STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 00 B. WING	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00378335, IN00378364, IN00380095, and IN00382207. Complaint IN00378335 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580 and F686. Complaint IN00378364 - Unsubstantiated due to lack of sufficient evidence. Complaint IN00380095 - Unsubstantiated due to lack of sufficient evidence. Complaint IN00382207 - Unsubstantiated due to lack of sufficient evidence. Unrelated deficiencies are cited. Survey dates: June 7, 8, and 9, 2022 Facility number: 000526 Provider number: 155488 AIM number: 100266970 Census Bed Type: SNF/NF: 99 Total: 99 Census Payor Type: Medicare: 6 Medicaid: 83 Other: 10 Total: 99 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.***	

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

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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	Quality review completed on June 16, 2022.			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.			

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	(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to ensure a resident's (Resident B) representative was notified of newly acquired wounds for 1 of 3 residents reviewed for family notification. Findings include: The clinical record for Resident B was reviewed on 6/7/22 at 12:37 p.m. The diagnosis included, but was not limited to, dementia. The quarterly MDS (Minimum Data Set) assessment, dated 1/23/22, indicated the resident's cognition was severely impaired. The wound evaluation report, dated 2/1/22, indicated the resident had a new stage 3 pressure ulcer to the sacrum, acquired in house, which measured 5.06 cm (centimeters) in length, 8.14 cm in width with a depth of .10 cm. The wound evaluation report, dated 2/1/22, indicated the resident had a new area to the right heel, acquired 2/1/22, which measured 0.64 cm in length, 0.74 cm in width with no depth.	F 0580	1. Resident B was not harmed by the alleged deficient practice. 2. All residents that have wounds were reviewed to ensure that appropriate notifications were made. 3. The DON/designee will educate all Licensed staff on Notification of Changes in Condition policy and procedure. 4. The DON/designee will complete audits on 10 residents weekly for 8 weeks, monthly times 4 months and Quarterly times 2 quarters that had a change in condition to ensure appropriate notification was made. The results of the audits will be reported and reviewed with the QAPI Committee monthly for 6 months or until compliance is achieved for 3 consecutive months.	07/13/2022

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The physician's order, dated 2/1/22, indicated to cleanse the coccyx with normal saline, pat dry, apply medihoney to the area with a dry dressing daily.

The physician's order, dated 2/1/22, indicated to paint the deep tissue injury to the right heel with betadine twice daily.

The wound evaluation report, dated 2/10/22, indicated the resident had a new area to the upper sacrum which measured 2.15 cm in length, 1.5 cm in width with no depth.

The clinical record lacked documentation of family notification related to the wounds.

During an interview on 6/9/22 at 1:58 p.m., LPN (License Practical Nurse) 4 indicated a resident's family should be notified of any changes of condition.

On 6/9/22 at 11:05 a.m., the Executive Director provided a current copy of the document titled "Notification for Changes in Condition" dated October 2013. It included, but was not limited to, "Policy...It is the policy of this facility to provide resident centered care...The purpose of this policy is to provide guidance for notifications mad to...resident representatives, and family for resident changes in condition...Changes may include...significant medical changes...When a change in condition is noted, the nursing staff with contact the resident representative...."

This Federal tag relates to Complaint IN00378335

3.1-5(a)(2)

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F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other			

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	appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on interview and record review, the facility failed to ensure comprehensive care plans were implemented in a timely manner to accurately reflect the needs of the residents (Resident B, Resident H, and Resident L) for 3 of 9 residents reviewed for care plans. Findings include: 1. The clinical record for Resident B was reviewed on 6/7/22 at 12:37 p.m. Diagnosis included, but was not limited to, need for assistance with personal care. The quarterly MDS (Minimum Data Set) assessment, dated 1/23/22, indicated the resident required assistance with ADL's (Activities of Daily Living) as follows: -extensive, physical assistance of one staff member with bed mobility -extensive, physical assistance of one staff member with transfers -extensive, physical assistance of one staff member with dressing -extensive, physical assistance of one staff member with toileting -extensive, physical assistance of one staff member with personal hygiene -extensive, physical assistance of one staff member with bathing Review of the clinical record lacked a plan of care for the resident's activities of daily living.	F 0656	1. Resident's B, H, and L were not harmed by the alleged deficient practice. Resident's B, H, and L care plans were reviewed and updated to reflect resident's current needs. 2. All residents will have care plans reviewed and updated as needed to reflect resident's current needs. 3. The DON/designee will educate all Licensed staff regarding Care Plan policy and procedure with emphasis on updating of Care Plans timely. 4. The DON/designee will audit 10 resident care plans weekly for 8 weeks, monthly times 4 months, and quarterly times 2 quarters. The results of the audits will be reported and reviewed with the QAPI Committee monthly for 6 months or until 100% compliance is achieved for 3 consecutive months.	07/13/2022

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	During an interview on 6/9/22 at 12:36 p.m., the MDS Coordinator indicated care plans should be implemented within 21 days of admission. 2. The clinical record for Resident H was reviewed on 6/8/22 at 12:54 p.m. The diagnosis included, but was not limited to, stage 4 pressure ulcer to the sacrum. The Admission Initial Evaluation, dated 3/4/22 at 6:20 p.m., indicated the resident admitted with an Indwelling catheter and an ostomy. The admission 5 day MDS assessment, dated 3/11/22, indicated the resident had an Indwelling Foley catheter and an Ostomy. Review of the clinical record indicated the resident's plan of care for the Indwelling catheter and ostomy were not initiated until 4/5/22. 3. The clinical record for Resident L was reviewed on 6/8/22 at 1:28 p.m. The diagnosis included, but was not limited to, right humerus fracture. The progress note, dated 5/11/22 at 2:20 p.m., indicated the resident slid out of bed and on to the floor beside her bed. The resident was assessed and denied pain. The progress note, dated 5/12/22 at 9:20 p.m., indicated it was reported that the resident had a fall . The resident had edema and bruising to her right elbow, grimaced during care, and favored her right arm. An X-ray had been ordered. The radiology report, dated 5/13/22 at 1:23 p.m., indicated the resident had an acute fracture of the right distal humerus.			

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	The clinical record lacked documentation of a plan of care for the resident's fracture. On 6/9/22 at 11:05 a.m., the Executive Director provided a current copy of the document titled "Plan of Care Overview" dated 7/26/2018. It included, but was not limited to, "Definitions...for the purpose of this policy the Plan of Care, also Care Plan is the written treatment provided for a resident that is resident-focused and provides for optimal personalized care....It is the policy of this facility to provide resident centered care...The purpose of this policy is to provide guidance to the facility to support the inclusion of the resident...in all aspects of person-centered care planning and that this planning includes the provision of services to enable the resident to live with dignity and supports the resident's goals, choices, and preferences including, but not limited to, goals related to their daily routines and goals to potentially return to a community setting...." 3.1-35(a) 3.1-35(b)(1) 3.1-35(c)(1) 3.1-35(d)(1)			
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 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	F 0684	1. Resident G was not harmed	07/13/2022

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	failed to ensure neurological checks were implemented for a resident (Resident G) after an unwitnessed fall for 1 of 3 residents reviewed for quality of care. Findings include: The clinical record for Resident G was reviewed on 6/8/22 at 11:15 a.m. The diagnoses included, but were not limited to, dementia and Alzheimer's disease. The progress note, dated 5/14/22 at 12:02 p.m., indicated the resident was found on the floor. The resident complained of left hip pain, the nurse practitioner was notified and a new order received for an X-ray. The post fall evaluation, dated 5/14/22 at 1:44 p.m., indicated the fall was not witnessed and staff were to initiate neurological checks. The clinical record lacked documentation of the initiation of neurological assessments. During an interview of 6/9/22 at 11:45 a.m., LPN (Licensed Practical Nurse) 3 indicated if a fall was not witnessed, neurological checks should be initiated. On 6/9/22 at 11:05 a.m., the Executive Director provided a current copy of the document titled "Fall Prevention and Management" dated 5/25/21. It included, but was not limited to, "It is the policy of this facility to provide resident centered care that meets the...physical...needs... of the residents...Process after a fall...Assessment...If the resident hit their head or it was an unwitnessed fall begin neurochecks per the neurocheck policy...."		by the alleged deficient practice. 2. All residents who have had a recent unwitnessed fall will be reviewed to ensure that Neurological Checks started per facility policy and procedure. 3. The DON/designee will educate all Licensed staff regarding Falls Management policy and procedure with an emphasis on Unwitnessed falls and completion of Neurological checks. 4. The DON/designee will audit 5 resident falls weekly for 8 weeks, monthly times 4 months, and Quarterly times 2 quarters, to ensure that Neurological checks were completed when appropriate. The results of the audits will be reported and reviewed with the QAPI Committee monthly for 6 months or until 100% compliance is achieved for 3 consecutive months.	

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	3.1-37			
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview and record review, the facility failed to ensure appropriate interventions were implemented for a resident (Resident B) with a moderate risk for impaired skin integrity which resulted in a stage 3 pressure ulcer (full thickness skin loss) to the sacrum, an unstageable pressure ulcer (full thickness skin loss either covered by extensive necrotic tissue or by eschar) to the upper sacrum, and a deep tissue injury (localized area of discolored skin caused by damage to underlying tissue from pressure and/or shear) to the right heel, and to ensure pressure ulcer treatments were completed for residents (Resident B and H) for 2 of 3 residents reviewed for pressure ulcers. Findings include: 1. The clinical record for Resident B was reviewed	F 0686	1. Resident's B and H will have the interventions reviewed and updated to ensure that appropriate interventions are in place. 2. All residents that have wounds will have their interventions reviewed and updated as needed. Any resident identified as not having appropriate interventions in place will be updated, physician and family notified, and new orders addressed. 3. DON/designee will educate all Licensed staff on facilities Skin Care and Wound Management overview with emphasis on	07/13/2022

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	on 6/7/22 at 12:37 p.m. The diagnoses included, but were not limited to, dementia, restless leg syndrome, and diabetes. The quarterly MDS (Minimum Data Set) assessment, dated 1/23/22, indicated the resident's cognition was severely impaired. The resident required one physical staff member's assistance with bed mobility. The Braden Observation Tool, dated 12/7/21, indicated the resident was at a moderate risk for pressure ulcers due to slightly limited sensory perception, very moist skin exposure, chairfast, slightly limited mobility, and a problem with friction/shearing. Potential interventions for those at a moderate risk for pressure ulcers included an actual turning schedule as the resident allowed'/tolerated, wedge support for 30 degree side positioning, and heel protection. The care plan, dated 2/9/22, indicated the resident had impaired skin integrity and at risk for altered skin integrity related to immobility, diabetes, and atrial fibrillation. The interventions included to administer medications as ordered, complete treatments as ordered, apply barrier creams post incontinent episodes, complete skin at risk assessments, complete weekly skin checks, and obtain labs as ordered. The care plan, dated 2/9/22, indicated the resident had actual impaired skin integrity that included a stage 3 to the coccyx, a deep tissue injury to the right heel, and an unstageable pressure ulcer to the sacrum. The interventions included to evaluate ulcer characteristics, measure ulcer at regular intervals, provide wound care per treatment orders, notify provider if no signs of improvement on current wound regimen, and to		appropriate interventions per the physician orders. 4. DON/designee will conduct audits of residents with wound treatments to ensure compliance weekly times 8 weeks, monthly times 1 month and quarterly times 1 quarter. The results of the audits will be reported and reviewed with the QAPI Committee during monthly meeting for a minimum 6 months, then randomly thereafter for further recommendations.	

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	monitor or signs of infection, wound progression or wound declination. The wound evaluation report, dated 2/1/22, indicated the resident had a new stage 3 pressure ulcer to the sacrum, acquired in house, which measured 5.06 cm (centimeters) in length, 8.14 cm in width with a depth of .10 cm. Staff were to ensure compliance with turning protocol and a wedge/foam cushion for offloading. The wound evaluation report, dated 2/1/22, indicated the resident had a new area to the right heel, acquired 2/1/22, which measured 0.64 cm in length, 0.74 cm in width with no depth. Staff were to elevate the resident's legs regularly and a wedge/foam cushion for offloading. The skin/wound evaluation note, dated 2/1/22, indicated the pressure reduction and turning precautions were discussed with staff at the time of visit, which included heel protection and pressure reduction to bony prominences. The physician's order, dated 2/1/22, indicated staff were to cleanse the coccyx with normal saline, pat dry, apply medihoney to the area with a dry dressing daily. The physician's order, dated 2/1/22, indicated staff were to paint the deep tissue injury to the right heel with betadine twice daily. Review of the February 2022 indicated the treatment to the coccyx was not completed on 2/2/22 and the treatment to the right heel was not completed on 2/2/22 (day shift) and 2/8/22 (night shift). The nurse practitioner note, dated 2/7//22 at 11:42			

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	a.m., indicated the resident had a deep tissue injury to the right heel, a stage 3 pressure ulcer to the sacrum, and that the resident refused to get out of bed. The progress note, dated 2/9/22 at 1:06 p.m., indicated the resident currently had a low air loss mattress in place. The wound evaluation report, dated 2/10/22, indicated the stage 3 to the sacrum measured 3.04 cm in length, 3.06 cm in width with a depth of .01 cm. Staff were to ensure compliance with turning protocol and a wedge/foam cushion for offloading. The wound evaluation report, dated 2/10/22, indicated the deep tissue injury to the right heel measured 0.47 cm in length, 0.39 cm in width with no depth. Staff were to elevate the resident's legs regularly and a wedge/foam cushion for offloading. The wound evaluation report, dated 2/10/22, indicated the resident had a new area to the upper sacrum which measured 2.15 cm in length, 1.5 cm in width with no depth. Staff were to ensure compliance with turning protocol, wedge/foam cushion for offloading, and specialty bed. The clinical record lacked documentation of turning/repositioning, offloading heels, or any refusal to turn, reposition, or offload heels. During an interview on 6/8/22 at 12:10 p.m., the Director of Nursing indicated the resident acquired the wounds due to actively dying and refused to move or get up out of bed. A confidential interview, during the survey			

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	155488	A. BUILDING 00 B. WING	06/09/2022

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	process, indicated Resident B was sent to the hospital on 2/11/22 for evaluation. The resident had stage 3 pressure sores which required multiple skin grafts during her stay at the hospital. The resident was discharged, after approximately 5 days in the hospital, to an out of State skilled nursing facility per family request. They were aware the resident was in the new skill nursing home for a couple of months after discharging from the hospital. 2. The clinical record for Resident H was reviewed on 6/8/22 at 12:54 p.m. The diagnosis included, but was not limited to, stage 4 pressure ulcer (pressure injury which was very deep, reaching into the muscle and bone) to the coccyx. The admission MDS assessment, dated 3/11/22, indicated the resident was admitted with a stage 4 pressure ulcer to the coccyx. The care plan, dated 3/8/22, indicated the resident had a stage 4 pressure ulcer to the coccyx and to provide wound per treatment orders. The wound evaluation report, dated 5/6/22, indicated the resident had a stage 4 wound to the coccyx which measured 8 cm in length, 5 cm in width with a depth of 0.2 cm. The May 2022 treatment administration record indicated staff were to cleanse the resident's coccyx wound with normal saline, pat dry, pack wound areas with calcium alginate with silver and cover with a dry dressing daily. Review of the May 2022 treatment administration record indicated the treatment was not completed on 5/15/22 or 5/26/22. The wound evaluation report, dated 6/3/22,			

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	indicated the resident's stage 4 wound measured 6.5 cm in length, 4.6 cm in width with a depth of .10 cm. The June 2022 treatment administration record indicated to cleanse the coccyx wound with normal saline, pat dry, pack left side of the wound with collagen and calcium alginate with silver, apply collagen to exposed wound bed, and cover with a dry dressing daily. Review of the June 2022 treatment administration record indicated the treatment was not completed on 6/6/22. On 6/9/22 at 11:45 a.m., LPN (Licensed Practical Nurse) 3 indicated when a treatment was completed, the nurse should initial the treatment record to show it was completed. On 6/9/22 at 11:05 a.m., the Executive Director provided a current copy of the document titled "Skin Care & Wound Management Overview" dated 7/2016. It included, but was not limited to, "Policy...The facility staff strives to prevent resident/patient skin impairment and to promote the healing of existing wounds...implement interventions to prevent...potential skin integrity issues...Implementation of prevention strategies to decrease the potential for developing pressure ulcers...Develop a care plan with individualized interventions to address risk factors...." This Federal tag relates to Complaint IN00378335 3.1-40(a)(1) 3.1-40(a)(2)			
F 0744 SS=D	483.40(b)(3) Treatment/Service for Dementia			

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Bldg. 00	§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 interview and record review, the facility failed to ensure appropriate interventions and strategies were implemented for a resident (Resident E) with a diagnosis of dementia, wandering behaviors, and physical behaviors, upon return from the behavioral hospital for 1 of 3 residents reviewed for dementia care. Findings include: The clinical record for Resident E was reviewed on 6/7/22 at 3:57 p.m. Diagnoses included, but were not limited to, metabolic encephalopathy, alcohol abuse with alcohol induced disorder, insomnia, anxiety, and dementia with behavioral disturbance. The quarterly MDS (Minimum Data Set) assessment, dated 4/18/22, indicated the resident's cognition was severely impaired. The resident had physical behaviors, verbal behaviors, and wandering behaviors. The care plan, dated 10/29/21, indicated the resident had a potential for mood/behavior related to his diagnosis of dementia with behavioral disturbance. The interventions included to allow resident to verbalize his feelings, perceptions and fears, caregivers to stop and talk with resident while passing by or performing care, provide the resident with opportunity for positive interaction, provide praise and positive interaction, and for staff to anticipate and meet the resident's needs. The progress note, dated 3/28/22 at 5:55 p.m., indicated Resident E was sitting in a wheel chair in	F 0744	1. Resident E was not harmed by the alleged deficient practice. Resident E's interventions were reviewed and updated as appropriate. 2. All residents with dementia that has had a behavioral hospital stay will have behavior interventions reviewed an updated as needed. 3. DON/Designee will educate all Licensed staff on the facilities Dementia Care Residents Rights and Privileges with emphasis on behavior interventions identified on the residents plan of care. 4. DON/designee will conduct audits on all residents with dementia that have had a Behavior Hospital stay weekly times 8 weeks, monthly times 4 months, and quarterly times 2 quarters to ensure that appropriate interventions are in place. The results of the audits will be reported and reviewed with the QAPI Committee monthly for 6 months or until 100% compliance is achieved for 3 consecutive months.	07/13/2022

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	the hallway. Resident L wandered up to his wheel chair and would not move. Staff overheard the verbal argument. Staff observed Resident E grab Resident L's head and punched her in the left eye. Staff intervened before the resident could strike Resident L a second time. Resident E was placed 1:1 (one staff to one resident continuous observations) and transferred to the emergency room to be evaluated for the behavior unit. The progress note, dated 3/29/22 at 12:55 a.m., indicated Resident E returned from the emergency room. He was diagnosed with a urinary tract infection and placed on an antibiotic, Cefdinir 300 mg (milligrams) twice daily for 10 days. The progress note, dated 3/29/22 at 10:00 a.m., indicated Resident E was standing at the entry door, banging on the door, and screaming at staff. When staff tried to re-direct him, he became verbally abusive and threatening staff. There was no re-directing him. The progress note, dated 3/29/22 at 11:29 a.m., indicated a new order was received from the psychiatrist to increase the resident's Buspirone (antipsychotic) to 20 mg three times a day. The progress note, dated 3/29/22 at 12:21 p.m., indicated the resident was standing at the front entry doorway screaming and banging on the door. He was asking everyone to let him out. When re-directed, he became verbally abusive and swinging at staff. He made contact with one staff member and could not be re-directed. The progress note, dated 3/29/22 at 3:30 p.m., indicated the resident was sent to the psychiatric hospital for evaluation due to increased behaviors.			

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	The progress note, dated 4/5/22 at 11:23 a.m., indicated the resident returned from the behavioral hospital. He was calm, cooperative, and seemed happy to be back. The clinical record lacked documentation of any new interventions upon readmission from the psychiatric hospital. The progress note, dated 4/6/22 at 4:32 p.m., indicated the resident had been calm and cooperative. He had gone to the double doors (front entrance) a few times this shift but was easily redirected. The progress note, dated 4/11/22 at 4:47 p.m., indicated the resident attempted to exit the unit behind a staff member. When staff attempted to re-direct him, the resident pushed and cussed staff, yelled he was leaving, balled up his fists, and swung at three different staff members. Staff were able to get the resident away from the door and get the door closed. The resident continued to yell and curse staff, stood by the doors for a while, sat in a chair, and then calmed down. The progress note, dated 5/26/22 at 4:17 p.m., indicated the resident was seen standing over Resident F. Resident E confirmed he hit Resident F in the face because he attempted to come into his room. Resident E was extremely agitated and unable to be redirected at the time. Nursing staff were one on one to talk with resident and allow him to express his feeling, which was ineffective. The resident was 1:1 with staff until sent to the hospital for psychiatric evaluation. The clinical record indicated Resident (E) returned from the behavioral hospital on 4/5/22 with no			

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	new interventions. During an interview on 6/7/22 at 4:45 p.m., LPN (Licensed Practical Nurse) 5 indicated Resident E usually does pretty good. He likes to try and help other residents and if the help was not welcomed, he would just "snap". During an interview on 6/9/22 at 12:49 p.m., the Director of Nursing indicated the intervention for Resident E's behavior was that he was sent to the behavioral hospital, treated, and deemed safe to return to the facility. The clinical record for Resident L was reviewed on 6/8/22 at 3:22 p.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance, anxiety, and Alzheimer's. The quarterly MDS assessment, dated 5/11/22, indicated the resident's cognition was severely impaired. The progress note, dated 3/28/22 at 5:42 p.m., indicated Resident L was struck in the left eye by Resident E. Staff intervened before she could be struck again and she just continued to wander. No injuries were observed. The clinical record for Resident F was reviewed on 6/7/22 at 4:21 p.m. The diagnosis included, but was not limited to, vascular dementia with behavioral disturbance. The progress note, dated 5/26/22 at 4:58 p.m., indicated Resident F was on the floor in the middle of the hallway yelling for help and Resident E was standing over him. Resident F reported to staff that Resident E punched him in the eye. The resident was assessed and observed with a skin tear to the right hand and bruising			

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	around the left eye. The resident refused to go to the hospital. The resident indicated he was fine, just shaken up a bit. On 6/9/22 at 1:54 p.m., the Director of Nursing provided a current copy of the document titled "Dementia Care Resident Rights and Privileges" dated 8/21/18. It included, but was not limited to, "Policy...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety is a primary concern for our residents...." 3.1-37			