment to Resident B, it was within ear shot. It was bad customer service and was considered abuse, so they terminated her employment.

A current, undated, facility policy titled "Abuse, Neglect, and Misappropriation Policy and Procedure," provided by the Administrator on 10/30/23 at 9:55 a.m., indicated the following: "...Verbal Abuse - the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to resident or their families or within their hearing distance, regardless of age, ability to comprehend, or

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	disability...." This citation relates to Complaint IN00417206.			
R 0064 Bldg. 00	410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident.			
	Based on interview and record review, the facility failed to ensure a resident's medication was free from misappropriation for 2 of 2 residents reviewed (Resident E and Resident F). Findings include: 1. Resident E's clinical record was reviewed on 10/30/23 at 12:36 p.m. Diagnoses included low back pain. A BIMS (Brief Interview for Mental Status) assessment, dated 10/12/23, indicated he was cognitively intact. His July medication administration record indicated his tramadol (pain medication) 100 mg at bedtime was not available from 7/18/23 through 7/23/23, and his 50 mg morning dose was not available from 7/18/23 through 7/24/23. During an interview with Resident E, on 10/30/23 at 3:31 p.m., he indicated his bottle of tramadol was missing. The bottle had 90 pills in it and he gave them to the DON. The DON, in turn, would give them to the nurse to give to him. The bottle was never found, and the DON indicated to him	R 0064	It is the policy of Priority Life Care that all residents medication remain free from misappropriation. Both findings for residents E and F occurred in July 2023. Facility was not made aware by the former DON of these occurrences. Resident E did have his medication reordered by former DON. Medication is in stock and is being received as per orders. Resident F no longer has the order for Xanax and medication had been removed. All residents have the potential to be affected. A review was completed for all residents in all units. Medication cart audits completed. Orders were verified with medications on hand to ensure residents had medications available as ordered by the physician. New system for reordering medications has been implemented to ensure those receiving medications from outside	12/01/2023

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	he didn't know what happened to them. He had to call his provider to get another prescription, which took about a week. He had pain in his neck, lower back, both knees, and neuropathy pain in his feet. 2. Resident F's clinical record was reviewed on 10/30/23 at 3:30 p.m. Diagnoses included anxiety disorder and unspecified dementia, unspecified severity. She had an order for Xanax 0.25 mg every six hours as needed for anxiety with a start date of 2/14/23 and a discontinue date of 2/28/23. The narcotic count sheet for Xanax 0.25 mg indicated on 2/12/23, 18 pills were received from the pharmacy. On 2/12/23, one dose was added from the Pyxis (medication dispensing system), so the count was 19 pills. On 2/26/23 at 11:45 a.m., Resident F received one pill, leaving the count at 18 pills. On 7/15/23 at midnight, a pill was withdrawn and the count was 17 pills. On 7/18/23, 17 pills were destroyed. During an interview with LPN 6, on 10/30/23 at 12:08 p.m., she indicated there had been some drug diversion in the facility. She had been counting narcotics with a QMA, and the QMA told her there was a narcotic sheet for a bottle of tramadol that belonged to Resident E, but the bottle was not in the medication cart. Resident E had brought the bottle of tramadol and gave it to the DON after an appointment. That was the last time anyone had seen the bottle. Also, Resident F had a punch card of 18 Xanax pills. Her order for the Xanax was discontinued in February and was never pulled from the medication cart or destroyed. A pill was removed in July from the punch card and replaced with with another pill that was not a Xanax. A piece of tape secured it		pharmacy are getting medications ordered and the orders are tracked when they come to the facility. Staff re-education will be completed on reordering medications and also on what to do when a medication is discontinued on or before 12/01/2023. To ensure ongoing compliance the DON/Designee will continue weekly medication cart audits. These audits will be ongoing per Priority Life care policy. Any issues identified will be addressed immediately. A QAPI plan has been initiated and will be followed/reviewed and revised in the monthly QA meeting. Date of compliance: 12/01/2023	

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in the punch card. She brought this to the attention of LPN 15. The next time she worked, the Xanax had been destroyed. They had a staff meeting and they were required to have the resident sign, along with the nurse or QMA, that the narcotic was given.

During an interview with LPN 15, on 10/30/23 at 2:05 p.m., she indicated Resident E had a bottle of tramadol missing and it didn't make since to her, but the bottle was never found. The DON had been in possession of the bottle, and she didn't know anything after that. She had seen the punch card of Xanax with tape on it for Resident F. The medication was discontinued but not destroyed. The pill that was taped inside the punch card and did not match the other pills.

During an interview with the Administrator and the Regional Nurse Consultant, on 10/30/23 at 2:57 p.m., they both indicated they were not aware of the missing bottle of tramadol, nor the missing Xanax.

A current, undated facility policy titled "Abuse, Neglect, and Misappropriation Policy and Procedure," provided by the Administrator on 10/30/23 at 9:55 a.m., indicated the following: "...Definitions...Misappropriation of Resident Property - the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent...."

A current facility policy, dated 2/2019, titled "Narcotic/Controlled Substance Monitoring," provided by the Administrator on 10/31/23 at 11:43 a.m., indicated the following: "...Procedure...Any discrepancies with the narcotic count will be reported to the Director of

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	Nursing and the Executive Director at the time of the discrepancy is found...." A current facility policy, dated 2/2019, titled "Narcotics/Controlled Substance Disposal," provided by the Administrator on 10/31/23 at 11:43 a.m., indicated the following: "...Procedure...Narcotic that have been discontinued...will be destroyed...within 72 hours...."			
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3.			
	Based on record review and interview, the facility failed to complete reference checks for 4 of 5 employee files reviewed (QMA 11, LPN 6, QMA 19 and CNA 18) and the facility failed to complete criminal background checks through the central repository (maintained by the Indiana State Police) for 5 of 5 employee files reviewed (QMA 11, QMA 23, LPN 6, QMA 19 and CNA 18). Findings include: Employee files were reviewed on 10/30/23 at 1:30 p.m. Pre-employment references were not completed for the following employees: QMA 11, hire date of 12/8/22.	R 0116	It is the policy of Priority Life Care that perspective employees have the proper pre-employment screenings to work in our facilities. All current employee files were audited on 11/10/2023 by the administrative assistant to ensure they were compliant with PLC policy. All files that were found to be out of compliance will be updated by 12/01/2023. All background checks for employees hired after 10/31/2023 will be ran through the State of Indiana Repository via the Indiana State Police and continue ongoing. All future employees will be onboarded according to PLC policy and will be ran through the	12/01/2023

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	LPN 6, hire date of 6/25/23. QMA 19, hire date of 7/9/23. CNA 18, hire date of 7/31/23. A third party company was used for criminal background screening for the following employees, and lacked use of the Indiana State Police repository: QMA 11, hire date of 12/8/22. QMA 23, hire date of 6/25/23. LPN 6, hire dated of 6/25/23. QMA 19, hire date of 7/9/23. CNA 18, hire date of 7/31/23. During an interview with the Administrator, on 10/30/23 at 2:57 p.m., he indicated reference checks were not completed QMA 11, QMA 23, LPN 6, QMA 19 and CNA 18. The company used to complete criminal background checks did not go through the Indiana repository. The company only checked the local counties and the national register. A current, undated facility policy, titled "Reference Checks," provided by the Administrator, on 10/31/23 at 11:43 a.m., indicated the following: "...1. A minimum of two reference checks will be made on each applicant being considered for any position...." A current, undated facility policy, titled "Criminal Background Checks," provided by the Administrator, on 10/31/23 at 11:43 a.m., indicated		State Repository via the Indiana State Police. Facility will review all required documentation and ensure all new employees have been properly onboarded. A review of the pre-employment policy will be done with department heads on 11/20/2023. All required procedures in the policy will be followed by facility going forward and no future employees will be allowed to work without required documentation. All pre-employment documentation will be reviewed prior to any new employees working on the floor to ensure that all required processes and policies are followed related to the hiring policy. This will be initiated and conducted by the ED/Designee and will be ongoing. A QAPI plan has been initiated and will be followed/reviewed and revised in the monthly QA meeting. Date of compliance: 12/01/2023	

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	the following: "...Priority Life Care may obtain information about you from a consumer reporting agency for employment purposes...Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into you education and/or employment history conducted by EmployeeScreenIQ...." This citation relates to Complaint IN00417206.			
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.			
	Based on record review and interview, the facility failed to update service plans to address preventative interventions to prevent recurrence of falls for 3 of 3 residents reviewed for falls (Resident B, Resident D and Resident G). Findings include: 1. Resident B's clinical record was reviewed on 10/27/23 at 10:29 a.m. Diagnoses included anxiety disorder, essential (primary) hypertension, unsteadiness on feet, and dementia in other disease classified elsewhere, moderate, with anxiety. A BIMS (Brief Interview for Mental Status) assessment, dated 9/11/23, indicated she was severely cognitively impaired.	R 0214	It is the policy of Priority Life Care that service plans are to be reviewed and updated as needed with all falls Residents B, D, and G care plans have been reviewed and updated as needed. All residents at risk for falls have the potential to be affected. Facility will review all residents at risk for falls. A review of fall risk and service plan will be completed to ensure accurate risks identified and proper interventions in place. Updates to service plans will be completed as needed. A review of policy for falls will be done with staff on or before	12/01/2023

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	Her medications included amlodipine besylate (treat high blood pressure) 10 mg daily, lisinopril (treat high blood pressure) 10 mg daily, sertraline (treat anxiety) 50 mg daily and hydralazine (treat high blood pressure) 25 mg three times daily. She had a care plan for falls (7/3/23). Interventions included remind her to call for assistance (7/3/23), rolling walker and proper footwear (8/23/23), she was at risk for falls due to fast gait and not using her walker at times (8/23/23), assure non-skid footwear (8/25/23), frequent checks (8/25/23). She had a care plan for an actual fall with fracture to her right shoulder due to weakness, ambulates with fast gait (7/6/23). She required frequent reminders to use her walker (7/6/23). Her interventions included evaluate and monitor for three days after the day the fall occurred. Report any changes with vital signs, changes with condition or status such as: pain, skin discolorations, swelling, difficulty moving an extremity, change in mental status to the nurse. Immediately report to the nurse any new onset of confusion, sleepiness, inability to maintain posture, agitation (7/6/23), evaluate the environment at the time and location of the fall and attempt to identify any factors that may have contributed to the fall, such as uneven surfaces, bed not in lowest position, poor lighting or glare present, not wearing footwear with non-skid soles, not using/wearing assistive device (sensory - glasses, hearing aid; function - walker, cane, etc.), frequently used items not within easy reach, etc. and report findings to supervisor (7/6/23), pharmacy consult for drug regimen review as needed (7/6/23), review medications administered in the last 24 hrs. that may have contributed to a fall (7/6/23), therapy referral for		12/01/2023. Will also include review of risks with falls and need for new interventions. All falls will be reviewed in the daily stand up meeting to ensure that all required processes are followed. This will be initiated by the DON/Designee and will be ongoing. A QAPI plan has been initiated and will be followed/reviewed and revised in the monthly QA meeting. Date of compliance: 12/01/2023	

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	strength and mobility/balance post fall and as needed per physician order (7/6/23) and assure proper footwear (8/9/23). Her nurses notes indicated the following: On 7/3/23 at 8:48 a.m., she fell in the hallway. Her fall intervention was to remind her to call for assistance (7/3/23). On 7/5/23 at 5:40 p.m., she was found lying on the floor in hallway on left side. On 7/6/23 at 3:35 p.m., she walked fast in the hallway, staff went to slow her down and she went around corner and fell, she complained of right shoulder pain. On 7/6/23 at 10:50 p.m., she had a fracture to her right shoulder. Her fall interventions were evaluate and monitor for three days after the day the fall occurred. Report any changes with vital signs, changes with condition or status such as: pain, skin discolorations, swelling, difficulty moving an extremity, change in mental status to the nurse. Immediately report to the nurse any new onset of confusion, sleepiness, inability to maintain posture, agitation (7/6/23), evaluate the environment at the time and location of the fall and attempt to identify any factors that may have contributed to the fall, such as uneven surfaces, bed not in lowest position, poor lighting or glare present, not wearing footwear with non-skid soles, not using/wearing assistive device (sensory - glasses, hearing aid; function - walker, cane, etc.), frequently used items not within easy reach, etc. and report findings to supervisor			

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		A. BUILDING 00 B. WING	10/31/2023

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	(7/6/23), pharmacy consult for drug regimen review as needed (7/6/23), review medications administered in the last 24 hrs. that may have contributed to a fall (7/6/23), and therapy referral for strength and mobility/balance post fall and as needed per physician order (7/6/23). On 7/9/23 at 10:15 a.m., she had three falls during the shift. She was found on floor of her bathroom, she stated she "tripped" and was unable to get up. She was witnessed attempting to go to the bathroom and tripped on her rug, she was caught by the staff member and eased to the ground. She was found in the hallway again after attempting to ambulate without rollator. On 7/10/23 at 5:26 a.m., she was educated several times on using her pendant to call for help before getting up. She was very forgetful and kept tripping on her feet when she attempted to ambulate with her rollator. She was now being checked on every 20 minutes. Her fall intervention was to assure proper footwear (implemented 8/9/23). On 8/11/23 at 5:50 p.m., she walked in the hallway with a fast gait and when she came around the corner, she fell on her right side, on the floor. Her fall interventions were a rolling walker, proper footwear and she was at risk for falls due to fast gait and not using her walker at times (implemented 8/23/23). On 8/24/23 at 4:00 p.m., she was found her in her room, on the floor, beside bed lying on her stomach. On 8/24/23 at 9:37 p.m., she was found in her			

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room, on the floor, beside her bed lying on her left side.

Her fall intervention was frequent checks (implemented 8/25/23).

On 9/20/23 at 3:48 p.m. she lost her balance and fell in the dining room landing on her buttocks.

On 10/9/23 at 5:26 a.m., she was found slumped over the living room couch. When approached, she was breathing hard, she had a bruise to her right side of her temple and eye, she had a skin tear to her right elbow.

On 10/9/23 at 3:29 p.m., she was found on floor in her room.

2. Resident D's clinical record was reviewed on 10/27/23 at 11:55 a.m. Diagnoses included essential (primary) hypertension atrial fibrillation and bradycardia.

Her medications included citalopram hydrobromide (treat depression) 10 mg daily, hydrochlorothiazide (treat high blood pressure) 12.5 mg daily, trazodone (treat depression) 100 mg daily, metoprolol tartrate (treat high blood pressure)50 mg twice daily, and amlodipine besylate (treat high blood pressure) 2.5 mg daily.

A BIMS assessment, dated 9/20/23, indicated she was moderately cognitively impaired.

She had a care plan for falls (7/21/23). Her interventions included a rolling walker (7/21/23) and remind her to call for assistance (7/21/23).

Her nurses notes indicated the following:

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On 10/17/23 at 9:41 p.m., she was returning to the front room from the shower. She backed up to the recliner with her walker and tripped over the arm of the recliner and fell onto her buttocks.

On 10/30/23 at 5:42 a.m., she pressed her call pendant, she was found lying on her back next to the bed.

Her service plan/care plan was not updated with new interventions to mitigate her risk for falls.

3. Resident G's clinical record was reviewed on 10/31/23 at 8:50 a.m. Diagnoses included syncope and collapse, age-related osteoporosis without current pathological fracture, unspecified dementia, severe with behavioral disturbance, and Alzheimer's disease.

Her medications included donepezil (treat Alzheimer's disease)10 mg daily, furosemide (treat high blood pressure) 20 mg daily, escitalopram oxalate (treat depression) 20 mg daily, olanzapine (treat mental disorders) 10 mg daily, trazodone 50 mg daily, and quetiapine fumarate (antipsychotic) 50 mg every morning and 75 mg at bedtime.

A BIMS assessment, dated 9/6/23, indicated she was severely cognitively impaired.

She had a care plan for being at risk for falls related to gait problems, impaired mobility, she had a fall with no injuries, she sat herself on the floor at times when she doesn't know what to do (revised 7/26/23) Her interventions included encourage participation in activities that would increase strength and mobility (6/15/23), encourage to ask for assistance when feeling weak (6/15/23), encourage her to stay in the common areas to promote more supervision

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	(6/15/23), evaluate, interview and document resident physical condition and cognitive status, observe environment to identify any potential factors that could contribute to a fall, such as lighting, uneven/slippery/cluttered floor surfaces, improper footwear, failure to use assistive devices, etc., remove any potential causes or hazards, if possible, educate of potential fall hazards (6/15/23), and inform her about safety reminders and what to do if a fall occurs (6/15/23). Her nurses notes indicated the following: On 7/17/23 at 8:03 a.m., she was found on the floor in another resident's bathroom. On 7/26/23 at 2:49 a.m., she was found on the floor in the hallway outside her room. Her fall intervention was to monitor frequently (7/26/23) On 7/29/23 at 9:30 a.m., she was found sitting on the floor in her room. On 10/21/23 at 6:15 a.m., on the previous shift, she was found sitting in an upright position on the floor in her room next to the bed with blankets on the floor within reach. On 10/27/23 at 11:06 a.m., she was laying on her left side in the doorway to her room. Her wheelchair was in front of her. On 10/28/23 at 1:30 p.m., she was on the floor in the dining room. On 10/28/23 at 4:30 p.m., she was observed on the floor in her apartment, she was laying on her right side in a lying position in the bathroom. Blood			

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was observed on the floor of the apartment, on bathroom floor, and in resident's hair. Head-to-toe assessment revealed a laceration to the right side of her head. Area was cleansed, but it was too deep to place steri-strip on. 911 called was called.

Her service plan/care plan was not updated with new interventions to mitigate her risk for falls.

During an interview with the Regional Nurse Consultant, on 10/31/23 at 10:24 a.m., she indicated the service plans should be updated after a fall.

A current, undated facility policy titled "Post-Fall Management After a Resident Fall," provided by the Administrator on 10/31/23 at 11:43 a.m., indicated the following: "...Service Plans are to be updated, including when the actual fall occurred and what interventions were put in to place to prevent future falls...."