STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE AT PARKWOOD	1001 N GRANT ST LEBANON, IN 46052

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00440685. Complaint IN00440685-Federal/State deficiencies related to the allegations are cited at F744. Survey date: August 13, 2024 Facility number: 000468 Provider number: 155378 AIM number: 100290270 Census bed type: SNF/NF: 88 Total: 88 Census payor type: Medicare: 1 Medicaid: 82 Other: 5 Total: 88 This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on August 21, 2024.	F 0000	Preparation and/or execution of this plan of correction in general, does not constitute an admission of an agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is 9/06/2024,	
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 ensure effective	F 0744	**F 744 Treatment/Service for Dementia**	09/06/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Lazar (Hurt)	Administrator	08/30/2024

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	person-centered dementia care was provided to prevent residents on the locked dementia unit from wandering into the room of a resident with known aggressive, impulsive, and sexually inappropriate behaviors and no diagnosis of dementia for 4 of 4 residents reviewed on the dementia care unit. (Residents D, C, B and E) Findings include: A document, titled "Intake Information," dated 8/9/24, indicated there was a concern of Resident B and C wandering into Resident D's room and disrobing. During an interview, on 8/13/24 at 4:05 p.m., the Director of Nursing (DON), Executive Director, and Nursing Consultant were in attendance. The DON indicated Resident D was sent to a neuropsychiatric hospital because he became aggressive when residents wandered into his room. They moved him to the end of the hallway to prevent residents from entering his room. He was 33 years old and had a cognitive impairment. During a phone interview, on 8/13/24 at 11:31 a.m., LPN 3 indicated she was on duty, on 8/1/24, when she observed Resident C coming out of Resident D's room without any pants or brief on. Resident D came out of his room right after her. She took Resident C to her room to get her dressed in pants and another brief. She found her other brief with feces laying on Resident D's bathroom floor. It was not uncommon for Resident C to take her brief off if she had a bowel movement. 15-minute checks were started on both residents and she was told by the DON to write a statement, but she did not document the event in either resident's record.		**1 What corrective action will be accomplished for those residents found to have been affected by alleged deficient practice:** a A comprehensive care plan was developed for resident D and updated to include specific interventions to address resident behaviors. Resident D was moved to room 71 next to the nurse station off the main hallway. b Residents B and C were be reassessed by the interdisciplinary team, and their care plans will be updated to include enhanced monitoring, particularly for wandering behaviors. Specific interventions, such as more frequent checks and structured activities, will be introduced to reduce wandering and ensure they do not enter other residents' rooms. c Resident E's care plan will be revised to focus on reducing her inappropriate interactions with Resident D and other male residents. **2 How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken:** a All residents residing on the	

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	A typed facility statement, dated 8/1/24, indicated the Assistant Director of Nursing (ADON) interviewed Resident D regarding the incident with Resident C. Resident D indicated he had been walking back and forth to the nurses' station throughout the shift. When he went back to his room, a female resident covered in feces was standing in his room. He escorted her out. She looked like she was looking for a bathroom. During an interview, on 8/13/24 at 11:46 p.m., LPN 6 indicated, on 8/5/24, she was looking for Resident B to give him his medication. She was unable to find him, so she asked the CNA to assist her in locating him. The CNA asked her to come to Resident D's room. Resident B was observed sitting on Resident D's bed with his brief undone with feces on it and one pant leg off. Resident D's room smelled of feces. Resident D indicated Resident B "barged" into his room. Resident D's door was shut prior to the CNA knocking and opening the door. Resident B was taken to his room, cleaned up, and management was notified. She was told to write a statement of the incident, but she did not document the incident in either of the resident's records. Resident D was placed on one-on-one at that time. A typed statement, dated 8/5/24, indicated the DON interviewed Resident D regarding the incident between him and Resident B. Resident D indicated he got up from bed to go to the bathroom and when he came out of the bathroom, a male resident was sitting on his bed and he smelled bad. When the staff came into his room, he was asking the male resident to get up and leave his room. 1. The clinical record for Resident D was reviewed on 8/13/24 at 10:00 a.m. The diagnoses included,		Dementia Care Unit have the potential to be affected by alleged deficient practice. b Current residents residing on the Dementia care unit had care plans reviewed and revised to ensure behavior care are personalized to reflect the residents needs **3 What measures will be put into place and what systemic changes will be made to ensure that alleged deficient practice does not occur.** a Nursing and care staff will be re- educated on dementia care, focusing on managing behaviors by The Director of Nursing or designee. The Life Enrichment Director will be re-educated on activity programming for residents with Dementia by The Administrator or designee. **4 How the corrective action will be monitored to ensure the alleged deficient practice will not recur, what quality assurance program will be put into place:** a The Director of Nursing or designee will conduct audits 4 times a week for 4 weeks, 3 times a week for 4 weeks and 2 times a week for 4 weeks to ensure care plans are updated and appropriate for any new behaviors identified. b Audit results will be	

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	but were not limited to, inappropriate sexual behaviors, delusional disorders, psychoactive substance abuse with psychoactive substance-induced mood disorder, and alcohol abuse with alcohol-induced mood disorder. The resident had a care plan which addressed the problem he had impaired cognition related to a history of substance abuse and intracranial injury as evidenced by memory deficits and poor decision-making ability. The care plan was initiated on 11/20/23 and edited 5/15/24. The approaches included, but were not limited to, 11/20/23, avoid an overly protective attitude toward the resident and determine if decisions made by the resident endangered the resident or others. Intervene if necessary. The resident had a care plan which addressed the problem he resided on the memory care unit due to his traumatic brain injury, he believed he was younger than what he was and thought he should be doing schoolwork. He enjoyed math, spelling, and word games. He participated in food related activities, music, TV and simple games. His prior occupation was a cook, so offer him diversional activities which had to do with cooking. The care plan was initiated on 12/5/23 and edited on 5/15/24. The approaches included, but were not limited to, 12/5/23, invite or encourage the resident to attend activity of choice, provide activity opportunities which meet the resident's interest, provide a monthly activity calendar, and provide reminders of activity opportunities. The resident had a care plan which addressed the problem he was at risk for behavior episodes related to the diagnoses of psychoactive substance abuse with psychoactive substance induced mood disorder as evidence by he had a		submitted to the CEO/designee for review by the QAPI Committee monthly for 3 months, or until QAPI Committee determines substantial compliance has been achieved. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes. **5 Date of Compliance: 9/6/24**	

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	history of refusing showers and cursing. The care plan was initiated on 5/15/24. The approaches included, but were not limited to, 3/4/24, approach the resident in a calm and unhurried manner, explain the care process prior to delivery of care, offer choices in hands-on care and contact, and allow the resident to exercise the right to decline treatment and services. A nursing progress note, dated 2/9/24 at 11:00 a.m., indicated Resident D had a negative verbal interaction with another resident and wanted to physically fight. A nursing progress note, dated 2/11/24 at 9:20 p.m., indicated the resident was speaking to his mother on the phone located at nurses the station. He constantly used profanity during his conversation and was making residents in the lounge visibly irritated. The nurse asked the resident to please use better language, and he answered, "I do not give a F*** about any of them." A nursing progress note, dated 2/19/24 at 9:20 p.m., indicated the resident was agitated with another resident who kept coming into his room this shift. A nursing progress note, dated 3/2/24 at 5:00 p.m., indicated the resident took a call from his mother at the nurses' desk. His conversation got louder, and the resident cursed while on the phone. Another resident asked him to "keep it down" as several were watching TV. Resident D indicated he would talk as loud and curse all he wanted. Several residents (mostly women) told him to "quit talking like that". He just got louder and cursed at all the residents. The male residents were now yelling at him. This writer told Resident			

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	D if he did not talk lower and stop cursing, she was going to hang up the phone. He continued and the nurse hung up the phone. His mother called back, and the nurse explained the facility would not have Resident D upsetting all the residents. A nursing progress note, dated 4/5/24 at 2:10 p.m., indicated the resident ambulated as he desired, wandered aimlessly, stood at the nurses' station often and talked with staff and other residents. He remained temperamental, had an unpredictable behavior, his mood changed quickly, he was somewhat difficult to redirect, he often left and went to his room independently when he got upset with situations. A nursing progress note, dated 4/13/24 at 3:07 p.m., indicated the resident was aggressive with verbalization and continued to stand at the nurses' station responding to all conversations even when they were not related to him. He questioned the 911 medical team and asked one of the men if he was here to take him on, while asking the guy "How much do you weigh and how often do you work out?" The Emergency attendant answered Resident D, then asked him to free the hallway near the nurses' station, so they were able to attend to someone on the unit who needed emergency help. He became loud stating "you don't tell me what to do, no one tells me." Facility staff attempted to redirect the resident, but he continued to refuse to leave the nurses' station area. The resident had increased agitation, was difficult to redirect, intrusive with continued commenting, and asked staff personal questions. A nursing progress note, dated 4/15/24 at 8:23 p.m., indicated Resident D touched the writer's hair today stating it was "so soft he had been			

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	wanting to do that" and he attempted to squeeze the writer's arm indicating "feel those muscles." Those episodes were unprovoked and not entertained. The resident was heard talking with other staff today stating, "I do what the f*** I want." A nursing progress note, dated 4/16/24 at 4:25 p.m., indicated Resident D's Depakote (a medication used to treat seizures and behavioral disorders) was increased to 500 mg (milligrams) by mouth twice a day for delusions and he was started on Paxil (a medication used to help with depression and sexually inappropriate behaviors) 20 mg by mouth daily for sexually inappropriate behaviors. Resident B had a care plan which addressed the problem he had inappropriate sexual behaviors as evidenced by the resident making inappropriate sexual comments to staff, approached staff, and touched staff. The care plan was initiated on 4/16/24 and edited on 5/15/24. The approaches included 4/16/24, to provide diversional activities as needed, provide privacy for the resident as needed/or requested, and to remind the resident to pull the curtain and shut the door as needed. A nursing progress note, dated 4/17/24 at 3:42 p.m., indicated the resident continued to talk of needing a woman, indicated "I will f*** her up." While he talked to a female friend on the phone, he indicated he did not put up with anything from women. He told her in detail his sexual plans for her once he got out of the facility. He continued to stand at the nurses' station, made comments and asked personal questions of staff. While staff attempted to redirect the resident, he immediately stated "what's wrong with you today, you're in a bad mood." Resident was intrusive with staff and			

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	repeatedly indicated he would do whatever he wanted. A nursing progress note, on 5/8/24 at 11:55 a.m., indicated Resident D continued to be intrusive and verbally aggressive, often argumentative behavior with any conversation. He reached out to touch female staff's hair and indicated he liked to play with it. He was redirected with some negative attitude indicating he was not hurting anyone; it was only hair. A nursing progress note, dated 6/19/24 at 8:34 p.m., indicated the resident was verbally aggressive with staff. Resident D was overheard asking another resident if he could spend time with her. Staff immediately removed the other resident from the area. Resident D began yelling out to staff. He indicated he was able to spend his time with who he wanted, and the staff was not his boss. A nursing progress note, dated 6/22/24 at 2:37 p.m., indicated Resident D was overheard encouraging a female resident to spend time with him. He cursed at staff when he was redirected from the other residents. He yelled at staff for them to shut their f****** faces up. The resident threatened staff stating, "I'll knock your head off if you don't leave me alone." The resident continued to ask staff if he could touch their hair and became agitated when redirected. A nursing progress note, dated 6/25/24 at 4:12 p.m., indicated the psychiatric Nurse Practitioner (NP) visited the resident and wrote new orders to increase his Paxil to 30 mg every day. He continued to interact with female peers. When appropriate behaviors were encouraged, Resident D immediately became angry.			

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	A nursing progress note, dated 7/5/24 at 4:11 p.m., indicated staff continued to remind and redirect Resident D from touching female staff. He would reach out for female staff's hair to touch it. He continued to often pursue female peers time and attention. A nursing progress note, dated 7/17/24 at 3:09 p.m., indicated Resident D was pursuing a female resident by blowing kisses at her and approached her very closely. Resident D was asked to separate, and he became loud. The resident cursed at staff. There was no change in his behaviors of inappropriate interactions. A nursing progress note, dated 7/21/24 at 12:13 p.m., indicated the resident continued to ambulate up and down the hallway, spending some time sitting in the recliner in the TV area near a female resident, which he often needed redirected from. The resident was standing in front of the female resident, smiling and blowing kisses. The resident was redirected, and he became verbally aggressive. A nursing progress note, dated 7/23/24 at 1:44 p.m., indicated Resident D continued to be hostile when encouraged to change his behavior. He would curse and yell at staff. He continued to seek attention of a female resident. He was redirected often. A nursing progress note, dated 7/25/24 at 4:18 p.m., indicated the resident continued to seek out the attention from a female resident. He became very loud when staff attempted to redirect him. A nursing progress note, dated 8/1/24 at 3:23 p.m., indicated Resident D continued to ambulate about			

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	and searched out a female resident several times. He would go sit next to the female resident in the TV room and he was overheard asking her to come to his room. He was immediately redirected. He spoke to his mother on the phone and his mother indicated she did not want him being inappropriate with other residents and she told him he knew better. A nursing progress note, dated 8/2/24 at 5:08 p.m., indicated the resident was monitored throughout the day. He was redirected from female residents. He was seeking out attention and continued to ambulate numerous times up and down the hallway. He was difficult to redirect. He was given Ativan (a medication used to treat restlessness and anxiety) at 8:00 a.m. and was somewhat sleepy and calmer for approximately 60 minutes, then he was back to his anxious and restless behavior and seeking out female resident's attention. A nursing progress note, dated 8/3/24 at 4:10 p.m., indicated the resident continued to seek out a female resident's attention. He was redirected and immediately became verbally agitated. He was difficult to redirect. After Ativan was given, it was effective for approximately one hour, then he was back to his usual inappropriate behaviors. A social service progress note, dated 8/5/24 at 6:26 p.m., indicated the resident resumed the behavior of seeking the attention of a female resident and was trying to encourage the resident to spend time with him. Staff attempted to redirect him on several occasions but was unsuccessful. He became agitated and angry. The treatment team referred him for inpatient psychiatric treatment services. A nursing progress note, dated 8/6/24 at 4:20 a.m.,			

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	indicated the resident was picked up by ambulance for transport to a neuropsychiatric hospital. A document, titled "Psychiatric Progress Note," dated 8/9/24, indicated Resident D was seen at the neuropsychiatric hospital for reevaluation of inappropriate boundaries, verbal aggression, impulsivity, and refusing care. He did not know what brought him to the hospital. He was isolative to his room, minimally engaging, and gave one-word answers. There was no documentation found in Resident D's record to indicate he had an interaction with Residents C or B in his room. 2. The clinical record for Resident C was reviewed on 8/13/24 at 10:50 a.m. The diagnoses included, but were not limited to, dementia, nontraumatic chronic subdural hemorrhage, cognitive communication deficit, need for assistance with personal care, anxiety disorder, psychotic disorder with delusions, and depression. The resident had a care plan which addressed the problem she wandered through the unit. The care plan was initiated on 12/13/19 and edited on 6/24/24. The approaches included, but were not limited to, 12/13/19, address the wandering behavior by walking with the resident, redirect her from inappropriate areas and engage her in diversional activities, and invite and encourage activity programs consistent with the resident's interests. The resident had a care plan which addressed the problem she had a history of altercation with other residents. The care plan was initiated on 10/6/22 and edited on 6/24/24. The approaches included,			

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	but were not limited to, 10/6/22, address wandering behavior by walking with resident, redirect her from inappropriate areas and engage her in diversional activities, intervene as needed to protect the rights and safety of others, approach the resident in a calm manner, divert her attention, remove her from the situation and take her to another location as needed, and invite and encourage activity programs consistent with the resident's interests. The resident had a care plan which addressed the problem she had a diagnosis of anxiety, and she experienced instances of feelings of dread and apprehension. The care plan was initiated on 1/22/24 and edited on 6/24/24. The approaches included, but were not limited to, 1/22/24, one on one visits with social services as needed, encourage and offer distractions and activities outside of her room such as the television, music, games, and exercise within the resident's ability. The resident had a care plan which addressed she enjoyed watching TV, listening to music, being outdoors when the weather was nice, enjoyed sensory and baby dolls. In the past, she liked to paint and look at old pictures of her family. Her occupation was a barber and a truck driver. The care plan was initiated on 12/11/19 and edited on 6/24/24. The approaches included, but were not limited to, 12/11/19, encourage the resident to participate in independent coloring activities, invite, encourage, remind and escort the resident to activity programs consistent with her interests daily for socialization once a day from 7:15 a.m. to 6:00 p.m., and encourage the resident to sign up and participate in community outings according to the rotating schedule. A nursing progress note, dated 4/30/24 at 6:48			

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	a.m., indicated Resident C was combative with staff during care, one-on-one attention, redirections and explanation of care was not helpful. She smacked the writer twice this morning while attempting to offer her med pass supplement. She took her meds with much effort needed. A nursing progress note, dated 5/3/24 at 1:34 p.m., indicated the resident continued with occasional unpredictable physical agitation toward staff especially when ADLs were being completed, periods of tearfulness with uncertainty of reason, she was unable to make needs known and she ambulated and wandered about the unit aimlessly. She was incontinent of bowel and bladder. A nursing progress note, dated 8/1/24 at 11:46 p.m., indicated safety checks were completed every 15 minutes to ensure Resident C was alone in her own bed. The nurse continued to monitor the resident frequently for her own safety. A nursing progress note, dated 8/2/24 at 5:37 p.m., indicated the resident was up and wandered about frequently. When redirected, she usually became aggravated and threw her hands up in the air or slapped at staff, then walked away. A nursing progress note, dated 8/3/24 at 4:28 p.m., indicated the resident had been up and wandered the hallways aimlessly this a.m. She wanted to be at the nurse's station moving items around. When redirected, she stormed off and threw her hands up in the air. She verbally and physically protested ADL care. A nursing progress note, dated 8/4/24 at 2:01 p.m., indicated the resident wandered around the unit aimlessly. She continued to get upset when she			

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	was redirected away from the nurse's station. A nursing progress note, dated 8/5/24 at 1:38 p.m., indicated Resident C was pacing and wandering as her usual behavior. The resident had a care plan which addressed the problem she had a history of getting naked and walking around. The care plan was initiated on 8/8/24. The approaches included, but were not limited to, 8/8/24, assist the resident away from other residents as needed and encourage participation in activities as appropriate. There was no documentation found in Resident C's record to indicate she had an interaction with Resident D in his room. On 8/13/24 at 3:33 p.m., CNA 2 was observed attempting to escort an unknown male resident out of a room at the end of the hallway to the right of the nurses' station. While the unknown male was resisting the CNA from escorting him out of the room, Resident C walked into the room. The CNA had to escort both the residents out of the room of another resident. 3. The clinical record for Resident B was reviewed on 8/13/24 at 11:15 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, need for assistance with personal care, and insomnia. The resident had a care plan which addressed the problem he was at risk for wandering and elopement related to his diagnosis of dementia. The care plan was initiated on 9/22/22 and edited on 8/2/24. The approaches included, but were not limited to, 9/22/22, develop an activities program to divert his attention and meet his needs for			

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	social and cognitive stimulation and place him in a gated community. The resident had a care plan which addressed the problem he had a history of wandering and pulling the fire alarm. The care plan was initiated on 10/14/22 and edited on 8/2/24. The approaches included, but were not limited to, 10/14/22, assist the resident away from other residents as needed and encourage participation in structured activities as appropriate. The resident had a care plan which addressed the problem he enjoyed being busy. He wandered the unit often and would go in and out of other residents' rooms. He liked to be outside and liked pets. His prior occupation was construction, so offer toolbox activities. The care plan was initiated on 10/31/22 and edited on 8/2/24. The approaches included, but were not limited to, 10/31/22, encourage and offer activities the resident would participate in such as; independent coloring activities, invite, encourage, remind and escort the resident to the activity programs consistent with his interests, encourage the resident to participate in outside activities as tolerated and weather permitting, encourage the resident to participate in sensory activities according to the rotating schedule, the resident will receive the Daily Chronicle with daily activities listed from 7:15 a.m. to 6 p.m., the resident would receive one-on-one programming per activity preference according to the rotating schedule, the resident would receive pet visits per preference when available, the resident would receive a weekend activity packet to encourage leisure time in his room. A nursing progress note, dated 3/3/24 at 2:30 a.m., indicated the resident had been up wandering the halls and going into other residents' rooms. He			

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	pulled the fire alarm. He was encouraged to stay in the lounge to watch TV while other residents were soothed after the alarm sounded. He was hard to redirect and became belligerent when he did not get his way. A nursing progress note, dated 3/18/24 at 2:34 a.m., indicated the resident had been roaming all over the unit. He was in and out of multiple residents' rooms. He did not redirect well. A nursing progress note, dated 3/23/24 at 4:53 a.m., indicated the resident was up ambulating in and out of other residents' room. He was assisted back to his room and placed in bed. A nursing progress note, dated 3/24/24 at 10:47 p.m., indicated the resident continued to roam and wander in and out other residents' room. Sometimes he was more difficult to redirect out of the other residents' rooms. A nursing progress note, dated 3/27/24 at 1:23 a.m., indicated the resident ambulated in the hallway half of the shift. He stood in front of other resident's doors. He had left his clothes on this night. A nursing progress note, dated 3/28/24 at 12:42 a.m., indicated the resident had been roaming in and out of other residents' room. He had been escorted back to his bed three times so far. A nursing progress note, dated 4/19/24 at 1:03 a.m., indicated the resident was up ambulating in the hallway and in and out of other residents' room. He was messing with the cords to the window blinds and the plug-ins to the TV. He did not redirect well.			

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	A nursing progress note, dated 4/23/24 at 2:30 a.m., indicated the resident ambulated in and out of other residents' rooms. While wandering, he picked up personal items from the other residents' rooms as he went along. Attempted to redirect him without success. A nursing progress note, dated 4/26/24 at 2:35 a.m., indicated the resident had been up and down the hallways and in and out of other residents' rooms. He even pushed the medication cart a short distance down the hallway. A nursing progress note, dated 5/6/24 at 7:00 p.m., indicated the resident had been in and out of residents' rooms, pulling blankets off their bed, moving furniture around, and was observed standing on a chair before dinner. Frequent redirection and attempts to engage in TV, books, and music was not helpful. A nursing progress note, dated 5/12/24 at 3:41 a.m., indicated the resident was wandering into other residents' rooms removing things which did not belong to him. Numerous attempts were made to redirect him back to bed or to the lounge to watch TV, but he would not comply. A nursing progress note, dated 5/24/24 at 1:27 a.m., indicated Resident B was ambulating in and out of other residents' rooms taking some of their belongings and laying those things down in the next room he went into. He was very hard to redirect to lay down in his bed or to watch TV in the lounge. He required continuous monitoring. A nursing progress note, dated 7/7/24 at 12:17 a.m., indicated the resident only slept one hour in the recliner, then was up wandering around the unit. Continuous monitoring was required to keep			

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	him out of other residents' rooms. A nursing progress note, dated 7/9/24 at 5:00 a.m., indicated the resident was ambulating in the hallway without any clothes on. He was assisted back to his room and clean clothes was placed on him. A nursing progress note, dated 7/25/24 at 5:30 a.m., indicated the resident was up in the hallway by his room attempting to rip the clear cover off the fire alarm. He was redirected to go to the lounge and visit with the other residents. The resident had a care plan which addressed the problem he was a risk for behaviors related to diagnoses of Alzheimer's Disease, dementia, anxiety and major depressive disorder as evidenced by trying to fix things, taking his clothes off, walking around the unit naked especially at nighttime and standing on chairs. The care plan was initiated on 7/27/23 and edited 8/2/24.The approaches included, but was not limited to, 7/27/23, approach the resident in a calm and unhurried manner to deliver and provide services. There was no documentation found in Resident B's record to indicate he had an interaction with Resident D in his room. 4. The clinical record for Resident E was reviewed on 8/13/24 at 2:00 p.m. The diagnoses included, but were not limited to, dementia, inappropriate sexual behaviors, attention and concentration deficit, need for assistance with personal care, Alzheimer's disease, and depression. A progress note, dated 4/30/24 at 9:41 p.m., indicated the resident was sitting in the common			

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	area with other residents being flirtatious with the male residents. A progress note, dated 6/19/22 at 8:50 p.m., indicated the resident ambulated aimlessly. Attempted to reorient and engage in activities, but rarely successful. She continued to seek out a certain resident's company and attention and became verbally angry when staff redirected her, frequently cursing at staff. She had difficulty completing her meals if she seen a certain resident in the dining room because she wanted to go to his table. She was encouraged several times to come back and complete her meal. A nursing progress note, dated 6/22/24 at 2:54 p.m., indicated the resident continued to wander the unit. She continued to seek out a certain resident and followed them around. She was difficult to redirect. She remained agitated and cursing at staff when redirected. A nursing progress note, dated 6/26/24 at 1:34 p.m., indicated the resident attempted to follow a certain male peer when he left the dining room even though her meal had not been eaten. She was redirected numerous times. She continued to curse at the staff and was difficult to redirect. She had to be monitored closely. A nursing progress note, dated 6/27/24 at 4:22 p.m., indicated Resident E occasionally referred to the certain male peer as her son, but other times she referred to him as her husband. She continued to be very verbally aggressive when redirected. A nursing progress note, dated 6/28/24 at 2:45 p.m., indicated the resident frequently followed other residents' directions and became upset when staff redirected her to finish her meals or			

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	when she was wandering into other residents' personal spaces and displayed intrusive behaviors. She was very focused on a certain male resident. She became upset if staff tried to interact with the male resident. A nursing progress note, dated 7/3/24 at 4:14 p.m., indicated the resident continued to curse at staff frequently. She continued to focus on one male resident and sought him out. A nursing progress note, dated 7/4/24 at 3:48 p.m., indicated the resident continued to seek out a certain male resident for attention and refused redirection frequently. A nursing progress note, dated 7/5/24 at 4:08 p.m., indicated the resident had periods of agitation with cursing at staff. She was redirected away from male residents. She required much assistance and redirection to focus on meals. A nursing progress note, dated 7/7/24 at 2:45 p.m., indicated the resident frequently expressed herself by cursing at staff when they redirected her. She struggled with meals due to wanting to know the whereabouts of a male peer and would attempt to join him. A nursing progress note, dated 7/18/24 at 1:42 a.m., indicated the resident refused to go to bed. A certain male resident was asked to go to her room with her. When she was redirected and told the behavior was not acceptable, she called the nurse a f****** b****. When given the choice to go to bed or stay in the lounge, she chose to stay in the lounge. She sat down in the recliner by the male resident, reached for his hand and started kissing his arm and hand. When redirected away from the male resident, she cursed at the nurse.			

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	A nursing progress note, dated 7/27/24 at 10:49 p.m., indicated when making initial rounds, the resident was discovered in another resident's bed. The resident who lived in that room was sitting in the chair. She was assisted to her own room and bed with some mild resistance. A nursing progress note, dated 8/4/24 at 3:21 p.m., indicated the resident continued to seek a male resident's attention. She required much encouragement to focus on meals as she attempted to get up from the table and leave her meal to follow the certain resident. She was redirected from following the resident numerous times. She became verbally aggressive and cursed at staff. She was difficult to redirect insisting the male resident was her husband or son. A nursing progress note, dated 8/6/24 at 2:44 p.m., indicated the resident was observed to be looking for a certain male resident, but she was redirected easily. A nursing progress note, dated 8/7/24 at 5:57 a.m., indicated the resident was attempting to ambulate into another residents' rooms. She was redirected into her own room. A nursing progress note, dated 8/7/24 at 2:04 p.m., indicated the resident was looking for a certain male resident. She was redirected and reassured severa l times throughout the day. During a confidential interview, the confidential interviewee indicated Resident D was the male resident that Resident E was following and looking for. Resident D would blow kisses at Resident E and ask her to show			

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	him her breasts. She had sexually inappropriate behaviors the same as he did, so they fed off each other. During a confidential interview, the confidential interviewee indicated the Activity Director for the dementia unit had been gone for at least two months. There were no activities being done on the unit because the staff did not have the time to devote to activities when they were continuously escorting wandering residents out of other residents' rooms, dealing with Resident D's aggressive and explosive behaviors, and his inappropriate sexual behaviors of trying to get a female resident to go to his room. Resident D had been caught in Resident E's room trying to get her to take her top off for the last two months now. The staff played music for the residents, so they would at least have some form of activity going on. During a confidential interview, the confidential interviewee indicated there was no activity person designated for the dementia unit. There had been no activity person for a while. The CNAs were expected to do the activities on top of showers, mealtimes, and assisting residents with their Activities of Daily Living (ADLS). Resident C and B wandered into other residents' rooms and Resident D was aggressive with staff. There was not enough time to do activities with the residents while			

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	trying to care for the residents. There were usually three staff members on duty for the dementia unit.This citation relates to Complaint IN00440685.3.1-37(a)			