STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN 47150

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00422843 and IN00424143. Complaint IN00422843 - Federal/State deficiency related to the allegations is cited at F0744 . Complaint IN00424143 - No deficiencies related to the allegations were cited. Survey date: December 18, 2023. Facility number: 000321 Provider number: 155614 AIM number: 100286130 Census Bed Type: SNF: 6 SNF/NF: 112 Total: 118 Census Payor Type: Medicare: 12 Medicaid: 78 Other: 28 Total: 118 These deficiencies reflect State Findings cited in accordance with 410 IAC.16.2-3.1 Quality review completed on December 21, 2023.	F 0000	December 18, 2023 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance **Survey Event SZNR11** Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the Complaint Survey conducted on December 18, 2023. This letter is to inform you that the plan of correction attached is to serve as Lincoln Hills of New Albany credible allegation of compliance. We allege substantial compliance on December 22,2023. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-512-4655. Sincerely, Kim Povinelli, HFA	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kimberly Povinelli	Administrator	01/02/2024

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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			Lincoln Hills of New Albany Submission of this plan of correction in no way constitutes an admission by Lincoln Hills of New Albany or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
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, record review, and interview, the facility failed to ensure appropriate	F 0744	**F 744 Treatment/Service for Dementia**	12/22/2023

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	interventions, supervision, and care were provided for a resident with dementia related behaviors for 1 of 3 residents reviewed for Dementia Care. (Resident B) Findings include: The record for Resident B was reviewed on 12/18/23 at 9:15 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia with other behavioral disturbance, severe with anxiety, colostomy status, need for assistance with personal care, attention and concentration deficit, and mild cognitive impairment of uncertain or unknown etiology. The care plan, dated 11/15/22, indicated the resident required care and assistance for his colostomy with a potential for complications. The interventions included, but were not limited to, change the ostomy as ordered, provide care as ordered, report abdominal distention or discomfort, erythema, edema, tenderness, or drainage to stoma. The Social Services note, dated 1/25/23 at 8:50 a.m., indicated the resident had increased confusion. He was stating he was leaving. He was able to be redirected and had a wander guard in place. He was then found at the doors again with his jacket on and his pictures in his hands. The IDT (Interdisciplinary Team) met with the resident's family and discussed moving him to the Memory Care Unit. The Social Services note, dated 1/25/23 at 9:55 p.m., indicated the resident's family agreed to place him on the secured unit. The Social Services note, dated 1/31/23 at 9:06		**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Resident B's care plans have been reviewed and updated by IDT. Memory care staff were educated on updated interventions and where to find them in Matrix. Resident suffered no ill effects from this alleged deficient practice. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents residing at Lincoln Hills memory care unit have the potential to be affected by this alleged deficient practice. Resident's care plans on the memory care unit have been reviewed and updated by IDT to ensure interventions allow for appropriate supervision and care. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Staff were re-educated regarding	

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	p.m., indicated the resident was adjusting well to the Memory Care Unit. He participated in activities, enjoyed listening to live music, and had no exit seeking behaviors. He did flirt with women, but it was not inappropriate. The care plan, dated 1/31/23, indicated the resident had a diagnosis of dementia which negatively impacted his cognition and judgement, causing him to require a locked, structured unit. The interventions included, but were not limited to, educating family of the disease process, encouraging the resident to eat in the dining room, participate in activities, and provide cues and reminders, as necessary. The care plan, dated 1/31/23, indicated the resident frequently liked to compliment women and tell them how beautiful they were. The interventions included, but were not limited to, encouraging outings with the resident's family on Thursday nights for a change in scenery, ensure he was not making the other person uncomfortable, remove him from that person if he was, and keep the resident active in facility life. The care plan had no revision or additional interventions after it's initiation on 1/31/23. The Social Services note, dated 2/9/23 at 3:57 p.m., indicated a care plan meeting was held with the resident's family. The family member stated Resident B liked to "flirt with the ladies" and asked the facility to please document that he did that because he meant no harm. The nurse's note, dated 2/11/23 at 9:39 p.m., indicated the resident came out of his room without any underwear on and went into another female resident's room. He was asked not to go into anyone's room, and to put on his underwear.		behavior management in a dementia care unit. New or worsening behavior events will be reviewed during morning clinical meeting with the IDT reviewing and updating the care plan at that time. **IV The facility will monitor the corrective action by implementing the following measures.** DON/Designee will audit 5 random residents records at least five (5) times per week for four (4) weeks, then weekly for four (4) weeks, then biweekly for (4) weeks, then monthly for an additional 3 months to ensure interventions allow for appropriate supervision and care. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve a 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **V. Plan of Correction completion date. December 22, 2023** This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment	

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	He apologized and went back to his room and got back into bed. The care plan, dated 2/23/23, indicated the resident urinated in other resident's rooms in their trash cans and their beds. The interventions included, but were not limited to, remind the resident to go to the restroom frequently and when walking down the hall redirect him to his room. The care plan, dated 2/23/23, indicated the resident masturbated without closing the door or pulling the curtain and would disrobe in public. The interventions included, but were not limited to, attempt to stop him before he leaves with no clothes on and remind him, he needed to wear clothing, encourage family outings for change in scenery, psychiatric services, and pull curtain and shut for the resident as needed. The nurse's note, dated 2/26/23 at 3:04 p.m., indicated the resident was continuously going in female rooms. When staff attempted to redirect him, he began to curse at staff. The resident threatened staff when redirected stating he was going to knock her head off and calling her names. The resident was standing behind staff continuing to call names and curse at her. He refused to move when asked. He eventually walked into the dining area and sat at a table. The resident cursed at two other female residents when sitting at table with them. He had no further behaviors. The nurse's note dated 2/27/23 indicated the Psychiatric NP (Nurse Practitioner) gave new orders for Paxil 20 mg daily for increased agitation and anxiety.		Committee meeting.	

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	The Social Services note, dated 2/27/23 at 8:56 p.m., indicated the MCC (Memory Care Coordinator) spoke with the resident's family concerning the weekend events. The resident had a history of getting confused when finding his room. A picture would be placed on his door to help him find his room to help him not wander into other resident rooms. The resident was very active and attended all activities that day. He was in a pleasant mood with no behaviors. The nurse's note, dated 2/28/23 at 4:50 a.m., indicated the resident was asked several times to stay out of female resident rooms. He was not easy to redirect. He went back in the same rooms again and would get angry and start cursing when asked to come out. The nurse's note, dated 3/21/23 at 10:39 a.m., indicated the resident tried to change his colostomy bag and placed toilet paper on his stoma. The nurse cleaned and changed the colostomy and would continue to monitor. The Social Services note, dated 4/20/23 at 4:58 p.m., indicated the resident was seen by psychiatric services with no new orders. He continued to remain very active in facility life and attended and participated in most activities. He continued to be flirtatious with female staff but had not done anything inappropriate. The Social Services note, dated 4/27/23 at 5:11 p.m., indicated the resident was seen by psychiatric services and started on mirtazapine and Depakote. The Social Services note, dated 5/12/23 at 3:44 p.m., indicated the resident continued to wander around the neighborhood and went into other			

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	residents' rooms but was now just focusing in on female residents' rooms. When the nurse attempted to redirect him, he balled his fist up and stated he was not going to move out of the room. Other staff assisted and the resident exited the room. The resident had a flirtatious demeanor since admitting to the neighborhood and usually was easy to redirect but lately he had some underlying anger issues and his focus, even when participating in activities, was on women. The Psychiatric NP was notified and gave orders to start the resident on a Climara patch. Staff had been monitoring closely and redirecting. The nurse's note, dated 5/30/23 at 10:57 a.m., indicated the resident continued to be flirtatious with female staff. He urinated in the dining room that morning and stated, "they told him to." The nurse's note, dated 6/6/23 at 10:54 a.m., indicated the resident was redirected several times to his restroom. He was attempting to use the restroom in the hallway and in other resident rooms. The nurse's note, dated 6/9/23 at 1:33 p.m., indicated the resident took his colostomy off and threw it in another resident's room. He was taken to his room and cleaned up and a new colostomy wafer and bag were applied. The resident's care plan was not updated with any interventions or goals related to the resident's behavior of removing his colostomy bag. The nurse's note, dated 6/14/23 at 3:48 p.m., indicated new orders were given to increase the resident's Paxil to 30 mg daily. The nurse's note, dated 6/19/23 at 11:15 a.m.,			

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	indicated the resident was attempting to push other residents in their wheelchairs and trying to feed residents.. He became agitated and verbally aggressive when staff attempted to redirect him. He kept stating he wanted something to eat when his plate was in front of him untouched. Staff attempted to show it to him, and he became argumentative. The nurse's note, dated 6/28/23 at 2:05 a.m., indicated the resident's colostomy bad was changed and he was educated on the rationale of keeping his colostomy bag in place. The nurse's note, dated 7/7/23 at 10:27 a.m., indicated the resident removed his colostomy and threw it in the trash. The bag was changed. The Quarterly MDS (Minimum Data Set) assessment, dated 7/12/23, indicated the resident was severely cognitively impaired and had no behaviors. The nurse's note, dated 7/24/23 at 9:00 a.m., indicated the resident was redirected from pushing another resident in her wheelchair and became verbally aggressive stating "I will knock you're a** out" to the nurse. He was again redirected and put his fists up and stood there stating he was going to hit the nurse. He walked off cussing and went to the dining area to sit at a table with another resident. Staff would continue to monitor. The nurse's note, dated 7/24/23 at 11:00 a.m., indicated the resident was redirected not to push resident's wheelchairs. The resident because verbally aggressive with the nurse and walked over to the nurse's station where another nurse was charting stating he was going to hit the nurse			

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	in the mouth. The nurse attempted to redirect the resident, the resident then put up his fists and jumped forward to hit the nurse's hand with his fist. The nurse blocked. The resident then started whispering "f**k you" several times, stating "you're ugly" several times while walking down the hall and returning to his room. The nurse's note, dated 7/24/23 at 12:45 p.m., indicated the resident was in the dining room trying to push a female in her wheelchair. The nurse tried to redirect the resident and asked him to go for a walk with her. He stated, "Yes I will go for a walk with you outside so I can beat you're a** because you are so ugly!" The nurse walked away, as the resident was away from other residents. Therapy took the resident to the gym to help defuse. Social Services and psychiatric services were notified. The Social Services note, dated 7/24/23 at 1:12 p.m., indicated the resident had been agitated most of the day and during report from weekend staff they stated he had been like that all weekend. He liked to push female residents in their wheelchairs even if they did not want pushed. When staff intervened, he would ball up his fists and threaten them. He had struck two nurses on that day. This SSD would speak to him after the incident and due to his cognitive deficits, he did not remember the incident. The SSD also was intervening when he stated, "I'm going to have you arrested but before that I am going to kick your a**". The Psychiatric NP was informed and gave new orders to increase his Depakote to 250 mg twice daily with meals. The Social Services note, dated 7/24/23 at 3:24 p.m., indicated the resident on three different occasions was yelling names and threatening to			

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	hit female staff when they were redirecting him out of other resident rooms. The resident's family was contacted and they were on the way to speak with him. He was currently with the MCC in one on one. Every time the MCC tried to speak to him he would turn it into an argument. The nurse's note, dated 7/29/23 at 12:58 p.m., indicated the resident tried to take another resident's sweater off her walker earlier in the shift. The resident asked him to leave it alone because it was hers. Resident B got agitated and told the female resident he would take it if he liked. The nurse intervened and was able to redirect the resident. The nurse's note, dated 8/3/23, indicated the psychiatric NP was in and ordered to change the resident's Depakote to 125 mg three times daily. The nurse's note, dated 8/8/23 at 12:55 a.m., indicated the resident was exit seeking, combative, placed his colostomy bag in the refrigerator, spit phlegm in inappropriate areas, forcefully shook the medication cart drawer handles in attempt to gain entry, and was very disruptive and disturbing to other residents. He required constant redirection all shift and did not sleep. He drew back his fists as if he was going to strike staff while exhibiting very angry facial expressions. The refrigerator was emptied, a new colostomy bag was given, the resident was given a snack and encouraged to watch an episode of his favorite show, the X-files, and he was encouraged not to hit staff. Communication was placed in the physician's rounding book. Staff were rounding per the facility protocol. The Social Services note, dated 8/8/23 at 2:05 p.m., indicated when an activities staff member			

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	mentioned she was getting hot the resident stated, "Take off all your clothes and I will watch". The resident was redirected back into the facility. The care plan, dated 8/8/23, indicated the resident had sexually inappropriate behaviors which required the use of Depakote. The only intervention was when the resident became aggressive, to give him space and allow him to calm down then re-approach him. The care plan did not provide any resident specific interventions for de-escalation of behaviors or safety of the resident and others. The care plan lacked documentation of any revision or new interventions past its initiation on 8/8/23. The nurse's note, dated 8/8/23 at 4:17 p.m., indicated the resident was seen by the NP and received new orders for a CBC (Complete Blood Count), BMP (Basic Metabolic Panel), and a urinalysis with c&s (Culture and Sensitivity). The Social Services Note, dated 8/21/23 at 10:46 a.m., indicated the resident had some increased agitation and cursing noted over the weekend. At times he could be hard to redirect but usually if another staff member came to assist; he would go with that other staff member without incident. He was placed on the list to have Psychiatric services see him. The Social Services note, dated 8/24/23 at 4:08 p.m., indicated the psychiatric NP increased the resident's Depakote for mood stabilization. The Social Services note, dated 8/30/23 at 5:00 p.m., indicated the resident was in the dining room waiting for dinner. He was pushing female residents in their wheelchairs even if they weren't			

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	ready to be pushed to a table. The MCC thanked the resident for his help but asked him to please leave the other resident alone. He turned around and stared at the MCC with a furrowed brow and piercing eye expression. She got the resident a cup of coffee and he went and sat with some other ladies. She then noticed arguing coming from that table and the female resident began to yell at the resident and told him to quit talking to her. The resident laughed, pointed his finger, and said things to the female resident who was getting visually upset along with two other ladies sitting there. She offered him to sit at another table with a male resident and to freshen his coffee. He proceeded to tell the MCC what she needed to do and was making fun of other staff members. He was redirected but only lasted a short time before he was up and trying to push other residents again. The nurse's note, dated 9/12/23 at 2:40 a.m., indicated the resident had increased sexual behaviors. The CNA (Certified Nurse Aide) found the resident with barrier cream on his hands, putting it in his anus. The physician was notified through the communication binder. The Social Services note, dated 9/12/23 at 10:53 a.m., indicated the Psychiatric NP was notified and gave orders to send the resident to an inpatient behavioral unit. The resident was accepted to the outside unit, however, was unable to go due to subsequently testing positive for COVID-19. The resident was on 15-minute checks during his isolation period and had no further sexual behaviors during the time. His isolation ended on 9/24/23, and he was seen by Psychiatric NP on 9/25/23 with no new orders given.			

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The nurse's note, dated 10/5/23 at 12:46 a.m., indicated the resident was following the CNAs to other rooms. He was attempting to wake his roommate up. He told the CNA multiple times he wanted to kiss her. He told the nurse, "I'm going to take you into my bed tonight, you need a little attention." He had also made references to the CNA going to bed with him. Several snacks were provided, and he was sitting at the nurses station for supervision.

The nurse's note, dated 10/10/23 at 10:06 p.m., indicated the resident smacked a CNA on the butt. The CNA explained to the resident that it was inappropriate, but the resident just laughed.

Multiple nursing notes, between 11/1/23 and 12/18/23, indicated the resident continued to remove his colostomy bag at night.

The nurse's note, dated 11/13/23, indicated the resident had increased insomnia, anxiety, was going in and out of other residents' rooms waking them up, refused to follow simple commands or instruction, was swinging his fists to fight staff, and urinating on the floor. The resident was placed on the physician's rounding log.

The nurse's note, dated 11/13/23 at 4:01 p.m., indicated the NP gave new orders for a CBC, BMP, and a urinalysis with C&S.

The urinalysis was unable to be obtained due to resident refusal and incontinence and the order was discontinued.

The nurse's note, dated 11/25/23 at 5:15 a.m., indicated the resident was found in another female resident's room sitting on the floor. He was naked

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	from the waist down with his legs and genitals facing the female resident who was watching him sitting on the floor. The supervisor and family were notified, and the resident was assisted back to his room. The Social Services note, dated 11/27/23 at 1:30 p.m., indicated the resident toileted himself and had frequent issues with putting his pants on properly and needed assistance from staff. Signs were made bigger that had his name and picture on them and placed next to his name plate to assist him in finding his room. The nurse's note, dated 12/11/23 at 12:41 a.m., indicated the resident was walking in and out of resident rooms, scaring some of the females. When redirected the resident would become aggressive with staff. He was urinating on his floor and was unable to be redirected. He was sitting at the nurse's station and staff would continue to monitor. The physician's note, dated 12/11/23 at 1:45 a.m., indicated the resident had aggressive behavior and was trying to hit staff and wandering into other resident rooms. He had an unspecified injury of the left wrist, hand, and fingers. Orders were given for an x-ray with 3 views of the left wrist and a 1-time dose of Haldol 3 mg intramuscular. The x-ray was negative for fracture. The nurse's note, dated 12/11/23 at 2:37 a.m., indicated the resident became more aggressive with staff and twisted right wrist and hit staff in the arm. The physician was notified, and a new order was given.			

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	The Social Services note, dated 12/12/23 at 11:33 a.m., indicated the resident was displaying anxious behaviors. He was asking if people wanted coffee and passed out empty bowls thinking they were coffee cups. When staff would try to redirect, he would stare at them and then continue. He was laying in other resident's beds. He became agitated when staff tried to assist him to the dining room. Psychiatric services would follow up with him on the next visit. The nurse's note, dated 12/17/23 at 10:29 p.m., indicated the resident's left hand had improved, but the knot and discoloration continued. The swelling had decreased. The resident had attempted to go in other resident rooms, was throwing trash in other resident rooms, and became aggravated with CNA redirection. He was hitting the CNA but calmed down when the nurse intervened. She walked him to his room, he stayed for a while but started to go into other rooms again. He was sitting at the nurse's station at the time talking about breasts and stated one of the CNA's had a "bunch of d***s inside of her." Staff would continue to monitor. The nurse's note, dated 12/18/23 at 5:18 a.m., indicated the resident was found urinating on another resident's bed. He was redirected back to his room, reminded of where his bathroom was, and made aware that urinating on beds was inappropriate. During an observation on 12/18/23 at 9:30 a.m., Resident B was observed to enter a female resident's room and lie down on the first bed in the room. He was fully clothed with shoes on. During an observation on 12/18/23 at 9:32 a.m., CNA 5 indicated the resident in the female's bed			

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	was Resident B. She entered the room and indicated to the resident,, "Hey you're in another resident's bed. Let me show you where your bed is." She then assisted the resident to his bed which was down the hall. There were signs and pictures on the door indicating it was his room with his pictures. Upon interview the CNA indicated Resident B sometimes went into the female resident beds. During an observation on 12/18/23 at 11:12 a.m., Resident B was in another room which belonged to two female residents. He was lying in the first bed and the curtain was drawn between him and the second bed. He smiled and waved as he laid in the bed. There were no staff observed to be on the hall. There was a nurse and an aide at the end of the hall behind the nurse's station. During a continuous observation, from 11:12 a.m. to 11:45 a.m., no staff members walked down the hall or checked on Resident B's location. Unit Manager 6 was down the hall providing care for another female resident. During an observation on 12/18/23 at 11:45 a.m., LPN (Licensed Practical Nurse) 7 walked down the hall and observed the resident in bed. She left to obtain assistance. During an observation on 12/18/23 at 11:47 a.m., LPN 7 returned with LPN 8 and indicated she was "getting my male patient out of this female bed." Upon entering the room, Resident B was lying abed. He had on no pants. His colostomy bag was removed, with the wafer in place. His abdomen, the stoma, and his brief were covered in brown stool. LPN 7 and LPN 8 assisted the resident to clean up and replace his colostomy wafer and bag. The second bed in the room was occupied by a			

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	female resident who was resting with her eyes closed. During an interview on 12/18/23 at 11:50 a.m., LPN 7 indicated it was a mystery where his colostomy bag could be. He removed them all the time. They would have to go and find it when they got done cleaning him up. The bag could be in any room. During an interview on 12/18/23 at 12:01 p.m., LPN 7 indicated she rounded and saw the resident in the female resident's room. She then got help to change him. They rounded on everyone every 2 hours. It was hard to redirect Resident B. He could get verbally and physically aggressive with staff. He went in and out of rooms, but he'd done that a lot. She was not aware of any recent sexual inappropriateness. They tried to redirect him away from women. She knew when he had specific behaviors before, she thought they'd done 15-minute checks on him, but he was not still on them. They did round on him more frequently, but she was not sure if there was a note in there or any orders for increased monitoring. Everybody tried to always keep track of him because of the stuff he did. He urinated in trash cans and took his colostomy bag off. When she had last rounded on the hall probably after breakfast, around 10:15 a.m., he was in his room, and he had clothes on at that time. She had been informed he'd been in another female resident's room prior. They would have to go find his colostomy bag. He threw them in the toilet, in the rooms, he'd put it in his room, he had left them in other rooms and that's where they would end up finding them at. During an observation on 12/18/23 at 12:12 p.m., Resident B was back in the same room from the prior observation, lying in the female resident's bed. LPN 7 redirected him back to his room once			

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	more. There was liquid on the floor to the right side of his bed, with yellow staining the edge of his sheet. There was brown matter on his roommate's bed, a stool covered towel in the bathroom, and his roommates drawers were open, appearing rifled through. The nurse could not locate the resident's colostomy bag after searching multiple rooms. During an interview on 12/18/23 at 12:46 p.m., the MCC indicated Resident B had a big cognitive decline over the last few months. He used to be very active in activities and would participate, but recently he was more to himself. He was anxious and agitated with redirection. Usually, he was really good if you came at it with a joking way. He liked to take care of people, so he was always wanting to do things for other people. She'd had him help wipe down and different things like that. She would give him towels, washcloths, he did participate in that. Then would get kind of bored. So, she would take him for walks. Occasionally they went off the unit. That helped him. He would help pass out shirt protectors. She was not typically there on weekend, but they had one activities staff there on day shift. When they weren't there the nursing staff were responsible for intervening with him. They probably had not developed specific care plans with interventions for him. He did not respond well to "instructive" redirection. He could not be educated and education for him would be inappropriate. He didn't like to hear from women. She did not know about the incident of him urinating on another resident's bed. She knew he did urinate in other areas. She was not aware of a toileting schedule for him. It couldn't hurt. The IDT had conversations, but she had not written a list of his likes and dislikes. They had not implemented more frequent monitoring or supervision interventions.			

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	It sounded like he did need to be checked on more frequently than every 2 hours. She didn't know he was still having issues with taking his colostomy off. She thought messing with it was part of his dementia. He'd had it 30 plus years. It wasn't anything new to him. She didn't realize taking it off consistently was a problem. She thought the one instance with the freezer was a behavior like a temper tantrum. She felt she should have a weekly communication with the nursing staff. That had done that in the past and then it just got crazy, but she thought it was something that needed to be started again. During an interview on 12/18/23 at 1:11 p.m., Unit Manager 6 indicated the resident had behaviors that were sexual in nature. He had made comments to female staff about getting naked in his bed. He would walk past and pat the female residents. He had been wandering into other resident rooms for quite a while. He would take off his colostomy bag and throw it in the trash or the toilet. Typically, she didn't go looking for it. It happened more on night shift than day shift. They would ask him to come to the common areas, to not touch other residents, they would redirect him to his room, and call his family. He did not, at the present moment, have increased monitoring. The standard was every 2 hours, but with him people checked on him whenever. With him it appeared as if the sweeter tone for the most part worked better than a firmer tone, but sometimes the firm worked. He didn't understand or he doesn't care when it came to being educated. She didn't know if it was the disease process or him just being defiant. Education was not appropriate and did not help with him. The most current Philosophy of Service and Care policy included, but was not limited to, " ... Our			

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	Cherished Memories program is focused on enriching the lives of residents, loved ones, our associates, and friends of persons with dementia through our activity focused approach to care. Our program allows you the opportunity to listen, love and accept the altered psychological and emotional status of our residents ... Values ... offers a safe, comfortable place that ... maximizes choice, service and care based on the personalized needs of our residents ... Meaning and purpose is the framework of our dementia program, empowering the resident's responses and participation with value ... Associates will focus on resident's strengths in order to achieve the highest opportunity for success ... Throughout the day all associates will be a part of our daily life enrichment programs ... We strive to know our residents' likes and dislikes, and teach our associates to allow our residents to make their own choices throughout the day ..." The most current Behavior Management policy included, but was not limited to, " ... Some of our residents have medical disabilities that can lead to disruptive behaviors and these behaviors have the potential to create a negative effect on the resident, other residents, visitors and staff. It is [Corporation Name] policy that each community will have a behavior program that: identifies, monitors, manages and disseminates (whenever possible) all behavioral events by utilizing the least invasive approach based on the individual resident affected ... [Corporation Name] believes in a person-centered approach and tailors all considerations for the individual affected, including physical and psychosocial aspects of well being when it comes to managing maladies that manifest behavioral disturbances ..." This citation relates to Complaint IN00422843.			

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