STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW BROOK SENIOR LIVING	11011 VILLAGE SQUARE LANE, FISHERS, , 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00370385 and a Residential COVID-19 Quality Assurance Walk Through. Complaint IN00370385 - Substantiated. State Residential Findings are cited at R52, R91, and R217. Survey Date: January 26, 2022 Facility Number: 013163 Residential: 78 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 28, 2022	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 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu a Post Survey Review.	
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from:	R 0052	<u>RO52 Resident Rights</u> ***What corrective actions will be accomplished for those residents found to have been***	03/10/2022

	(1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to ensure residents were free from sexual abuse for 3 of 3 residents reviewed for abuse. (Residents B, D, and F) Findings include: The clinical record for Resident B was reviewed on 1/26/22 at 11:51 a.m. The diagnoses included, but were not limited to, dementia and end stage renal disease. The 12/23/21, 11:43 a.m. nurse's note, written by QMA (Qualified Medication Aide) 2, read, "Today at lunch [name of Resident B] was touching [name of Resident F's] breast and private area. He was removed from table. He then began to use loud profanity causing a scene in the dinner room. I explained to him the reason why he was being moved from table and also let him now [sic] that touching inappropriately is against our the [sic] policy."		***affected by the finding:*** No negative outcome was determined for the residents involved. As noted by no s/s of psychosocial distress noted. All resident's involved have continued at their baseline cognitive, emotional, and physical functioning. In both incidents staff immediately separated resident's and intervened in behaviors. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All memory care residents had the potential to be affected. No memory care resident was found to be adversely affected. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Staff will be in serviced on the Abuse prevention, Reporting, Investigating and the Resident Rights on March 10th, 2022 by the Executive Director. The	

	The November, 2021 to present incident reports were provided by the ED (Executive Director) on 1/26/22 at 11:50 a.m. There was no incident report for the 12/23/21 incident involving Resident B and Resident F. The 1/4/22 nurse's note, written by QMA 2, read, "At 1:45 pm I observed resident in another resident room. He was fully dressed laying on top of another resident with his right leg out of bed. He was immediately removed from the resident room. MC [Memory Care] manager was notified."		facility also conducts these in-services for new employees on hire, annually, and as needed for ongoing training. The Administrator or Designee will randomly select 5 staff members each week to take a test regarding abuse and reporting for 8 weeks, then 1 X a month times 4 months, the 1 X a quarter. The results will be reviewed at the monthly At Risk meeting. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** Staff will be in serviced on the Abuse prevention, Reporting, Investigating and the Resident Rights on March 10th, 2022 by the Executive Director. The facility also conducts these in-services for new employees on hire, annually, and as needed for ongoing training. The Administrator or Designee will randomly select 5 staff members each week to take a test regarding abuse and reporting for 8 weeks, then 1 X a month times 4 months, the 1 X a quarter. The results will be reviewed at the monthly At Risk meeting. ED or Designee will review	

	The 1/4/22 incident report involving Resident B and Resident D, observed by QMA 2, was provided by the ED on 1/26/22 at 11:50 a.m. It read, "QMA observed male resident entering female resident apartment while in hallway. QMA completed task and went directly to female residents apartment. The following was observed: Female Resident observed in bed laying without her clothes on, male resident was also laying in bed, partial [sic] on top of her, with his right leg off the bed. The male resident was immediately removed from her room. She was redressed and displayed resident assessed no visual marks and no signs or symptoms or distress voiced or noted." A telephone interview was conducted on speaker phone with QMA 2 in the presence of the DON (Director of Nursing) on 1/26/22 at 1:58 p.m. QMA 2 indicated she'd been working at the facility for a little over a year. On 12/23/21, on the memory care unit, she observed Resident B touching Resident F's breasts and between her legs. Resident B became hostile when QMA 2 intervened. Both residents were in their wheel chairs at the time. QMA 2 didn't think the behavior was suitable, because she wasn't sure Resident F understood what		Observation Center to ensure incidents are reported correctly ongoing. Regional Nurse or RVPO will review audit 1 X week X 3 Months and then monthly via At Risk report thereafter. ***By what date the systemic changes will be completed:*** ***March 10th, 2022***	

	was going on. QMA 2 hadn't observed Resident B display this type of behavior prior to this 12/23/21 incident with Resident F, but did have another incident with Resident D on 1/4/22 on the memory care unit of the facility. QMA 2 was in the medication room and saw Resident B making his way down the hallway. When QMA 2 left the medication room and walked by Resident F's room, she observed Resident D lying naked in her bed and Resident B was "trying to get on top of her", with one leg on the bed and the other one off the bed. It was approximately 4 to 5 minutes, but no longer than 7 minutes, from the time she saw Resident B going down the hallway while she was in the medication room until she witnessed Resident B and Resident D in bed together. QMA 2 intervened and explained to Resident B that "it wasn't okay," and she separated them. An interview was conducted with the DON while QMA 2 was on the telephone on 1/26/22 at 1:58 p.m. He indicated Resident B lived in the assisted living portion of the facility with his wife and did not live in the memory care unit of the facility where both incidents occurred. In December, 2021, Resident B began going to the memory care unit during the day for a daycare			

program, as he had dementia. He stopped going after the 1/4/22 incident with Resident D.

An interview was conducted with the EDIT (Executive Director in Training) on 1/26/22 at 3:16 p.m. She indicated she was unaware of the 12/23/21 incident involving Resident B and Resident F until today, 1/26/22. If they had known about Resident B's 12/23/21 incident with Resident F, they wouldn't have continued to have Resident B go to the memory care unit for the day care program.

The Abusive Resident Behavior policy was provided by the EDIT on 1/26/22 at 1:40 p.m. It read, "No resident shall be permitted to endanger the safety or well-being of another resident or themselves by physical violence or verbal abuse....The Executive Director and Wellness Director and staff will attempt to identify the cause(s) of the behavior and will implement alternative interventions to prevent a reoccurrence of the behavior."

This Residential Tag relates to Complaint IN00370385.

Based on interview and record review, the facility failed to ensure residents were free from sexual abuse for 3 of 3 residents reviewed for abuse. (Residents B, D, and F)

Findings include:

The clinical record for Resident B was reviewed on 1/26/22 at 11:51 a.m. The diagnoses included, but were not limited to, dementia and end stage renal disease.

The 12/23/21, 11:43 a.m. nurse's note, written by QMA (Qualified Medication Aide) 2, read, "Today at lunch [name of Resident B] was touching [name of Resident F's] breast and private area. He was removed from table. He then began to use loud profanity causing a scene in the dinner room. I explained to him the reason why he was being moved from table and also let him now [sic] that touching inappropriately is against our the [sic] policy."

The November, 2021 to present incident reports were provided by the ED (Executive Director) on 1/26/22 at 11:50 a.m. There was no incident report for the 12/23/21 incident involving Resident B and Resident F.

The 1/4/22 nurse's note, written by QMA 2, read, "At 1:45 pm I observed resident in another resident room. He was fully dressed laying on top of another resident with his right leg out of bed. He was immediately removed from the resident room. MC [Memory Care] manager was notified."

	The 1/4/22 incident report involving Resident B and Resident D, observed by QMA 2, was provided by the ED on 1/26/22 at 11:50 a.m. It read, "QMA observed male resident entering female resident apartment while in hallway. QMA completed task and went directly to female residents apartment. The following was observed: Female Resident observed in bed laying without her clothes on, male resident was also laying in bed, partial [sic] on top of her, with his right leg off the bed. The male resident was immediately removed from her room. She was redressed and displayed resident assessed no visual marks and no signs or symptoms or distress voiced or noted." A telephone interview was conducted on speaker phone with QMA 2 in the presence of the DON (Director of Nursing) on 1/26/22 at 1:58 p.m. QMA 2 indicated she'd been working at the facility for a little over a year. On 12/23/21, on the memory care unit, she observed Resident B touching Resident F's breasts and between her legs. Resident B became hostile when QMA 2 intervened. Both residents were in their wheel chairs at the time. QMA 2 didn't think the behavior was suitable, because she wasn't sure Resident F understood what			

	was going on. QMA 2 hadn't observed Resident B display this type of behavior prior to this 12/23/21 incident with Resident F, but did have another incident with Resident D on 1/4/22 on the memory care unit of the facility. QMA 2 was in the medication room and saw Resident B making his way down the hallway. When QMA 2 left the medication room and walked by Resident F's room, she observed Resident D lying naked in her bed and Resident B was "trying to get on top of her", with one leg on the bed and the other one off the bed. It was approximately 4 to 5 minutes, but no longer than 7 minutes, from the time she saw Resident B going down the hallway while she was in the medication room until she witnessed Resident B and Resident D in bed together. QMA 2 intervened and explained to Resident B that "it wasn't okay," and she separated them. An interview was conducted with the DON while QMA 2 was on the telephone on 1/26/22 at 1:58 p.m. He indicated Resident B lived in the assisted living portion of the facility with his wife and did not live in the memory care unit of the facility where both incidents occurred. In December, 2021, Resident B began going to the memory care unit during the day for a daycare			

	program, as he had dementia. He stopped going after the 1/4/22 incident with Resident D. An interview was conducted with the EDIT (Executive Director in Training) on 1/26/22 at 3:16 p.m. She indicated she was unaware of the 12/23/21 incident involving Resident B and Resident F until today, 1/26/22. If they had known about Resident B's 12/23/21 incident with Resident F, they wouldn't have continued to have Resident B go to the memory care unit for the day care program. The Abusive Resident Behavior policy was provided by the EDIT on 1/26/22 at 1:40 p.m. It read, "No resident shall be permitted to endanger the safety or well-being of another resident or themselves by physical violence or verbal abuse....The Executive Director and Wellness Director and staff will attempt to identify the cause(s) of the behavior and will implement alternative interventions to prevent a reoccurrence of the behavior." This Residential Tag relates to Complaint IN00370385.			
R 0091	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(h)(1-4) (h) The facility shall establish and	R 0091	<u>R91 Resident Rights</u> With regards to finding R91	03/10/2022

	implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the facility failed to report an incident of sexual abuse to the Executive Director, the Indiana State Department of Health, and the residents' families/representatives, per facility policy, for 2 of 3 residents reviewed for abuse. (Residents B and F) Findings include: The clinical record for Resident B was reviewed on 1/26/22 at 11:51 a.m. The diagnoses included, but were not limited to, dementia and end stage renal disease. The 12/23/21, 11:43 a.m. nurse's note, written by QMA (Qualified Medication Aide) 2, read, "Today at lunch [name of Resident B] was touching [name of Resident F's] breast and private area. He was removed		Resident Rights Meadow Brook Senior Living, LLC will; ***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** Upon notification Administrator will follow all reporting and investigating policy & procedures. Incident on 1/4/22 was reported appropriately and interventions put in place. Appropriate notifications for Resident's B and F were made immediately. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All residents had the potential to be affected. No resident was found to be adversely affected. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Staff will be in serviced on the Reporting, Investigating and Resident Rights on March 10th, 2022 by the Executive Director.	

	from table. He then began to use loud profanity causing a scene in the dinner room. I explained to him the reason why he was being moved from table and also let him now [sic] that touching inappropriately is against our the [sic] policy." The November, 2021 to present Indiana Department of Health incident reports were provided by the ED (Executive Director) on 1/26/22 at 11:50 a.m. There was no incident report for the 12/23/21 incident involving Resident B and Resident F. A telephone interview was conducted on speaker phone with QMA 2 in the presence of the DON (Director of Nursing) on 1/26/22 at 1:58 p.m. QMA 2 indicated she'd been working at the facility for a little over a year. On 12/23/21, in the common area of the memory care unit, she observed Resident B touching Resident F's breasts and between her legs. Resident B became hostile when QMA 2 intervened. Both residents were in their wheel chairs at the time. QMA 2 didn't think the behavior was suitable, because she wasn't sure Resident F understood what was going on. QMA 2 informed the MCD (Memory Care Director) of the incident, but did not inform Resident B's or Resident F's family of the incident. She was unsure if the MCD informed		The facility also conducts these in-services for new employees on hire, annually, and as needed for ongoing training. ED or Designee will review Observation Center to ensure incidents are reported correctly ongoing. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** The Administrator or Designee will randomly select 5 staff members each week to take a test regarding reporting X 2 months, then 1 X a month X 4 months, the 1 X a quarter. The results will be reviewed at the monthly At Risk meeting. ED or Designee will review Observation Center to ensure incidents are reported correctly ongoing. Regional Nurse or RVPO will review audit 1 X week X 3 Months and then monthly via At Risk report thereafter. ***By what date the systemic changes will be completed:***	

	either residents family. An interview was conducted with the DON on 1/26/22 at 1:58 p.m. He indicated the 12/23/21 incident involving Resident B and Resident F should have been reported to both residents' families and to the Indiana Department of Health. An interview was conducted with the EDIT (Executive Director in Training) in the presence of the ED on 1/26/22 at 3:16 p.m. She indicated they were unaware of the 12/23/21 incident involving Resident B and Resident F until today, 1/26/22, so it was not reported to the residents' families or the Indiana Department of Health. She believed the MCD knew about the 12/23/21 incident, but she did not report it to the residents' families. The Abusive Resident Behavior policy was provided by the EDIT on 1/26/22 at 1:40 p.m. It read, "The Executive Director and Wellness Director will be notified of the actual or potential abusive situation for evaluation and follow up....The involved resident's physician and family will be notified regarding the incident." This Residential Tag relates to Complaint IN00370385. Based on interview and record review, the facility failed to		March 10th, 2022	

report an incident of sexual abuse to the Executive Director, the Indiana State Department of Health, and the residents' families/representatives, per facility policy, for 2 of 3 residents reviewed for abuse. (Residents B and F)

Findings include:

The clinical record for Resident B was reviewed on 1/26/22 at 11:51 a.m. The diagnoses included, but were not limited to, dementia and end stage renal disease.

The 12/23/21, 11:43 a.m. nurse's note, written by QMA (Qualified Medication Aide) 2, read, "Today at lunch [name of Resident B] was touching [name of Resident F's] breast and private area. He was removed from table. He then began to use loud profanity causing a scene in the dinner room. I explained to him the reason why he was being moved from table and also let him now [sic] that touching inappropriately is against our the [sic] policy."

The November, 2021 to present Indiana Department of Health incident reports were provided by the ED (Executive Director) on 1/26/22 at 11:50 a.m. There was no incident report for the 12/23/21 incident involving Resident B and Resident F.

A telephone interview was

	conducted on speaker phone with QMA 2 in the presence of the DON (Director of Nursing) on 1/26/22 at 1:58 p.m. QMA 2 indicated she'd been working at the facility for a little over a year. On 12/23/21, in the common area of the memory care unit, she observed Resident B touching Resident F's breasts and between her legs. Resident B became hostile when QMA 2 intervened. Both residents were in their wheel chairs at the time. QMA 2 didn't think the behavior was suitable, because she wasn't sure Resident F understood what was going on. QMA 2 informed the MCD (Memory Care Director) of the incident, but did not inform Resident B's or Resident F's family of the incident. She was unsure if the MCD informed either residents family. An interview was conducted with the DON on 1/26/22 at 1:58 p.m. He indicated the 12/23/21 incident involving Resident B and Resident F should have been reported to both residents' families and to the Indiana Department of Health. An interview was conducted with the EDIT (Executive Director in Training) in the presence of the ED on 1/26/22 at 3:16 p.m. She indicated they were unaware of the 12/23/21 incident involving Resident B and Resident F until today,			

	1/26/22, so it was not reported to the residents' families or the Indiana Department of Health. She believed the MCD knew about the 12/23/21 incident, but she did not report it to the residents' families. The Abusive Resident Behavior policy was provided by the EDIT on 1/26/22 at 1:40 p.m. It read, "The Executive Director and Wellness Director will be notified of the actual or potential abusive situation for evaluation and follow up....The involved resident's physician and family will be notified regarding the incident." This Residential Tag relates to Complaint IN00370385.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and	R 0217	R217 Evaluation With regards to finding R216 Evaluation Meadow Brook Senior Living, LLC will; ***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** No negative outcome was determined for the residents involved. As noted by no s/s of psychosocial distress noted. All	03/10/2022

	(D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to revise residents' service plans to include interventions to address their behaviors for 3 of 3 residents reviewed for behaviors. (Residents B, D, and K) Findings include: 1. The clinical record for Resident B was reviewed on		resident's involved have continued at their baseline cognitive, emotional, and physical functioning. In both incidents staff immediately separated resident's and intervened in behaviors. Service Plans for Resident's B, D and F were updated immediately. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All MC residents had the potential to be affected. No resident was adversely affected. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** ED or Designee will review Observation Center to ensure incidents are reported correctly ongoing. Service plans will be updated to reflect any changes in resident's behaviors accordingly. Wellness Director will be in-serviced on policy for updating service plans. Nursing staff will be in-serviced on notification of resident change of condition to Wellness	

	1/26/22 at 11:51 a.m. The diagnoses included, but were not limited to, dementia and end stage renal disease. The 12/23/21, 11:43 a.m. nurse's note, written by QMA (Qualified Medication Aide) 2, read, "Today at lunch [name of Resident B] was touching [name of Resident F's] breast and private area. He was removed from table. He then began to use loud profanity causing a scene in the dinner room. I explained to him the reason why he was being moved from table and also let him now [sic] that touching inappropriately is against our the [sic] policy." The 1/4/22, 1:45 a.m. nurse's note, written by QMA 2, read, "At 1:45 pm I observed resident in another resident room. He was fully dressed laying on top of another resident with his right leg out of bed. He was immediately removed from the resident room. MC [Memory Care] manager was notified." The 1/4/22 incident report involving Resident B and Resident D, observed by QMA 2, was provided by the ED on 1/26/22 at 11:50 a.m. It read, "QMA observed male resident entering female resident apartment while in hallway. QMA completed task and went directly to female residents apartment. The following was		Director. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** ED or Designee will review Observation Center to ensure incidents are reported correctly ongoing. Service plans will be updated to reflect any changes in resident's behaviors accordingly. Regional Nurse or RVPO will review audit 1 X week X 3 Months and then monthly via At Risk monthly report thereafter. ***By what date the systemic changes will be completed:*** March 10th, 2022	

observed: Female Resident observed in bed laying without her clothes on, male resident was also laying in bed, partial on top of her, with his right leg off the bed. The male resident was immediately removed from her room. She was redressed and displayed resident assessed no visual marks and no signs or symptoms or distress voiced or noted."

Resident B's service plan did not reference his sexual behaviors.

An interview was conducted with the DON on 1/26/22 at 1:58 p.m. He indicated Resident B's service plan should have been updated to address his behaviors. He was currently in the process of catching up on service plans.

2. The clinical record for Resident D was reviewed on 1/26/22 at 12:41 p.m. Resident D's diagnosis included, but was not limited to, anxiety.

A nursing progress note dated 1/4/22 at 12:50 p.m., indicated " ...I observed resident in bed lying without her clothes on, another resident was also lying in bed, partial on top of her, with his right leg off the bed..."

The service plan for Resident D dated 10/28/21, did not address the resident removes her clothes and lays in bed.

An interview was conducted with Qualified Nurse Aide (QMA) 2 on 1/26/22 at 1:58 p.m. She indicated Resident D does have a behavior with removal of all her clothing.

3. The clinical record for Resident K was reviewed on 1/26/22 at 1:41 p.m. Resident K's diagnosis included, but was not limited to, Alzheimer's Disease. The resident resided in a locked memory care unit.

A nursing progress note dated 1/15/22, indicated "CNA [Certified Nursing Assistant] reported that resident in al [Assisted Living] area on night shift when she arrived at 5:55am (sic) [a.m.] this morning. Resident brought back to memory care successfully ..."

A nursing progress note dated 1/16/22, indicated " ...RA [Resident Aide] brought to my attention that she heard alarm going off at doors leading out to AL [Assisted Living]. No one was present, but she opened doors and saw resident near front desk in lobby. She went and got resident and brought her back to MC [Memory Care] unit with out incident ..."

The service plan for Resident K

dated 12/14/21, did not address the resident's behavior with elopement.

An interview was Director of Nursing on 1/26/22 at 2:51 p.m. He indicated the residents' care plans should be revised to reflect their behaviors. Resident K's service plan should include elopement, and Resident D's service plan should include she removes all her clothing at times. The residents' service plans will be updated.

A service plan policy was provided by the AIT (Administrator in Training) on 1/26/22 at 3:17 p.m. It indicated " ...Policy statement: The community utilizes an individualized, comprehensive service plan for each resident that includes measurable objectives important in meeting the needs of the resident. The "Select Your Care" Service Plan is a communication tool that assists the staff in providing quality, individualized service. Procedure: ...4. Service plans shall be reviewed and revised as appropriate and discussed by the resident and community as needs or desires change. Either the community or the resident may request a service plan review. 5. The service plan is reviewed and revised every 6 months or following a change in condition ..."

This Residential Tag relates to Complaint IN00370385.

Based on interview and record review, the facility failed to revise residents' service plans to include interventions to address their behaviors for 3 of 3 residents reviewed for behaviors. (Residents B, D, and K)

Findings include:

1. The clinical record for Resident B was reviewed on 1/26/22 at 11:51 a.m. The diagnoses included, but were not limited to, dementia and end stage renal disease.

The 12/23/21, 11:43 a.m. nurse's note, written by QMA (Qualified Medication Aide) 2, read, "Today at lunch [name of Resident B] was touching [name of Resident F's] breast and private area. He was removed from table. He then began to use loud profanity causing a scene in the dinner room. I explained to him the reason why he was being moved from table and also let him now [sic] that touching inappropriately is against our the [sic] policy."

The 1/4/22, 1:45 a.m. nurse's note, written by QMA 2, read, "At 1:45 pm I observed resident in another resident room. He was fully dressed laying on top of another resident with his right leg out of bed. He was

immediately removed from the resident room. MC [Memory Care] manager was notified."

The 1/4/22 incident report involving Resident B and Resident D, observed by QMA 2, was provided by the ED on 1/26/22 at 11:50 a.m. It read, "QMA observed male resident entering female resident apartment while in hallway. QMA completed task and went directly to female residents apartment. The following was observed: Female Resident observed in bed laying without her clothes on, male resident was also laying in bed, partial on top of her, with his right leg off the bed. The male resident was immediately removed from her room. She was redressed and displayed resident assessed no visual marks and no signs or symptoms or distress voiced or noted."

Resident B's service plan did not reference his sexual behaviors.

An interview was conducted with the DON on 1/26/22 at 1:58 p.m. He indicated Resident B's service plan should have been updated to address his behaviors. He was currently in the process of catching up on service plans.

2. The clinical record for Resident D was reviewed on

1/26/22 at 12:41 p.m. Resident D's diagnosis included, but was not limited to, anxiety.

A nursing progress note dated 1/4/22 at 12:50 p.m., indicated " ...I observed resident in bed lying without her clothes on, another resident was also lying in bed, partial on top of her, with his right leg off the bed..."

The service plan for Resident D dated 10/28/21, did not address the resident removes her clothes and lays in bed.

An interview was conducted with Qualified Nurse Aide (QMA) 2 on 1/26/22 at 1:58 p.m. She indicated Resident D does have a behavior with removal of all her clothing.

3. The clinical record for Resident K was reviewed on 1/26/22 at 1:41 p.m. Resident K's diagnosis included, but was not limited to, Alzheimer's Disease. The resident resided in a locked memory care unit.

A nursing progress note dated 1/15/22, indicated "CNA [Certified Nursing Assistant] reported that resident in al [Assisted Living] area on night shift when she arrived at 5:55am (sic) [a.m.] this morning. Resident brought back to memory care successfully ..."

A nursing progress note dated 1/16/22, indicated " ...RA

[Resident Aide] brought to my attention that she heard alarm going off at doors leading out to AL [Assisted Living]. No one was present, but she opened doors and saw resident near front desk in lobby. She went and got resident and brought her back to MC [Memory Care] unit with out incident ..."

The service plan for Resident K dated 12/14/21, did not address the resident's behavior with elopement.

An interview was Director of Nursing on 1/26/22 at 2:51 p.m. He indicated the residents' care plans should be revised to reflect their behaviors. Resident K's service plan should include elopement, and Resident D's service plan should include she removes all her clothing at times. The residents' service plans will be updated.

A service plan policy was provided by the AIT (Administrator in Training) on 1/26/22 at 3:17 p.m. It indicated " ...Policy statement: The community utilizes an individualized, comprehensive service plan for each resident that includes measurable objectives important in meeting the needs of the resident. The "Select Your Care" Service Plan is a communication tool that assists the staff in providing quality, individualized service.

Procedure: ...4. Service plans shall be reviewed and revised as appropriate and discussed by the resident and community as needs or desires change. Either the community or the resident may request a service plan review. 5. The service plan is reviewed and revised every 6 months or following a change in condition ..."

This Residential Tag relates to Complaint IN00370385.

Based on interview and record review, the facility failed to revise residents' service plans to include interventions to address their behaviors for 3 of 3 residents reviewed for behaviors. (Residents B, D, and K)

Findings include:

1. The clinical record for Resident B was reviewed on 1/26/22 at 11:51 a.m. The diagnoses included, but were not limited to, dementia and end stage renal disease.

The 12/23/21, 11:43 a.m. nurse's note, written by QMA (Qualified Medication Aide) 2, read, "Today at lunch [name of Resident B] was touching [name of Resident F's] breast and private area. He was removed from table. He then began to use loud profanity causing a scene in the dinner room. I explained to him the reason why

	he was being moved from table and also let him now [sic] that touching inappropriately is against our the [sic] policy." The 1/4/22, 1:45 a.m. nurse's note, written by QMA 2, read, "At 1:45 pm I observed resident in another resident room. He was fully dressed laying on top of another resident with his right leg out of bed. He was immediately removed from the resident room. MC [Memory Care] manager was notified." The 1/4/22 incident report involving Resident B and Resident D, observed by QMA 2, was provided by the ED on 1/26/22 at 11:50 a.m. It read, "QMA observed male resident entering female resident apartment while in hallway. QMA completed task and went directly to female residents apartment. The following was observed: Female Resident observed in bed laying without her clothes on, male resident was also laying in bed, partial on top of her, with his right leg off the bed. The male resident was immediately removed from her room. She was redressed and displayed resident assessed no visual marks and no signs or symptoms or distress voiced or noted."				

Resident B's service plan did not reference his sexual behaviors.

An interview was conducted with the DON on 1/26/22 at 1:58 p.m. He indicated Resident B's service plan should have been updated to address his behaviors. He was currently in the process of catching up on service plans.

2. The clinical record for Resident D was reviewed on 1/26/22 at 12:41 p.m. Resident D's diagnosis included, but was not limited to, anxiety.

A nursing progress note dated 1/4/22 at 12:50 p.m., indicated " ...I observed resident in bed lying without her clothes on, another resident was also lying in bed, partial on top of her, with his right leg off the bed..."

The service plan for Resident D dated 10/28/21, did not address the resident removes her clothes and lays in bed.

An interview was conducted with Qualified Nurse Aide (QMA) 2 on 1/26/22 at 1:58 p.m. She indicated Resident D does have a behavior with removal of all her clothing.

3. The clinical record for Resident K was reviewed on 1/26/22 at 1:41 p.m. Resident K's diagnosis included, but was not limited to, Alzheimer's

Disease. The resident resided in a locked memory care unit.

A nursing progress note dated 1/15/22, indicated "CNA [Certified Nursing Assistant] reported that resident in al [Assisted Living] area on night shift when she arrived at 5:55am (sic) [a.m.] this morning. Resident brought back to memory care successfully ..."

A nursing progress note dated 1/16/22, indicated " ...RA [Resident Aide] brought to my attention that she heard alarm going off at doors leading out to AL [Assisted Living]. No one was present, but she opened doors and saw resident near front desk in lobby. She went and got resident and brought her back to MC [Memory Care] unit with out incident ..."

The service plan for Resident K dated 12/14/21, did not address the resident's behavior with elopement.

An interview was Director of Nursing on 1/26/22 at 2:51 p.m. He indicated the residents' care plans should be revised to reflect their behaviors. Resident K's service plan should include elopement, and Resident D's service plan should include she removes all her clothing at times. The residents' service plans will be updated.

A service plan policy was

provided by the AIT (Administrator in Training) on 1/26/22 at 3:17 p.m. It indicated " ...Policy statement: The community utilizes an individualized, comprehensive service plan for each resident that includes measurable objectives important in meeting the needs of the resident. The "Select Your Care" Service Plan is a communication tool that assists the staff in providing quality, individualized service. Procedure: ...4. Service plans shall be reviewed and revised as appropriate and discussed by the resident and community as needs or desires change. Either the community or the resident may request a service plan review. 5. The service plan is reviewed and revised every 6 months or following a change in condition ..."

This Residential Tag relates to Complaint IN00370385.

Based on interview and record review, the facility failed to revise residents' service plans to include interventions to address their behaviors for 3 of 3 residents reviewed for behaviors. (Residents B, D, and K)

Findings include:

1. The clinical record for Resident B was reviewed on 1/26/22 at 11:51 a.m. The

diagnoses included, but were not limited to, dementia and end stage renal disease.

The 12/23/21, 11:43 a.m. nurse's note, written by QMA (Qualified Medication Aide) 2, read, "Today at lunch [name of Resident B] was touching [name of Resident F's] breast and private area. He was removed from table. He then began to use loud profanity causing a scene in the dinner room. I explained to him the reason why he was being moved from table and also let him now [sic] that touching inappropriately is against our the [sic] policy."

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observed in bed laying without her clothes on, male resident was also laying in bed, partial on top of her, with his right leg off the bed. The male resident was immediately removed from her room. She was redressed and displayed resident assessed no visual marks and no signs or symptoms or distress voiced or noted."

Resident B's service plan did not reference his sexual behaviors.

An interview was conducted with the DON on 1/26/22 at 1:58 p.m. He indicated Resident B's service plan should have been updated to address his behaviors. He was currently in the process of catching up on service plans.

2. The clinical record for Resident D was reviewed on 1/26/22 at 12:41 p.m. Resident D's diagnosis included, but was not limited to, anxiety.

A nursing progress note dated 1/4/22 at 12:50 p.m., indicated " ...I observed resident in bed lying without her clothes on, another resident was also lying in bed, partial on top of her, with his right leg off the bed..."

The service plan for Resident D dated 10/28/21, did not address the resident removes her clothes and lays in bed.

An interview was conducted with Qualified Nurse Aide (QMA) 2 on 1/26/22 at 1:58 p.m. She indicated Resident D does have a behavior with removal of all her clothing.

3. The clinical record for Resident K was reviewed on 1/26/22 at 1:41 p.m. Resident K's diagnosis included, but was not limited to, Alzheimer's Disease. The resident resided in a locked memory care unit.

A nursing progress note dated 1/15/22, indicated "CNA [Certified Nursing Assistant] reported that resident in al [Assisted Living] area on night shift when she arrived at 5:55am (sic) [a.m.] this morning. Resident brought back to memory care successfully ..."

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The service plan for Resident K dated 12/14/21, did not address the resident's behavior with elopement.

An interview was Director of

Nursing on 1/26/22 at 2:51 p.m. He indicated the residents' care plans should be revised to reflect their behaviors. Resident K's service plan should include elopement, and Resident D's service plan should include she removes all her clothing at times. The residents' service plans will be updated.

A service plan policy was provided by the AIT (Administrator in Training) on 1/26/22 at 3:17 p.m. It indicated " ...Policy statement: The community utilizes an individualized, comprehensive service plan for each resident that includes measurable objectives important in meeting the needs of the resident. The "Select Your Care" Service Plan is a communication tool that assists the staff in providing quality, individualized service. Procedure: ...4. Service plans shall be reviewed and revised as appropriate and discussed by the resident and community as needs or desires change. Either the community or the resident may request a service plan review. 5. The service plan is reviewed and revised every 6 months or following a change in condition ..."

This Residential Tag relates to Complaint IN00370385.

correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE