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	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLARKSVILLE SENIOR LIVING LLC	400 HUNTER STATION ROAD SELLERSBURG, IN 47172

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00443193. Complaint IN00443193 - State deficiencies related to the allegations are cited at R0052 and R0006. Survey dates: October 2 and 3, 2024. Facility number: 013841 Residential Census: 101 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 13, 2024.	R 0000		
R 0006 Bldg. 00	410 IAC 16.2-5-0.5(f)(1-5) Scope of Residential Care - Deficiency Based on record review and interview, the facility failed to ensure a resident with abuse behaviors was reviewed for placement to prevent harm to other residents residing in the dementia unit for 1 of 2 residents reviewed for placement. (Resident F) Finding includes: The record for Resident F was reviewed on 10/2/24 at 9:14 a.m. The resident's diagnosis included, but was not limited to, Lewy Body dementia with hallucinations and delusions. The nurse's note, dated 1/16/24 at 7:15 p.m., indicated that a CNA (Certified Nurse Aide)	R 0006	**Corrective Action(s) for Residents Affected by the Deficient Practice**Residents F and H no longer reside at the community. **Corrective Action(s) for Other Residents Potentially Affected** **A**ll other memory care residents have the potential to be affected by this deficient practice; however, none were affected. **Measures to Ensure the Deficient Practice Does Not Recur** Wellness Director and Executive Director was educated on scope of residential care and	11/01/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathy Jones	Executive Director	10/22/2024

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	witnessed Resident F on his knees in front of Resident H on the floor. Resident F was hitting Resident H in the facial area. The Psychiatric Progress note, dated 2/1/24, indicated the resident had physical aggression, anxiety, confusion and SAO (Sexually Acting Out). The Psychiatrist indicated the resident's family member was concerned that the resident was on too much medication, and this was causing him to fall. He had been involved in altercations over the past few weeks. The nurse's note, dated 2/6/24 at 6:00 p.m., indicated the resident was agitated and picked up chairs. The nurse attempted to redirect the resident three times and was unsuccessful. The prn (as needed) ativan was given. The nurse's note, dated 5/21/24 at 3:30 p.m., indicated the resident became agitated while sitting in the day room. The resident used foul language and tried to grab the furniture. He was not easily redirected. The CNA was able to relocate him to another area in the day room without incident. The nurse's note, dated 6/4/24 at 8:37 p.m., indicated Resident H was sitting on the couch when Resident F began crawling on the floor. Resident F was attempting to "pick items off the floor" and was close to Resident H's foot. Resident F then kicked Resident H. Resident F crawled away from Resident H. Staff approached the living room area and saw Resident F was still kicking toward Resident H. Resident F and Resident H were separated immediately. The nurse's note, dated 7/8/24 at 4:46 p.m., indicated Resident F was in the dining area, when		discharge criteria by Area Vice President of Operations (AVPO) and Regional Director of Clinical Operations (RDCO). Memory Care Staff will be educated on the scope of residential care related to the discharge process and criteria. Education will be presented by the Executive Director and/or designee by 10/31/2024. Newly hired memory care staff will be educated during orientation ongoing. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Memory Care Director and/or Wellness Director will interview staff to ensure understanding of the scope of R006 and our discharge criteria. The Memory Care Director and/or designee will interview 3 staff members weekly for 4 weeks then 2 staff members weekly for 4 weeks then 1 staff member weekly for 4 weeks. The Memory Care Director will review results of the interviews at the QA meeting. The Quality Assurance committee will determine the need for further revisions or corrective actions as well as a need to change the frequency and length of continued audits.	

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	he reached out for the activity aide's hand, as if he was going to shake it. The resident then grabbed the activity aide's hand and started twisting and squeezing it. The aide screamed for help, and the nurse and CNA rushed over to help the activity aide. That was when the resident started hitting and punching staff and walking towards other residents. The nurse and CNA grabbed the resident's arms and walked the resident away from the other residents. The nurse's note, dated 7/15/24 at 10:15 a.m., indicated that Resident F was walking up to Resident K in the common area and kick him from behind. The nurse tried to redirect Resident F and he attempted to punch the nurse several times. Resident F indicated, "He tried to attack me." A CNA and two other nurses attempted to redirect Resident F. Resident F was now sitting outside with another nurse. The nurse's note, dated 8/12/24 at 5:26 p.m., indicated a CNA called the nurse over to the nurse's station. The resident was actively hallucinating and attempting to hit staff. The resident was up, within the unit, running throughout the halls and indicated he was "trapped" and he was "trying to get out." The resident was not easily redirected. Multiple staff members attempted to calm the resident down and were unsuccessful. The resident began pushing chairs, throwing them at staff, and attempting to throw the dining room tables. The resident then walked over to a bookshelf and began to hit and kick. The nurse was able to redirect the resident. The resident began to swing his fists and curse at the nurse. The nurse's note, dated 8/21/24 at 2:45 p.m., indicated the nurse observed the resident walking,			

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	unstable, around the unit with no socks or shoes on. A CNA attempted to sit the resident down and put shoes on him when the resident indicated, "I will knock your teeth out." The resident walked to a chair and tried to sit down, when he missed the chair and fell to his bottom. The nurse's note, dated 9/5/24 at 2:16 a.m., indicated the nurse and CNA were in the kitchen area getting bedtime snacks together when we heard resident J say, "Get off me, don't touch me." When they turned around Resident F had hold of resident J's right wrist. When the nurse got to Resident J, she was able to get Resident F to let go of Resident J's wrist. Resident J then drew hand back and hit Resident F in the chest. The review of the Psychiatric progress note, dated 9/5/24, indicated staff reported that Resident F was having increased sexual behaviors. He asked a CNA, "Do you want to go F**k." The nurse's note, dated 9/12/24 at 7:13 p.m., indicated Resident E came up to the nurse and indicated Resident F punched Resident E in the face five times while Resident E was in the hall. The nurse took Resident E to the office to be assessed. The nurse noticed Resident E had red areas on the bilateral cheekbones. The nurse's note, dated 10/2/24 at 10:46 p.m., indicated a CNA heard Resident F yelling down the hallway. When the CNA got to Resident F he had Resident P by the arm and Resident P was trying to shut the door on Resident F. The CNA was able to get the residents separated. Resident F was unable to tell the nurse what had happened. Resident F kept indicating it would have to go in front of the jury.			

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	During an interview on 10/3/24 at 9:10 a.m., LPN (Licensed Practical Nurse) 3 indicated Resident F's dementia was worse than the other residents' dementia. He hovered over residents. He was not appropriate for the dementia unit. The other residents could not be protected from him, and he could not be protected from other residents. He would hallucinate a lot, and he would turn on the staff if they tried to keep him one on one. Everyone could be a target for the resident. He would calm down when he heard his family member, but they didn't have a recording of her. All of the sudden he would become escalated. Sounds made him agitated, and he would just snap. During an interview on 10/3/24 at 10:12 a.m., the Memory Care Director indicated Resident F's altercations with other residents were provided to the DON (Director of Nursing) when they occurred, and the DON would let her know. She had only been the Director for a few months and didn't know a lot about him. He had Lewy Body dementia and was unpredictable. His behaviors had gotten more erratic recently. She felt it was not always about it being a trigger. One-on-one care could be provided, but staff had to be there ahead of time for a whole shift. Otherwise, his family member would provide that care. If he didn't have family, he would be sent to a psychiatric facility if he couldn't be redirected. The Psychiatric NP would be notified of an altercation. His Lewy Body's was progressing. His family member refused to allow the use of medication. She was unrealistic with it. There would be a point when he would not be appropriate. She felt that the other residents were safe from him. Staff monitored him and she felt that there was enough staff. There weren't triggers and it would be hard to say when it would occur. He liked to be			

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	independent and would not attend activities. He was sensitive to noise. He would be taken to a quiet corner or to his room. Candy calmed him down, or he would be taken to her office and sometimes he would stay sitting there. Wandering was a part of his disease process. To discharge the resident, he would have to have multiple behaviors in a short amount of time. She couldn't say how many or how often that would be. She wasn't the one to make that call because she wasn't a nurse. That would be up to the ED (Executive Director) and DON (Director of Nursing). During an interview on 10/3/24 at 11:21 a.m., the ED indicated the approach by employees for Resident F was monitored. If two or three staff at a time were coming at him he became upset. Everything was geared toward the approach. He was sent back from the hospital soon after being sent there. Other facilities wouldn't take him due to his Lewy Body dementia. Only certain medications could be given for the Lewy Body dementia. With all of his events, his medications were changed. He would just flip out at times. She had looked at alternate placement, but they would not accept him. He had behaviors at home. His family member was not able to take care of him. During an interview on 10/3/24 at 2:06 p.m., CNA (Certified Nurse Aide) 4 indicated Resident F had behaviors and they just happened. He was the aggressor. He was a danger to the residents. He would have hallucinations and thought he was somewhere else. He should be more in a psychiatric facility than in assisted living. His behaviors came out of nowhere. He could be okay with care and then after the care started, he would become agitated. Loud noises did cause issues.			

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	The current Residency Agreement Assist Living Memory Care Indiana, included, but was not limited to, "... D. Discharge. The Community is required by law to discharge any resident who requires services or accommodation beyond that which it is licensed to provide, to that which it actually provides to residents. The Community may also discharge a resident in accordance with provisions listed in the State Addendum Under Discharge Criteria... M. Discharge Criteria. The resident must be discharged if the resident: 1. Is a danger to the residents or others..." This State tag relates to Complaint IN00443193 Cross Reference 0052			
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense Based on observation, interview and record review, the facility failed to provide adequate supervision and behavioral interventions to prevent abuse (Resident F and Resident H) and to effectively assess Resident F for appropriate placement prior Resident F returning from the psych hospital stay to prevent further abuse for 2 of 11 residents reviewed for abuse. Findings include: 1.a. The nurse's note, dated 1/16/24 at 7:15 p.m., indicated that a Certified Nurse Aide (CNA) witnessed Resident F on his knees in front of Resident H on the floor. Resident F was hitting Resident H in the facial area. Resident H was kicking Resident F in the face and head. The CNA stopped the residents from hitting each other and separated the residents to different locations. Upon assessment Resident F had no complaints	R 0052	**Corrective Action(s) for Residents Affected by the Deficient Practice** Residents F, H, L, O, and N are no longer reside at the community. **Corrective Action(s) for Other Residents Potentially Affected** All other memory care residents have the potential to be affected by this deficient practice; however, none have been affected. **Measures to Ensure the Deficient Practice Does Not Recur** Memory care staff will be educated on resident rights, behavioral interventions and adequate supervision Education will be presented by the ED and/or designee by 10/31/2024. Newly	11/01/2024

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	of pain with no injuries at that time. Resident F indicated that they were playing Rock em Sock em Robots and he didn't know who won. The record for Resident F was reviewed on 10/2/24 at 9:14 a.m. The resident's diagnosis included, but was not limited to, Lewy Body dementia with hallucinations and delusions. The nurse's note, dated 1/18/24 at 12:29 p.m., indicated the physician ordered Depakote 125 mg (milligrams) twice daily for Resident F for a diagnosis of mood disorder. The NP wrote new orders to discontinue the previous dose of lorazepam, and start lorazepam 0.25 mg at night, and to discontinue the lorazepam 0.25 mg daily prn (as needed). The nurse's note, dated 1/29/24 at 10:25 a.m., indicated Resident F was very tearful and indicated he had bad thoughts and was scared that he might act on them. A call was placed to the Psychiatric Nurse Practitioner (NP). The Psychiatric NP indicated she didn't want to treat the resident, unless he was combative or agitated. The Psychiatric NP wanted staff to decrease the resident's environment and separate residents from others. The nurse took the resident to his room and tried laying the resident down. The resident came back out and was in the common area. The Psychiatric Progress note, dated 2/1/24, indicated Resident F had physical aggression, anxiety, confusion and Sexually Acting Out (SAO). The Psychiatrist indicated the resident's family member was concerned that the resident was on too much medication and was causing him to fall. He had been involved in altercations over the past few weeks.		hired memory care staff will provide education during orientation ongoing. Investigation form updated to include record review completion and service plan review completion. ED, WD and/or MCD will review observations and complete investigation form to ensure incident is reviewed and service plan reflects current needs. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** ED, WD, and MCD will sign off that observations were completed. The AVPO and RDCO will audit investigation forms to ensure they are signed and completed as well as to ensure the ED, WD and MCD have completed review of observations. The audit will be completed weekly for 4 weeks then bi-weekly for 8 weeks then monthly for 3 months. The Executive Director will review results with the Quality Assurance committee. The Quality Assurance committee will determine the need for further revisions or corrective actions as well as a need to change the frequency and length of continued audits.	

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	The nurse's note, dated 2/1/24 at 3:46 p.m., indicated the NP was in the facility. A new order was documented to discontinue Resident F's depakote, previous lorazepam, and previous seroquel. Then start seroquel 12.5 mg twice daily, lorazepam 0.25 mg that night and every other night times 3 doses, lorazepam 0.25 mg daily prn. The nurse's note, dated 2/6/24 at 6:00 p.m., indicated the resident was agitated and picked up chairs. The nurse attempted to redirect the resident three times and was unsuccessful. The prn ativan was given. The nurse's note, dated 5/21/24 at 3:30 p.m., indicated the resident became agitated while sitting in the day room. The resident used foul language and tried to grab the furniture. He was not easily redirected. The CNA was able to relocate him to another area in the day room without incident. The nurse's note, dated 6/4/24 at 8:37 p.m., indicated Resident H was sitting on the couch when Resident F began crawling on the floor. Resident F was attempting to "pick items off the floor" and was close to Resident H's foot. Resident H then kicked Resident F. Staff approached the living room area and saw Resident F still kicking toward Resident H. Resident F and Resident H were separated immediately. The nurse's note, dated 7/8/24 at 4:46 p.m., indicated Resident F was in the dining area, when he reached out for the activity aide's hand as if he was going to shake it. The resident then grabbed the activity aide's hand and started twisting and squeezing it. The aide screamed for help, and the			

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	nurse and CNA rushed over to help the activity aide. That was when the resident started hitting and punching staff and walking toward other residents. The nurse and CNA grabbed the resident's arms and walked the resident away from the other residents. The nurse told the resident that they were his friends, and they were not there to hurt him. The residents continued to have hallucinations and continued to hit and kick toward staff. The CNA went up to the resident and tried to talk to him to calm him down. He headbutted the CNA in the mouth. The nurse and CNA called for help from other staff members. Staff came over to help and the resident calmed down after multiple attempts of trying to hit and kick staff but were unsuccessful. The DON and ED came over to assist and took the resident outside to calm him down. The ED stayed with the resident until a family member came to sit with the resident. When asked what happened, the resident indicated he was walking down a slope when he saw a teenager with green hair coming after him and was trying to hurt him. 1.b. The nurse's note, dated 7/15/24 at 10:15 a.m., indicated that Resident F was walking up to Resident K in the common area and kick him from behind. The nurse tried to redirect Resident F and he attempted to punch the nurse several times. Resident F indicated, "He tried to attack me." A CNA and two other nurses attempted to redirect Resident F. Resident F was now sitting outside with another nurse. PRN lorazepam was given and 15-minute checks were in place. During an interview on 10/3/24 at 9:15 a.m., Licensed Practical Nurse (LPN) 3 indicated Resident F kicked Resident K in the butt. He walked up to Resident K and kicked him from behind. Resident F tried to hit the nurse. A CNA			

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	and nurse tried to redirect Resident F. The nurse's note, dated 7/15/24 at 10:35 a.m., indicated a new order was received. The Psychiatric NP ordered to send Resident F to a psychiatric hospital related to his aggressive behavior. The ED was to contact the resident's family member. The Service Plan, dated 8/6/24, indicated Resident F displayed behaviors. The intervention indicated staff were to intervene accordingly when the resident exhibited behaviors. The resident had a diagnosis of Lewy Body dementia and could have hallucinations and delusions and could be aggressive at times. Please attempt redirection. The service plan did not include documentation to show the service plan was revised with new, effective interventions to prevent resident to resident abuse perpetrated by Resident F between 1/16/24 and 7/15/24. The nurse's note, dated 8/12/24 at 5:26 p.m., indicated a CNA called the nurse over to the nurse's station. Resident F was actively hallucinating and attempting to hit staff. The resident was up, within the unit, running throughout the halls and indicated he was "trapped" and he was "trying to get out." The resident was not easily redirected. Multiple staff members attempted to calm the resident down and were unsuccessful. The resident began pushing chairs, throwing them at staff, and attempting to throw the dining room tables. The resident then walked over to a bookshelf and began to hit and kick. The nurse was able to redirect the resident. The resident began to swing his fists and curse at the nurse. The nurse and another staff member were able to remove all tables and chairs from the resident's line of sight. The resident then became			

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	unsteady and was assisted into a wheelchair. The resident attempted to hit and kick staff from his seated position. The Psychiatric NP was notified, and a new order was received for the resident to be given one dose of Risperdal 0.25 mg now and every evening, routinely. The nurse was unable to attempt to administer medication due to the resident being agitated and aggressive. The nurse was able to call resident's family member. The resident's family member was able to speak to the resident and the resident calmed down. The resident then allowed the nurse to administer the one-time dose of Risperdal. The resident was taken back to his room for 15-minutes. After the 15 minutes, the resident was placed in his wheelchair by the nurse's station. The nurse's note, dated 8/21/24 at 2:45 p.m., indicated the nurse observed the resident walking, unstable, around the unit with no socks or shoes on. A CNA attempted to sit the resident down and put shoes on him when the resident indicated, "I will knock your teeth out." The resident walked to a chair and tried to sit down, when he missed the chair and fell to his bottom. The resident did not hit his head and did not sustain any injuries. He denied any pain or discomfort. 1.c. The nurse's note, dated 9/5/24 at 2:16 a.m., indicated the nurse and CNA were in the kitchen area getting bedtime snacks together when they heard Resident J say, " Get off me, don't touch me." When they turned around Resident F had hold of Resident J's right wrist. When the nurse got to Resident J, she was able to get Resident F to let go of Resident J's wrist. Resident J then drew his hand back and hit Resident F in the chest. At that point the nurse got between the residents and was able to redirect both residents away from each other. Resident J was assessed,			

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	and no injuries were observed. During an interview on 9/4/24 at 9:18 a.m., LPN 3 indicated during the incident, the nurse heard Resident J yell, "Get off of me, don't touch me." Resident F had grabbed Resident J's wrists and walker. Resident F was brought off of Resident J. Resident J then punched Resident F in the chest. An order for cimetidine 400 mg was given to Resident F. The review of the Psychiatric progress note, dated 9/5/24, indicated staff reported that Resident F was having increased sexual behaviors. He asked a CNA, "Do you want to go F***." The nurse's note, dated 9/7/24 at 2:26 p.m., indicated the resident had an increase in sexually inappropriate behavior. Resident F had a history of Lewy Body dementia. Resident F declined vital signs from being obtained. A call out to the on-call Psychiatric NP was made and a new order for Estradiol Transdermal Patch 0.1 mg every 7 days was obtained. 1.d. The nurse's note, dated 9/12/24 at 7:13 p.m., indicated Resident E came up to the nurse and indicated Resident F had punched Resident E in the face five times, while Resident E was in the hall. The nurse took Resident E to the office to be assessed. The nurse noticed Resident E had red areas on the bilateral cheekbones. When the nurse went and asked Resident F what happened, he indicated Resident E was coming at him and he asked her to stop. Resident F's family member was notified. A new order for Resident F to have one on one supervision for 24 hours until he was behavior free for 24 hours. Resident F's family member was called, and came to get the resident until Saturday morning.			

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	During an observation on 10/3/24 at 9:15 a.m., Resident F walked into the resident dining room without clothes on. The resident was naked. There were 11 residents still in the dining room eating breakfast. During an interview on 10/3/24 at 9:22 a.m., LPN 3 indicated Resident F was asleep on the couch. He walked and gave the LPN a hug. Resident F fell asleep on the couch again. He got up and went walking. There were no distractions. Resident F went around the hall's corner. Resident E told the LPN that Resident F just punched her in the face. Resident F had already returned to the couch and was asleep. They watched the cameras and saw Resident F punch Resident E in her face 12 times. Resident F acted as if nothing had happened. His behaviors were unpredictable. He could think someone was coming to get him. Resident F's family member did one on ones for 24 hours and the NP gave new orders. Resident F's depakote was changed to 4:00 p.m. A week later it was increased to three times a day, at 8:00 a.m., 2:00 p.m. and 8:00 p.m. His Seroquel was changed to mornings. Resident F's family member was reluctant to let him have medications, because she didn't want him snowed (under the influence of neuroleptic drug/powerless). During an interview on 10/3/24 at 9:10 a.m., LPN 3 indicated Resident F and Resident H had multiple altercations. The residents could be separated from each other, but then Resident F would wonder. His dementia was worse than the other residents' dementia. He hovered over residents. He was not appropriate for the dementia unit. The other residents could not be protected from him, and he could not be protected from other residents. He would hallucinate a lot and he would			

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	turn on the staff if they tried to keep him one-on-one (one staff to one resident observation). Everyone could be a target for the resident. He would calm down when he heard his family member, but they didn't have a recording of her. His family member allowed his depakote and Seroquel increased now. All of the sudden he would become escalated. Sounds made him agitated, and he would just snap. Resident F had hallucinated, and he could not be brought back to reality. He didn't have a personal space. During an interview on 10/3/24 at 10:12 a.m., the Memory Care Director indicated Resident F's altercations with other residents were provided to the DON when they occurred. The DON would let her know what to do. She had only been the Director for a few months and didn't know a lot about him. He had Lewy Body Dementia and was unpredictable. His behaviors had gotten more erratic recently. She felt it was not always about it being a trigger. One-on-one care could be provided, but staff had to be there ahead of time for a whole shift. Otherwise, his family member would provide that care. If he didn't have family, he would be sent to a psychiatric facility if he couldn't be redirected. The Psychiatric NP would be notified of an altercation. His Lewy Body's was progressing. His family member refused to allow the use of medication. She was unrealistic with it. There would be a point when he would not be appropriate. She felt that the other residents were safe from him. Staff monitored him and she felt that there was enough staff. There weren't triggers and it would be hard to say when it would occur. He liked to be independent and would not attend activities. He was sensitive to noise. He would be taken to a quiet corner or to his room. Candy calmed him down, or he would be taken to her office and sometimes he would stay sitting there.			

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	Wandering was a part of his disease process. To discharge the resident, he would have to have multiple behaviors in a short amount of time. She couldn't say how many or how often that would be. She wasn't the one to make that call because she wasn't a nurse. That would be up to the ED and DON. During an interview on 10/3/24 at 11:21 a.m., the ED indicated she monitored the residents by camera after an occurrence. On every event, he was not the aggressor. The whole plan had changed. It was his surroundings that caused occurrences. Things would be adjusted, or family was called. He would be asleep on all fours at times. He would get kicked by Resident H. Resident F didn't know about his own whereabouts. The approach by employees was monitored and if two to three staff at a time were coming at him, he became upset. Everything was geared toward the approach. On the incident with Resident J, she was hitting him with the walker and he just wanted to get past her to go to his room. He grabbed her hand and her walker at the same time. She had talked to the resident's family member several times about hospice and a psychiatric facility. This was after the employee event. He was sent back from the hospital soon after being sent there. Other facilities wouldn't take him due to his Lewy Body dementia. He was the aggressor with Resident E because to him, she was like one of the employees and she was coming toward him. He was not ever sexual. She would look at those cases for the Estradiol patch and Tagamet, but she felt those medications were for his dementia. That wasn't for being sexual though. Only certain medications could be given for the Lewy Body dementia. With all of his events, his medications were changed. He would just flip out at times. She had looked at alternate			

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	placement, but they would not accept him. He had behaviors at home. His family member was not able to take care of him. She was calming to him though. During an interview on 10/3/24 at 2:06 p.m., CNA 4 indicated Resident F had behaviors and they just happened. He was the aggressor. He was a danger to the residents. He would have hallucinations and thought he was somewhere else. He should be more in a psychiatric facility than in assisted living. His behaviors came out of nowhere. He could be okay with care and then after the care started, he would become agitated. Loud noises did cause issues. Cross Reference 0006 2.a. The Incident Form, dated 5/7/24 at 1:00 a.m., indicated the CNA was doing her rounds and found Resident N in bed with Resident H. Resident H had his shirt off. Resident N became verbally aggressive and was not easily redirected but was finally redirected back to her room. The residents were placed on 15-minute checks. The nurse's note, dated 5/25/24 at 7:45 p.m., indicated Resident N voiced complaints that Resident H pushed her down. When staff questioned Resident H he refused to answer, and ignored all staff. No apparent injury, emotional or psycho-social distress was observed. The other residents that were present indicated Resident H did make contact with Resident N. He was without any signs of aggression or agitation at that time. Staff removed Resident H and Resident N away from each other with continued every 15-minute observation provided to Resident H by staff. The nurse's note, dated 5/30/24 at 10:00 a.m., indicated the Psychiatric NP to see Resident H. A			

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	new order was received for cimetidine 400 mg oral one time daily. The record for Resident H was reviewed on 10/2/24 at 11:14 a.m. The resident's diagnosis included, but was not limited to, Alzheimer's disease. 2.b. The Aggressive Act Incident report, dated 6/4/24 at 8:35 p.m., indicated Resident H was sitting on the couch when Resident F was observed to be crawling on the floor. Resident F was attempting to "pick items off the floor" and was close to Resident H's foot. Resident H then kicked Resident F. Resident F crawled away from Resident H. The staff approached the living room area and observed Resident H still kicking towards Resident F. Resident H and Resident F were separated immediately. The NP and the families were notified. The nurse's note, dated 6/6/24 at 3:28 p.m., indicated the Psychiatric NP saw Resident H. A new order was received to discontinue Escitalopram and Paroxetine 10 mg, oral daily. 2.c. The nurse's note, dated 6/13/24 at 4:09 p.m., indicated Resident H was found in his room in bed with a female Resident L, unclothed. The resident was easily redirected. The resident was assessed with no signs and symptoms of distress or visible injury was observed. His mood was pleasant and cooperative. Resident H chose to stay in his room and indicated he would, "be out in a bit." The Psychiatric NP was on the unit and gave new orders to discontinue the lorazepam, increase Paroxetine to 20 mg QD (everyday), depo provera 150 mg IM (intramuscular) every 2 weeks related to SAO. The POA was notified.			

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	2.d. The nurse's note, dated 7/4/24 at 3:55 p.m., indicated Resident H was in the common area when he approached another female resident. Resident H then began to rub on the female's arms. Resident O's family member called the CNA over for help with Resident H. When the CNA tried to remove Resident H away from Resident O, he told the CNA, "don't touch me again. I don't have to do anything," and he would not move away. Resident O's family member started to get frustrated with Resident H. The CNA called the nurse to assist with the situation. When the nurse came over, she asked Resident H to move away from Resident O and stop rubbing her arm and blowing in her ear. Resident H told the nurse he didn't have to do anything. He refused to move and then started blowing in Resident O's ear. The nurse moved Resident O away from Resident H. Resident H walked away and went to sit on the couch in front of the television. The DON and the resident's POA were notified and a new order for Risperdal 0.25 mg oral at bedtime was received from the Psychiatric NP. The first dose was to be given with his bedtime medications. During an interview on 10/3/24 at 9:45 a.m., LPN 3 indicated during the incident with Resident H, he went up to Resident O and tried to kiss her. She tried to get away from Resident H. The Psychiatric NP put him on Risperdal and 15 minute checks for three days. 2.e. The nurse's note, dated 7/5/24 at 11:13 a.m., indicated Resident H was in the dining area. He was observed sticking his fingers in the other residents' food. The nurse attempted to redirect the resident, and the resident indicated, "Leave me the hell alone!" After multiple attempts, the nurse was able to remove the other residents' food away from Resident H. Resident H finished			

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	breakfast, got up, and was ambulating throughout the unit with a butter knife in his hand. The staff attempted to remove the knife, and the resident became upset. The staff was able to eventually get the knife away from the resident. Resident H then walked over to a female resident, and got in her face. The female resident began to yell. The staff intervened immediately. The staff asked Resident H to please move away from the female resident and he became agitated and angry with staff. The female resident was moved away from Resident H. He then sat down on the couch. The NP was notified and a new order was received for Depakote Sprinkles 125 mg oral twice a day, and obtain a UA (Urinalysis) and a culture and sensitivity. 2.f. The nurse's note, dated 7/6/24 at 3:00 p.m., indicated the nurse was called to the dining room where Resident H was standing in between two CNAs. Resident H was observed rubbing on another resident. The CNA tried to intervene, and Resident H indicated, "I'm not going, I'm not going." A second CNA tried to redirect the resident. Resident H attempted to punch the CNA. The CNA stopped the resident's punch. The nurse directed Resident H to a seat. Resident H was under supervision. A referral was sent out to the behavioral hospital per the NP request. Every 15-minute checks were in place. The nurse's note, dated 7/6/24 at 5:57 p.m., indicated paperwork was sent to the behavioral hospital. The resident was denied admission. The Psychiatric NP was notified and a new order was received to increase his Depakote to three times daily. 2.g. The nurse's note. dated 7/8/24 at 11:30 a.m., indicated Resident H was in the common area			

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	touching Resident L's arm. Multiple attempts were made to get Resident H to stop touching the female's arm. Resident L was removed from the situation. Resident H then walked over to Resident N and started rubbing on her and trying to kiss her on the mouth. When Resident H was asked to stop, he became aggravated and refused to leave Resident N alone. The CNA moved Resident N away from Resident H after multiple attempts of trying to get him away from the females. The nurse's note, dated 7/8/24 at 5:17 p.m., indicated the behavioral hospital arrived to transport the resident. Resident H was made aware that transport was here to get him, and the resident indicated to the nurse, "I ain't going nowhere, shut the f--k up." Resident H went to use the bathroom and then transport approached the resident and he left without incident. The review of the Service Plan, dated 7/16/24, indicated Resident H displayed behaviors. The resident had a history of sexual behaviors and was observed at times to hold hands, kiss residents on the cheek and pat them on the back. The resident's service plan did not include documentation to show the service plan was revised with new, effective interventions to prevent resident to resident abuse between 5/7/24 and 7/8/24. The record lacked documentation indicating Resident H was effectively provided continuous supervision to prevent further resident-to-resident physical altercations prior to the events. The resident's plan of care lacked effective interventions to prevent further resident-to-resident physical altercations.			

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	The nurse's note, dated 7/17/24 at 3:37 p.m., indicated Resident H was sitting in the common area when he got up and walked over to a female resident with a wheelchair cushion in his hand. The CNA asked the resident nicely to put the wheelchair cushion away and the resident started getting aggressive towards the CNA. The CNA called the nurse over to help. When the nurse walked over and asked the resident to put the wheelchair cushion back, the resident became combative and started to kick and hit the staff. The nurse was able to get the cushion away from the resident, but the resident grabbed the nurse by her arms and wouldn't let go. The nurse was able to remove her arms away from the resident. While all of this happened, the resident indicated, "I'll beat the s--t out of all of you guys. During an interview on 10/3/24 at 9:38 a.m., LPN (Licensed Practical Nurse) 3 indicated interventions worked for a while with Resident H. As his neck growth became larger, he was harder to redirect. He was appropriate for the unit but had sexual behaviors. Most of the men in the unit did. Resident H and Resident F were observed to have aggressive behaviors toward each other. They were protective of their women. During an interview on 10/3/24 at 2:14 p.m., CNA 4 indicated Resident H did not want to listen to anyone. He was hard to redirect, and the interventions didn't always work. He had issues with the male residents if they got in his way. The Resident Neglect, Abuse and Misappropriation of Property policy, dated June, 2014, and last revised February, 2022, included, but was not limited to, " ...(Residents will be free from misappropriations of resident property, and verbal, sexual, physical, and mental abuse,			

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	corporal punishment and involuntary seclusion... 6. The results of all investigations are reported to the Executive Director. The outcome of investigations will be utilized to identify, correct, and intervene in precipitating factors that led to the allegations of abuse, neglect, or misappropriation of property or injury of unknown etiology..." This State tag relates to Complaint IN00443193			