STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155636	A. BUILDING 00 B. WING	06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON TERRACE	1924 WELLESLEY BLVD INDIANAPOLIS, IN 46219

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00409906. Complaint IN00409906-Federal/State deficiencies related to the allegations are cited at F744. Survey dates: May 31, June 1, 2, and 5, 2023 Facility number: 000241 Provider number: 155636 AIM number: 100291310 Census Bed Type: SNF/NF: 69 Total: 69 Census Payor Type: Medicare: 1 Medicaid: 53 Other: 15 Total: 69 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 9, 2023	F 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 of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Natalie Bergman | DNS | 06/22/2023

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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	treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to complete an admission assessment and monitor a resident's blood pressure, as care planned, for 1 of 2 residents reviewed for hospitalization. (Resident F) Findings include: The clinical record for Resident F was reviewed on 6/1/23 at 11:56 a.m. Her diagnoses included, but were not limited to: hypertension, dementia, type 2 diabetes mellitus, seizures, hyperlipidemia, aortic stenosis, and anxiety disorder. She was admitted to the facility on 12/14/22; discharged from the facility to a psychiatric hospital on 5/3/23; readmitted to the facility on 5/11/23; and discharged to the hospital on 5/13/23. Resident F's 12/14/22 original admission assessment included an assessment of the following: mental/neurological status, eyes, ears, nose and throat, respiratory, cardiovascular, gastrointestinal, genitourinary, musculoskeletal, skin, and pain. There was no 5/11/23 admission/readmission assessment in Resident F's clinical record. The 5/11/23, 2:06 p.m. nurse's note read, "MD her [sic] to evaluate resident upon return from [name of psychiatric hospital] stay and resident continues to remain delusional and states she is not [name of Resident F] she is [name of famous singer] and is up pacing the halls and persistent delusions of place. New order to increase Abilify	F 0684	Resident F continues to reside in the facility and has had BP obtained and recorded per care plan and assessments completed and documented per policy. Resident F has had no recent changes in condition. All residents admitted/re-admitted within the last 30 days will be reviewed for the need to monitor and document BP. Care plans will be updated as indicated from the review. Residents admitted/readmitted in the past 30 days will be reviewed for nursing assessment per policy. Nursing assessment will be completed and documented as needed per policy Licensed nursing staff will be in-serviced by the DNS/Designee regarding policy/procedure for assessment and documentation of VS, including BP, and admission/readmission policy/procedure on or before June 30, 2023 Licensed nursing staff will be inserviced by the DNS/Designee regarding policy/procedure for assessment and documentation of VS, including BP, and	06/30/2023

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	to 5mg q [every] day and to give an extra 4mg x [times] 1. MD and sister, [name of sister], aware of current plan of care." The 5/11/23 physician evaluation was not available in Resident F's clinical record. The 1/5/23, last reviewed/revised 6/1/23, at risk for ineffective tissue perfusion care plan indicated the goal was to maintain adequate tissue perfusion as evidenced by blood pressure within normal limits for resident, no change in mental status, no complaints of dizziness/lightheadedness/syncope, or edema. An approach was to monitor her vital signs, starting 1/5/23. The physician's orders indicated she was taking a carvedilol 25 mg tablet twice a day for hypertension from 3/7/23 through 5/3/23, which was restarted upon her 5/11/23 readmission. She was taking a Norvasc 10 mg tablet once a day for hypertension from 3/9/23 through 5/3/23 and a Losartan 50 mg tablet once day for hypertension starting 5/11/23. The Administration History report from 4/1/23 through 6/2/23 indicated her blood pressure was being taken and documented daily with the administration of her Carvedilol until she discharged from the facility on 5/3/23. There were no documented blood pressures on the report after her 5/11/23 readmission to the facility. An interview was conducted with the ADON (Assistant Director of Nursing) on 6/1/23 at 2:48 p.m. She indicated they completed admission assessments on residents who were newly admitted or readmitted every shift for 72 hours, which included vital signs. Nursing should be documenting the vitals under the vitals section of		admission/readmission policy/procedure on or before June 30, 2023 Admission/readmission orders will include assessing /documenting VS each shift for 72 hours Admission/readmission checklist will be used by the licensed nurse to verify that admission assessment observation has been completed. IDT admission review tool will be utilized for all new admits and re-admissions. To ensure compliance, the DNS/Designee is responsible for the completion of the Admission/Readmission QAPI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	the electronic health record, including blood pressure. The ADON reviewed Resident F's clinical record at this time and indicated the only documented blood pressure she could find after Resident F's 5/11/23 readmission to the facility was the one from the 5/13/23 nurse's note when she was sent to the hospital. The 5/13/23, 6:50 a.m. nurse's note read, "upon nurse assessment, resident showing change in condition, previous accu [blood sugar checks] 72, 79, resident unable to answer questions or commands from staff, unsteady gait, slurred speech, vitals 156/119 [blood pressure.] pr [pulse rate] 131, r [respirations] 14, temp [temperature] 97.9, md notified of change, order given to send to er [emergency room] for assessment, sister [name of sister] notified, don [director of nursing] notified, report called to [name of staff member at local hospital,] resident picked up by ambulance at this time, stable upon transfer." The 5/13/23, 1:14 p.m. nurse's note read, "resident to be admitted to [name of local hospital] for elevated blood pressure." The every shift for 72-hour nursing assessments referenced by the ADON were documented in the 5/12/23, 12:08 a.m. progress note, the 5/12/23, 11:56 a.m. progress note, and the 5/12/23, 7:54 p.m. progress note. All 3 notes indicated vital signs were assessed and documented in the vital sign section of the EHR (electronic health record) and were within normal limits. The vitals section of the EHR did not include documented blood pressures for the above 3 assessments. An interview was conducted with the DON			

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	(Director of Nursing) on 6/2/23 at 11:16 a.m. She reviewed Resident F's clinical record and indicated she was unable to locate an admission assessment for her 5/11/23 readmission to the facility. She expected one to have been completed. The purpose of the admission assessment was to have a current plan of care since readmission. She spoke to nursing about Resident F and was informed the vitals were taken, but not documented. Prior to Resident F discharging from the facility on 5/3/23, her blood pressures were taken and documented with the administration of medication, but upon her 5/11/23 readmission, the EHR was not set up that way. The 5/13/23 hospital notes indicated she presented to the emergency department for altered mental status. The ED note for 5/13/23 at 7:12 a.m. read, "Today she has no hypoxia but is still profoundly hypertensive requiring nicardipine drip, admission and will get MRI as an inpatient." Her blood pressures in the emergency department on 5/13/23 were as follows at the following times: 7:16 a.m. @ 134/79, 8:26 a.m. @ 219/92, 8:31 am 226/100, 8:46 a.m. @ 223/102, 9:17 a.m. @ 213/110, 9:32 a.m. @ 202/97, and 9:47 a.m. @ 231/93. The clinical impression was listed as, "1. Encephalopathy 2. History of seizure disorder 3. Hypertensive emergency." The Nursing Admission/Return Admission Policy and Procedure was provided by the DON on 6/2/23 at 10:39 a.m. It read, "Resident admission to the nursing unit: ...3. Admitting nurse must interview resident and/or family in order to accurately complete the admission assessment (Admission Observation)....Nursing assessment/documentation at admission: 1. All residents will be assessed at least every shift for the first 72 hours following admission.			

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	Documentation will be related to pertinent health conditions, including vital signs, pain symptoms, orientation to surroundings, and any physical complaints he/she may have....Initial nursing assessment: Admission Observation 1. The initial nursing assessment must be completed within the 1st 24 hours of admission (initiated by the admitting nurse...)" 3.1-37(a)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to assess a resident's pain that included location and intensity of the resident's pain when staff provided an as needed (PRN) pain medication, and ensure nonpharmacological interventions were provided to address a resident's pain for 1 of 1 resident reviewed for pain. (Resident 4) Findings include: The clinical record for Resident 4 was reviewed on 5/31/23 at 12:30 p.m. The diagnosis for Resident 4 included, but was not limited to, chronic pain. The Quarterly MDS (Minimum Data Set) Assessment completed on 5/8/23 indicated Resident 4 was moderately impaired.	F 0697	Resident 4 continues to reside in facility and has been provided PRN pain medication and non-pharmacological interventions for pain with effective results after assessment of location and intensity of pain by the nurse with no negative outcomes or changes in condition. Residents who receive PRN pain medications have the potential to be affected by this practice. Licensed nursing staff will be in-serviced by the DNS/designee on assessment and documentation of pain on or before June 30, 2023	06/30/2023

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	A pain care plan dated 2/15/23 indicated "...Resident is at risk for pain related to: hx [history] of vascular wounds, dementia, BLE [bilateral lower extremities] chronic pain. Resident may refuse to get out of bed at times and yells out for assistance maybe related to pain....Approach: reposition resident for comfort as tolerated. Observe for adverse side effects of pain medication including, but not limited to over sedation, constipation, skin rash, nausea/vomiting, loss of appetite, change in mental status, stomach upset. Document abnormal findings and notify MD [medical doctor]. Notify MD if pain is unrelieved and/or worsening. Assist with positioning to comfort. Document effectiveness of prn medications. Administer meds as ordered. Observe for non verbal signs of pain: changes in breathing, vocalizations, mood/behavior changes, eyes change expression, sad/worried face, crying, teeth clenched, changes in posture. Offer non pharmacological interventions such as quiet environment, rest, shower, back rub, reposition..." An interview was conducted with Resident 4 on 5/31/23 at 12:24 p.m. He indicated his bottom was in moderate pain all the time. A physician order dated 2/3/23 indicated staff was to monitor effectiveness of routine pain medication every shift. The staff was to mark a yes or a no on electronic medication administration record (MAR). If the resident indicated a "no" a pain assessment was to be conducted. A physician order dated 2/15/23 indicated Resident 4 was to receive 325 milligrams of Tylenol for mild pain every 6 hours as needed.		Orders for PRN pain medications will include level of pain, non-pharmacological interventions provided and indicator for nurse to document location. To ensure compliance, the DNS/Designee is responsible for the completion of the Pain Management QAPI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	A physician order dated 2/17/23 indicated the resident was to receive 1/2 tablet of 5-325 milligrams of hydrocodone every 12 hours for chronic pain. A physician order dated 2/17/23 indicated Resident 4 was to receive 5-325 milligrams of hydrocodone every 4 hours as needed. A pain assessment dated 5/4/23 indicated Resident 4 had experienced frequent mild pain in the last 5 days. The assessment indicated Resident 4 did not indicate his pain was affecting his sleep or daily activities. The May 2023 MAR for Resident 4 indicated the following days Resident 4 had received as needed hydrocodone and did not include a location of the resident's pain, intensity of his pain on all administrations of as needed pain medication administrations nor nonpharmacological interventions attempted: 5/6/23 at 2:12 a.m., = reason given - documented as pain - and medication was effective, 5/15/23 at 12:34 p.m., = reason given - documented as pain - and medication was effective, 5/15/23 at 4:47 p.m., = reason given- documented as buttocks - and medication was effective, & 5/16/23 at 5:56 a.m., and 5:31 p.m., = reason given - documented as pain - and medication was effective. The MAR indicated Resident's routine pain medication was effective on 5/6/23, 5/15/23 and 5/16/23. The residents clinical record did not include nonpharmacological interventions attempted on 5/6/23, 5/15/23, nor 5/16/23 to address the			

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	resident's pain. An interview was conducted with the Director of Nursing on 6/2/23 at 8:53 a.m. She indicated she was unable to provide staff assessments of the residents' pain intensity or location of his pain on the following days the resident received as needed hydrocodone: 5/6/23 at 2:12 a.m., 5/15/23 at 12:34 p.m., and 5/16/23 5:56 a.m., and 5:31 p.m. She did not have documentation on 5/15/23 the resident's intensity of his buttock pain. The staff follow the plan of care and do not document nonpharmacological interventions that were attempted to address Resident 4's pain. A pain management policy was provided by the Regional Vice President Director of Operations on 5/8/23 at 10:58 a.m. It indicated "...Policy: It is the policy of American Senior Communities to provide the necessary care and services to maintain the highest practicable physical, mental, and psychosocial wellbeing, including pain management. 1. Residents are assessed for pain upon admission, weekly, and during medication administration as outlined below. 2. The following will be used when assessing pain. Nursing Admission Observation, Weekly Summary, IDT [Interdisciplinary Team] Pain Interview, Ongoing nursing assessments can also be documented in matrix progress notes or matrix vitals. 3. Interviewable Resident - Pain medications will be prescribed and given based upon the intensity of the pain as follows using the verbal descriptive, numerical scale (1-10) or Wong-Baker FACES Scale....7. Residents receiving routine pain medication should be assessed each shift by the charge nurse during rounds and/or medication pass. 8. Documentation of administration of ordered PRN pain medication will be documented on the Electronic Medication Administration			

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	Record (EMAR). 9. Additional information including, but not limited to reasons for administration, and effectiveness of pain medications will be documented on the Electronic Medication Administration Record (EMAR)..." 3.1-37(a)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record review, the facility failed to provide residents with an identified diagnosis of dementia and the need for close supervision as to prevent them from wandering into the rooms of other residents for 2 of 4 residents reviewed for abuse. (Resident B and D) Findings include: 1. The clinical record for Resident D was reviewed on 5/31/23 at 11:30 a.m. The diagnoses for Resident D included, but were not limited to, dementia, mood disturbance, anxiety, obsessive-compulsive disorder, restlessness and agitation. A care plan, initiated 4/26/22, indicated Resident D may become upset with redirection as exhibited by using inappropriate language with staff at times. He at times may experience feelings of loss of independence due to skilled nursing facility placement. The goal was for him to have no	F 0744	Resident B and D continue to reside in the facility and have had no negative outcomes related to intrusive wandering. Care plans have been updated related to intrusive wandering. All residents may be at risk to be affected by intrusively wandering. Residents who intrusively wander and not easily redirected are at risk. Staff will be interviewed regarding residents who intrusively wander and not easily redirected. Resident care plans will be reviewed for intrusive wandering and interventions will be evaluated for effectiveness. Resident interventions will be developed in conjunction with behavioral health and interdisciplinary team. Staff will be educated about these interventions and evaluated for effectiveness.	06/30/2023

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	negative outcomes related to behavioral expressions. The interventions were to encourage him by using phrases that emphasize choices, initiated 4/26/22, and male staff member to redirect as available with therapeutic conversations, initiated 7/20/22. A care plan, initiated 7/25/22, indicated Resident D attempted to take peers' personal care items at times. He may become preoccupied with grooming and cleanliness, such as repetitive tooth brushing, hand washing, and requests for multiple showers. He may utilize multiple tubes of toothpaste and multiple toothbrushes per day. He becomes upset if staff attempt to secure his toothbrush and toothpaste. He becomes upset if staff disturbs his towels, washcloths or any toiletry items. He may enter peers' rooms and attempt to take their toiletry items. He could become disoriented in his environment and becomes anxious when redirected. Resident D had a diagnosis of dementia and obsessive-compulsive disorder. The goal was for him not to take peers' personal items. The approaches included, but were not limited to, when he attempts to take peers' items offer him the opportunity to engage in hygiene tasks such as brushing teeth, showering, brushing his hair with his own items, initiated 7/25/23, room sign to door, 8/31/22, encourage him to keep toiletry items in walker basket during meals, initiated 10/27/22, offer occupational task to redirect such as folding napkins or clothing protectors, initiated 11/6/22, offer showers on Sundays, initiated 11/28/22, psychiatric physician to review as indicated, initiated 1/19/23, Offer walking or physical activities when he begins to wander into peers' rooms, initiated 2/1/23. The Quarterly MDS (Minimum Data Set)		Staff will be in-serviced by the Dementia Education Specialist on managing intrusive wandering on or before June 30, 2023. Effectiveness of intrusive wandering interventions will be evaluated by staff during clinical rounds. If interventions developed in conjunction with behavioral health are found to not be effective, then new interventions will be updated to care plan for intrusive wandering. Staff will be educated on new interventions. Licensed nursing staff will complete a New/Worsening Behavior Event when intrusive wandering occurs. The IDT will review the New/Worsening Behavior Event the next business day. IDT will add preventative interventions to plan of care. Staff will be educated on changes to the plan of care. Staff will be interviewed in clinical rounds for new/worsening behaviors that include intrusive wandering. IDT will ask direct care staff regarding effectiveness of interventions. To ensure compliance, the SSD/Designee is responsible for the completion of the Behavior Management QAPI tool weekly times 4 weeks, monthly times 6 and then quarterly to	

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	Assessment completed on 2/1/23 indicated Resident D was moderately impaired. The resident's functional abilities required supervision, oversite for walking in a room walking in a corridor, locomotion on and off unit with no impairments to upper or lower extremities, and used a walker for ambulation. A physician's order, dated 3/11/23, indicated he was to receive sertraline (anti-depressant medication) 200 mg (milligram) once daily for obsessive- compulsive disorder. A behavior progress note dated 3/18/23 indicated Resident D had been wandering in and out of residents' rooms. A care plan, initiated 3/20/23, indicated that Resident D would make comments to peers that they found offensive, intrusive wandering into peers' rooms and disrobe at times. The intrusive wandering places resident at higher risk for resident-to-resident altercations. He rummages through peers' personal items and taking peers items. He has increased anxiety and will attempt to take peers' drinks at times. He has a diagnosis of dementia and personality disorder. The goal was for him to have no negative outcomes related to his wandering. The interventions, initiated 3/20/23, were to redirect with diversional activity such as painting or sketching, offer snacks and drinks, offer to have him walk off of the cottage, offer one on one conversations, place on 15 minute checks, initiated 3/29/23, created occupational tasks such as assisting with setting up dining room, initiated 4/3/23, administer scheduled anti- anxiety medication, initiated 4/4, have him assist with making beds, initiated 4/26/23, place on 15 minute checks, initiated 5/3/23, and when increased wandering occurs		encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	assess for any unmet needs such as hunger, thirst, or toileting, initiated 5/8/23. A behavior progress note dated 3/20/23 indicated Resident D had been intrusive wandering in residents' rooms uninvited on 3/18/23 and 3/19/23. A behavior progress note dated 3/25/23 indicate Resident D was intrusive wandering in resident's rooms. A nursing note dated 3/26/23 indicated the resident was intrusive wandering in a resident's room while the other resident had visitors. A behavior progress note dated 3/28/23 indicated the resident was intrusive wandering in and out of residents' rooms. A physician's order, dated 3/28/23, indicated he was to receive Ativan (anti-anxiety medication) 0.5 mg twice daily, as needed, for 7 days. A behaviors progress note dated 3/29/23 indicated the resident continues to intrusive wander in and out of residents' rooms. A physician's order, dated 3/30/23, indicated his sertraline was to be decreased to 100 mg once daily and he was to receive Paxil (anti-depressant medication) 5 mg daily for depression. A behavior progress note dated 4/1/23 indicated the resident "going through roommate's clothes and in roommates' personal space while he was trying to sleep..." A physician's order, dated 4/4/23, indicated he was to receive Ativan 0.5 mg twice daily in the morning and evening.			

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	A behavior progress note dated 4/6/23 indicated the "resident was going into peers' rooms attempting to take peers personal items from rooms and became upset with staff when staff attempted to redirect telling staff they are insane and need to be locked up in a mental hospital...Resident kept insisting on going in peer rooms to read personal books..." A progress note date 4/7/23 indicated resident was going to an inpatient psychiatric hospital due to difficulty with redirection and disrobing. On 4/21/23, Resident D returned from the inpatient psychiatric hospital. A physician's order, dated 4/21/23, indicated he was to receive nortriptyline (anti-depressant medication) 25 mg daily for depression. This medication was discontinued on 4/27/23. A behavior progress note dated 4/25/23 dated 7:00 p.m., indicated Resident D was intrusive wandering in other resident's room and room pulling cable cords on wall. The staff had redirected 3 times out of the room. The staff had given medications, offered snacks and drinks, and the interventions were not effective. A nursing progress note dated 4/26/23 at 5:49 a.m., indicated the QMA [Qualified Medication Aide] on night shift reported resident had to have direct supervision because of intrusive wandering into another resident's room. He has been awake all night and needed redirection throughout the night. He had kept the other resident up all night. The other resident had told staff he would use a stick to make contact with Resident D if Resident D kept coming in the other resident's room.			

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	A physician's order, dated 4/26/23, indicated he was to receive trazadone (anti-depressant medication) 25 mg daily for generalized anxiety disorder. A physician's order, dated 4/26/23, indicated he was to receive Ativan 0.5 mg twice daily, as needed, for anxiety. A nursing progress note dated 4/27/23 at 5:17 a.m., indicated Resident D was intrusive wandering, but "took redirection well." An Interdisciplinary Team note dated 4/27/23 indicated Resident D had behaviors of intrusive wandering and would be transferred to Mapleton Cottage that day. A nursing progress note dated 4/27/23 at 8:09 p.m., indicated Resident D had been very active, walking about the unit, entering all rooms with the stop signs, open and closing doors. He had testing locked doors. Redirections have not been successful for more than a minute or two at a time. Staff has offered snacks and fluids; activities staff took him for a walk off the unit. He was asked if he could sort papers, he refused stating he was too busy. Has stood in the middle of the short hallway, doing standing exercises with his walker. The physician was notified of wandering and exit seeking behaviors. A progress note for Resident D dated 4/28/23 at 9:06 p.m., indicated Resident D continued to intrusively wander in and out of rooms of female peers. He would enter a room and then will turn around and walk out. Has been very focused on past experience of being asked to leave his apartment. Staff has provided reassurance that he			

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	does not have to leave here. He was attempting to rearrange the furniture in the dining room. He was offered yarn and asked to roll into a ball, but stated he would do that later, he was busy. He was provided a snack and fluids. He continues to ambulate on unit. A behavior event progress note for Resident D dated 4/28/23 at 9:23 p.m., indicated Resident D had entered a peer's room multiples times and when asked to leave, states he was tired and was going to bed. He tried to lay down on the second bed in the peer's room. The staff provided assistance to his room and reoriented to the location of the bathroom, call light and his bed with each redirection, within minutes he enters the peers room again. During the last entry Resident D began talking of reimbursing the peer for any problems. When redirection was attempted, he grabbed the doorknob holding tight and stated he wasn't leaving he was going to go to bed. Resident D was educated that his room was next door, again directed him back to his room, where he pulled the call lights out of the walls and attempted to pull call box off the wall. A sandwich and fluids were offered in the dining room. Resident D sat in dining room and ate his snack then he went back to his peer's room and opened the door. Peer yelled at Resident D to leave their room and told him to stop coming in because they were trying to sleep. Resident D was redirected back to the dining room, where he straightened a ball of yarn for a few minutes. A nursing progress note for Resident D dated 4/30/23 at 1:38 p.m., indicated Resident D was "going in and out of rooms. Resident trying to pull stuff off the wall. Resident redirected several times to his room but will keep coming out."			

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	A behavior progress note for Resident D dated 5/1/23 at 1:24 a.m., indicated Resident D continues to intrusively wander in and out residents' rooms waking up other residents. The staff offered activities, snacks and fluids. The interventions were effective but had to be attempted "numerous times." A behavior progress note for Resident D dated 5/1/23 indicated, he was exhibiting behaviors of intrusive wandering. He was clogging toilets and smearing feces. He was redirected and provided one on one support. The root cause of the behavior was a change in units and cognitive decline. His medications were reviewed, and he was given as needed medications. A behavior expression note for Resident D dated 5/2/23 indicated "...Resident was hit on the head by his peer when he tried entering peer's room. No injury or redness to head...Resident redirected to room with staff closely monitoring..." A nursing progress note dated 5/4/23 indicated Resident D continues to enter the rooms of peers, even if doors are closed or he has been asked not to enter. He states he has to get something out of the rooms when staff attempts to redirect him. He remains on 15-minute checks. A behavior expression note dated 5/8/23 indicated Resident D had walked into female peer's room while she was undressing. A physician's order, dated 5/11/23, indicated to give trazadone 75 mg each bedtime for generalized anxiety disorder. A physician's order, dated 5/14/23, indicated he was to receive Ativan 0.25 mg twice daily as			

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	needed for generalized anxiety disorder. A behavior note dated 5/15/23 indicated Resident D was intrusive wandering. He was transferred to a new unit. A nursing progress note for Resident D dated 5/16/23 indicated "Staff overheard this resident and peer resident raising their voices in peer's room and upon entering the room both CNAs observed this resident standing next to peer's bed with blood on his lower lip and peer resident was in his own bed. One CNA immediately took this resident out of the room to the nurse's station for further assessment and the other CNA stayed with peer resident in his room. It should be noted that this resident was previously in this room as he has had a recent room change. This resident has increased staff supervision..." An IDT note for Resident D dated 5/16/23 indicated the resident was placed on one-on-one supervision. A nursing progress note, dated 5/17/23 at 5:54 a.m., indicated Resident D had a restful night and slept in the common area in a recliner. One-on-one monitoring was done throughout the night shift. A physician's order, dated 5/18/23, indicated he was to receive Rexulti (anti-psychotic medication) 0.25 mg twice daily for major depressive disorder. A nursing progress note, dated 5/19/23 at 1:51 p.m., indicate Resident D continued with one-on-one supervision, with no distress. He had no intrusive wandering behaviors. A nursing progress note, dated 5/20/23 at 8:22			

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	a.m., indicated Resident D continued with one-on-one supervision. He was ambulating continuously on the cottage; activities had been encouraged and were effective for a short time. He was focusing on brushing teeth, getting into the sink and cabinets and thinking of various tasks he needed to do. A physician's order, dated 5/21/23, indicated to increase Rexulti to 0.5 mg twice daily. A nursing progress note, dated 5/24/23 at 3:54 p.m., indicated Resident D continued to receive one-on-one care and was in a pleasant mood, with not agitation or behaviors. A physician's order, dated 5/25/23, indicated to increase his Ativan 0.5 mg every 6 hours as needed, for generalized anxiety disorder. The nursing progress notes from 5/25/23 through 6/2/23 indicated continued one-on-one supervision and did not contain any documentation of further intrusive wandering behaviors. During an interview on 6/02/23 at 10:27 a.m., CNA (Certified Nursing Assistant) 6 indicated Resident D frequently wandered into other resident's rooms. During an interview on 6/5/23 at 10:13 a.m., CNA 5 indicated that Resident D did have wandering behaviors and the staff tried to "keep him busy". Resident D was currently receiving one-on-one care due to his wandering behaviors. An interview was conducted with Social Services Director 2 on 6/5/23 at 11:13 a.m. She indicated Resident D first resided on the Chatham unit. He			

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	continued to have wandering and disrobing behaviors, so he was sent for a psych stay in early April 2023. After he returned from the psych stay, Resident D did have continued behaviors with intrusively wandering in and out of residents' rooms. Another resident had gotten upset with Resident D's wandering in his room, so it had been decided to transfer Resident D to Mapleton Unit, which is larger and had more space to wander in the common areas. The residents that reside on the Mapleton unit also were less cognitively intact and may not be bothered by Resident D's intrusive wandering. There were some residents that already live on the Mapleton Unit who also had wandering behaviors. One of the residents on Mapleton was upset that Resident D was continuing going in and out of her room. On 5/2/23, he had attempted to go into her room, and she got upset and "swatted" Resident D in the back of the head after staff redirected Resident D way from the other resident's doorway. It then was decided to transfer Resident D back to the Chatham Unit. The resident who had previously been upset about Resident D's wandering had been moved off the Chatham Unit. After Resident D returned to the Chatham Unit, he did continue to have intrusive wandering behaviors. The staff attempted multiple interventions, but Resident D was very restless. The management staff would assist with taking him off the unit for errands with them or to walk. After the management staff left for the day, the staff on the unit continued to monitor him and provide interventions. On 5/16/23, the CNAs were providing care to another resident and had heard loud voices coming from the room across the hall. The CNAs went into Resident G's room and observed Resident D with a bloody lip while standing at the bedside, and Resident G was in bed. Resident D had wandered into Resident G's			

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room and "startled" Resident G while he was sleeping. Resident G accidentally hit Resident D on the lip. Resident G was not aggressive, and it was not intentional. Resident D was placed on one-on-one supervision and was currently still receiving one-on-one care.

During an interview on 6/5/23 at 2:33 p.m., the Psychiatric Physician indicated that Resident D was a very complex patient. Resident D suffered from 5 mental health issues simultaneously, dementia, depression, obsessive- compulsive disorder, generalized anxiety disorder, and delusions which had started this year. There had been multiple attempts to adjust his medications to an optimal dose and regimen since Resident D had been admitted to the facility. Resident D's behaviors were routine based and predictable.

During an interview on 6/5/23 at 2:33 p.m., the DON (Director of Nursing) indicated that when Resident got up from sleeping, he was constantly on the move. Resident D became fixated on certain thing due to his OCD (obsessive - compulsive disorder).

2. The clinical record for Resident B was reviewed on 6/2/23 at 9:48 a.m. Resident B's diagnoses included, but not limited to, anxiety disorder and dementia.

Resident B's quarterly MDS (Minimum Data Set) dated 5/17/23 indicated, Resident B was unable to complete the cognitive assessment related to refusal or the resident provided nonsensical answers. Resident B's cognitive pattern was described as fluctuates with inattention and disorganized thinking. Resident B required supervision with set up for locomotion on/off the unit and for walking in the corridors.

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	A nursing note dated 2/1/2023 at 11:51 p.m. indicated, Resident B "wandered the unit this evening, entered peers rooms multiple times, wanting to sit/lay down in the beds. Staff redirected to her room and assisted into bed." A nursing note dated 2/3/2023 at 1:33 a.m. indicated, Resident B "has been restless this shift, has wandered the unit entering peers rooms multiple times, wanting to sit/lay down in the beds. Staff has redirected to her room and assisted into bed, multiple times". A Behavior Communication Note (recorded as late entry on 2/5/2023 at 6:11 p.m.) dated 2/3/2023 at 6:09 p.m. indicated the following: "Date and Time of behavioral expression: 02/03/2023 01:33 AM Location of expression: Mapleton unit Describe the specific behavioral expression: [sic, Resident B's name] has been restless this shift, has wandered the unit entering peers rooms multiple times, wanting to sit/lay down in the beds. Staff has redirected to her room and assisted into bed, multiple times. [sic, Resident B's name] is currently resting in her bed with eyes closed. Interventions attempted: Redirected to her bed Effectiveness of Interventions: somewhat effective Suggestions/Other information: None" An IDT (Interdisciplinary Team) note dated 3/15/2023 at 3 p.m. indicated, IDT met for behavior management on this date regarding Resident B and discussed a medication review which was denied related to Resident B remained restless with noted frequent pacing. A nursing note dated 5/28/2023 at 5:31 a.m.			

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	indicated, Resident B "was found lying on the bed with another female resident in her room at 3.am [sic]. Resident was redirected back to her room." An IDT note dated 5/30/23 at 10:13 a.m. indicated the following: "Resident found in bed with another female in the middle of the night. Immediate interventions: Redirected resident back to her room... Potential correlation(s) to root cause: Dementia and anxiety Root cause of behavioral expression: Resident has little stimulation throughout the day. Describe preventative intervention relating to above root cause: Walk client throughout the day Care plan updated and current interventions revised as applicable: Yes" The nursing and/or IDT notes did not indicate if Resident B's representative was notified of each occurrence nor the other resident's representatives whose rooms Resident B had entered, sat or whose beds she had lay. Resident B's care plan dated 4/8/22 identified Resident B had a behavior in which they may show increased signs/symptoms of anxiety as evidenced by increased pacing, facial grimacing, dwelling at exits, and repetitive speech. Resident may follow peers around Cottage. Resident has a diagnosis of anxiety. Interventions included, medications per order, offer resident to sit with robotic pet, offer resident a shower to help relieve signs/symptoms of anxiety, and offer books with cats in them or other activities that have cats in them. Resident B's care plan dated 12/8/21 indicated,			

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	Resident has a diagnosis of Dementia and was at risk of having altercations with her peers related to: attempts to take food/items that belong to peers, attempts to get in peer's beds at times, and attempts to touch a babydoll that another resident was holding. Interventions added on 6/5/23 included, but not limited to, remove resident from area of peer and redirect to activities of interest i.e., walk, music, watching TV or electronic cat, stuffed bear or baby doll that resident can hold. Resident B's care plan dated 8/31/21 indicated, Resident may intrusively wander at times and look for a place to rest but will also wander in and out of peers' rooms looking for her stuffed cat or laying in their beds. Interventions included, but not limited to, assist resident back to room, assist resident to activity of choice, offer resident snack of choice, offer a shower to help relieve anxiety. An interview with CNA (Certified Nursing Assistant) 7 was conducted on 6/2/23 at 10:03 a.m. CNA 7 indicated, Resident B wanders every night and has been found in other residents' beds. CNA 7 indicated; she was working the night of 5/28/23 when Resident B was found in Resident C's bed. She indicated; she was approached by CNA 8 asking her for assistance with getting Resident B out of Resident C's bed. When she arrived at the room, both residents were sleeping in the same bed, fully clothed. CNA 7 stated, Resident B intrusively wanders into other residents' rooms all the time and seems to have a 'favorite' room which was the first room next to the exit leaving the unit and near the front entrance. She further indicated, Resident B's behaviors of intrusive wandering and lying in peers' beds (occupied and unoccupied) has been getting more frequent. An interview with CNA 8 was conducted on			

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	6/5/23 at 10:05 a.m. CNA 8 indicated; Resident B was an extreme wanderer. She gets into bed with everyone and on 5/28/23 at about 3:30 a.m. she found Resident B in bed with Resident C. She stated both residents were both under the covers and asleep. CNA 8 indicated; she was surprised to see Resident B under the covers because usually she would lay on top of the covers. When she pulled the covers back, she could see both residents were clothed and not touching each other. In fact, they were back-to-back in the bed. She then left the room and got Resident B's aide and the nurse to assist with getting Resident B back to her own room. CNA 8 indicated; Resident B intrusively wanders into everyone's room. She believes Resident B's behaviors are excessive and it was becoming more difficult to get her out of the other residents' beds. CNA 8 indicated she had called the Executive Director (ED) during the night to report the incident because "it was strange to me because she was under the covers". An interview with CNA 6 was conducted on 6/2/23 at 10:27 a.m. CNA 6 indicated; she had worked on Mapleton (where Resident B, C, and 10 reside) yesterday. She indicated, there were several residents who wander into other resident's rooms on the unit and Resident B has climbed into bed with other residents. She indicated; Resident B seemed to really like getting into bed with Resident 10. An observation of Resident B was conducted on 6/2/23 at 10:56 a.m. She was observed walking out of Resident 10 and 18's room. Residents 10 and 18's room did not have a stop sign across their door. An interview with DON (Director of Nursing) and ED was conducted on 6/2/23 at 2:15 p.m. DON			

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	155636	A. BUILDING 00 B. WING	06/05/2023

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	indicated; they follow the plan of care when it comes to dealing with residents' behaviors. She stated the main goal was to redirect the resident. She indicated when a resident has displayed a behavior, the expectation was for the nurse to place a behavior communication note in the progress notes. When asked how any other staff member such as CNAs would document on behaviors, she indicated, the CNA or other staff member would inform the nurse and the nurse would document the behavior. She indicated; she did not believe residents with dementia who wander into another resident's room was considered intrusive unless an event occurred. When asked how they track the behaviors frequency, the effectiveness of interventions, what interventions were utilized for each resident, she indicated, they review the progress notes daily. The ED indicated, she could see how Resident B's behaviors of wandering into other resident rooms and lying in other residents' beds had been considered her baseline. A Behavior Management policy was provided by ED on 6/2/23 at 11:43 a.m. The policy indicated, "to provide behavior interventions for residents with problematic or distressing behaviors. Interventions provided are both individualized and non pharmacological and part of a supportive physical and psychosocial environment that is directed toward preventing, relieving and/or accommodating a resident's behavioral expressions... 1. Care plans should be initiated for any behavioral expression that is problematic or distressing to the resident, other resident or caregivers. Care plan interventions should...address both proactive and responsive interventions... 3. When a behavioral expression occurs, the staff			

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	communicates to the nurse what behavior occurred. The nurse records the behavior in Matrix [sic, their charting system]. 4. If the behavioral expression is new, worsening, or high risk, the nurse will record the behavior using the New/Worsening Behavior Event...New/Worsening behaviors include...b. behaviors that are directed at another resident... c. behaviors that are increasing in either frequency or severity d. Behaviors that have potential for risk to others including sexual advances, intrusive wandering, exit seeking and chronic combativeness with care... 6. Residents with documented behaviors will have a Behavioral Health Monthly Review. This review includes evaluation of behaviors which have occurred that month and that interventions for behavioral expressions are current and effective." This Federal tag relates to Complaint IN00409906. 3.1-37(a)			