STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155022	A. BUILDING 00 B. WING	05/02/2024

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WILLOWS OF SHELBYVILLE	2309 S MILLER ST SHELBYVILLE, IN 46176

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00429302, IN00429472, IN00429975, IN00429966, IN00430642, IN00431020, IN00432211, IN00432416, IN00432418, IN00432649, IN00432991, and IN00433278. Complaint IN00429302 - Federal/state deficiencies related to the allegations are cited at F755. Complaint IN00429472 - No deficiencies related to the allegations are cited. Complaint IN00429975 - No deficiencies related to the allegations are cited. Complaint IN00429966 - No deficiencies related to the allegations are cited. Complaint IN00430642 - No deficiencies related to the allegations are cited. Complaint IN00431020 - No deficiencies related to the allegations are cited. Complaint IN00432211 - No deficiencies related to the allegations are cited. Complaint IN00432416 - Federal/state deficiencies related to the allegations are cited at F740. Complaint IN00432418 - Federal/state deficiencies related to the allegations are cited at F740. Complaint IN00432649 - No deficiencies related to the allegations are cited.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mandi Paul	AIT	05/16/2024

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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	Complaint IN00432991 - Federal/state deficiencies related to the allegations are cited at F744. Complaint IN00433278 - Federal/state deficiencies related to the allegations are cited at F744. Survey dates: April 30, May 1 and 2, 2024 Facility number: 000009 Provider number: 155022 AIM number: 100274760 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 4 Medicaid: 45 Other: 15 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 3, 2024			
F 0740 SS=G Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental			

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	and substance use disorders. Based on observation, interview, and record review, the facility failed to ensure a resident's plan of care for behavioral health was implemented and evaluated after having physical behavioral symptoms directed towards staff and other residents, document a resident's behaviors in the clinical record, document interventions in response to such behaviors, document the reasoning for administration of an intramuscular (IM) injection of antianxiety and antipsychotic medications, and ensure other residents' safety was maintained during behavioral episodes to where a resident (Resident E) was found to have their hands around another resident (Resident F's) neck that resulted in redness. Resident F had felt fearful, anxious, and the need to relocate to another nursing facility. Findings include: 1a. The clinical record for Resident E was reviewed on 5/1/24 at 11:00 a.m. The diagnoses included, but were not limited to, Huntington's disease, extrapyramidal and movement disorder, psychosis, anxiety disorder, major depressive disorder, schizophrenia, and insomnia. A significant change minimum data set (MDS) assessment, dated 12/19/23, indicated severe cognitive impairment and physical behavior directed towards others that occurred in 1-3 days. A quarterly MDS assessment, dated 3/19/24, indicated severe cognitive impairment and physical behavior directed towards others that occurred in 1-3 days. An activities care plan, revised 4/25/24, indicated	F 0740	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident E continues to reside at the facility and has not had any further aggressive behavior towards staff or other residents. 2. Resident F no longer resides at the facility. 3. Resident E will continue to receive psychiatric services at the facility and the facility will follow recommendations in collaboration with MD/NP. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. 1. All residents have the potential to be affected. 2. SSD/MCF completed facility wide audit for all residents displaying or having a history of aggressive behavior. Behavioral task added to the point of care documentation for all residents identified. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur. 1. DNS/designee educated nursing staff of Behavior Management Policy on/by 5/20/24, including required	05/20/2024

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	Resident E prefers to engage in independent leisure activities such as playing his X-box, watching TV/movies, listening to music, snacking, daily visits with family. At times, resident chooses to stay awake through the night playing video games and watching TV. The interventions included to encourage/invite Resident E to group activities and provide transportation to and from activities, provide a large activity calendar each month, and provide resident with activities supplies. A care plan, revised on 4/25/24, indicated Resident E has Huntington's disease and may experience: delusions, hallucinations, paranoia, lack of concentration, mental confusion, memory loss, involuntary movements, compulsive behaviors, irritability, lack of restraint, mood swings, and chorea (a symptom that causes involuntary, irregular or unpredictable muscle movements). The interventions included to administer medications as ordered and notify the medical director as needed as the only interventions. There had been no added interventions since 1/15/21. A care plan related to the diagnosis of schizophrenia and depressive disorder, revised 4/25/24, included the interventions to continue current mental health services, family involvement in care, therapy evaluations as needed, socialization/leisure/recreation activities, and supportive counseling from nursing facility staff. There had been no added interventions since 3/18/21. A care plan, revised 4/25/24 but initiated on 7/17/23, indicated Resident E had potential to appear physically aggressive at times with resident wanting to interact with others and due		documentation for administration of PRN antipsychotics and antianxiety medications. 2. SSD will review behavioral documentation 5x/week in daily clinical meetings to identify new/worsening behaviors and ensure appropriate interventions and documentation. 3. DNS/designee will audit PRN antianxiety or antipsychotic administration weekly x4 weeks then monthly x6 months. How the corrective actions will be monitored to ensure the deficient practice will not recur. 1. All results and audits will be reviewed by the QA committee monthly x6 months for substantial compliance and ongoing until 100% compliance is achieved.	

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	to tremors, it may cause unwanted contact with others. The interventions included administering medications as ordered, give resident choices about care and activities, modify environment, monitor for closeness in dining room with other residents, and psychiatric consult as needed. There had been no added interventions since 7/17/23. A care plan for physical aggression, dated 4/12/24, indicated a history of physical aggression towards others related to Huntington's disease and impulse control deficits. The interventions included, but not limited to, the following: - Administer medications as ordered, - Anticipate and meet the resident's needs, - Discuss the resident's behavior, if reasonable, - Intervene as necessary to protect the rights and safety of others, & - Monitor behavior episodes and attempt to determine underlying cause. A behavior note, dated 12/12/23 at 10:36 a.m., indicated the following, "...IDT [interdisciplinary team] note. Resident in dining room for breakfast and left his table and went to another resident's table. Resident states that he was trying to get the attention of the other resident. Resident grabbed other resident's arm to get his attention causing a skin tear to other resident's left hand and bruising to left forearm. Staff with attempted to talk with, remove, redirect and offer care helped behaviors to decrease and eventually stop..." A behavior communication form, dated 12/12/23, indicated Resident E grabbed another resident's arm to get their attention and caused a skin tear and bruising. There were interventions listed that were utilized and deemed effective.			

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	A behavior note, dated 12/13/23 at 6:12 a.m., indicated the following, "...pt [patient] woke up at approx [approximately] 0500 [5:00 a.m.] agitated d/t [due to] unknown cause. pt started getting physically aggressive c [with] other pt in common area. when staff attempted to intervene [name of Resident E] began getting aggressive c [with] staff. staff eventually able to physically pick up patient and take to room. pt keeps attempting to come back out to common area to approach the same patient. poa [power of attorney] contacted, left vm [voicemail]. going to be in touch with hospice per day shift nurse when they open at 0700 [7:00 a.m.]...." A behavior communication form, dated 12/13/23 at 8:00 a.m., indicated Resident E was extremely agitated with repetitive verbalization and aggressively wheeling himself up and down the hallways. He was persistent with attempting to go up to other residents in an aggressive manner. Staff intervened before Resident E was able to approach any other resident. Resident E was combative with staff. Resident was grabbing arms, hands, and twisting while attempting to bite the staff. The PRN (as needed) intramuscular injection was administered and deemed effective. The two events where Resident E became physical with another resident was not reported to the Indiana Department of Health. There were no further names or description of the other residents that Resident E came into contact with on 12/12/23 and 12/13/23. There were no follow up notes in Resident E's clinical record to indicate if a root cause of the physical contact was discussed or determined. An administration note, dated 12/13/23 at 1:51			

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	p.m., indicated a lorazepam (antianxiety) injection was administered to Resident E's left arm at 8:20 a.m. on 12/13/23 in regards to aggressive behavior. There was no indication of what was occurring with Resident E prior to administration of the antianxiety injection along with attempts that staff made in response to Resident E being aggressive. A physician order, dated 12/13/23, was noted for an intramuscular (IM) injection of Haldol and lorazepam every 6 hours as needed for aggression. A psychotherapy progress note, dated 12/13/23, indicated the following, "...Three weeks ago, the patient's antipsychotic medication was increased by the Hospice provider due to behavioral disturbances, including recent physical aggression towards other residents...The patient's perception of reality was impaired, consistent with the psychotic disorder...Insight into mental health needs was poor, and judgement was compromised, as evidenced by the denial of reported behavioral disturbances...Recommendations...you may wish to consider the medical appropriateness of adding Haldol po [by mouth] bid [twice daily] for better control of psychosis resulting in aggression...." An administration note, dated 12/16/23 at 7:00 a.m., indicated PRN lorazepam injection was administered. There was no documentation on what behavior was occurring, staff response/interventions to any behaviors, and follow up to any behaviors that were occurring. An administration note, dated 12/16/23 at 10:00 a.m., indicated PRN Haldol injection was administered for aggression. There was no			

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	documentation on what behavior was occurring, staff response/interventions to any behaviors, and follow up to any behaviors that were occurring. An administration note, dated 12/16/23, indicated the PRN lorazepam and Haldol injections were listed as "ineffective". A progress note, dated 12/16/23 at 1:24 p.m., indicated Resident E was sent to the emergency room at 10:45 a.m. due to "extreme aggression". They returned to the facility the same day. A behavior communication form, dated 12/20/23, indicated Resident E had to be removed from 2 resident rooms due to him wandering into those rooms. A psychotherapy progress note, dated 12/26/23, indicated the following, "...Recommendations...2. Facility staff should re-consult if current condition is exacerbated or new symptoms arise. Will follow up as appropriate...." An administration note, dated 1/8/24 at 4:00 p.m., indicated a lorazepam injection administration was effective. There were no indications on why the injection was administered or what interventions were attempted prior to the administration of the injection. An administration note, dated 3/17/24 at 9:45 a.m., indicated a lorazepam injection was administered due to aggressive behaviors towards staff and other residents. Resident E grabbed, squeezed, and twisted staff arms. Resident was grabbing belongings to other residents and attempting to hit. Resident E remained aggressive despite being taken to a less stimulating environment. The			

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	injection was listed as effective. An administration note, dated 4/4/24 at 12:32 a.m., indicated a lorazepam injection was administered but no indication why the injection was administered and what interventions were attempted prior to administration of the injection. The injection was listed as effective. An administration note, dated 4/11/24 at 5:40 p.m., indicated a lorazepam injection was administered but no indication why the injection was administered and what interventions were attempted prior to administration of the injection. The injection was listed as effective. A psychosocial note, dated 4/12/24 at 10:37 a.m., indicated the following, "Resident could not verbalize recall of incident w/ [with] another resident on 4/11/24...." An incident note, dated 4/12/24 at 3:54 p.m., indicated Resident E was put on 15-minute checks and redness was noted to Resident F's neck at the time of incident. Resident E's 15-minute checks were stopped on 4/12/24 at 3:15 p.m. Resident E had been pleasant watching video games at that time. An incident reported to the Indiana State Department of Health survey report system, dated 4/11/24 at 2:45 p.m., indicated staff responded to Resident F's room to where Resident E was observed to have his hands around Resident F's neck. The immediate action taken listed Resident E to continue to be followed by the facility psychiatric provider. There were no further psychiatric/psychotherapy notes for Resident E in the clinical record since			

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	12/26/23. An interview conducted with Resident F, on 5/1/24 at 11:38 a.m., indicated she "was choked". She indicated she was sitting in the doorway, in her wheelchair, with her back facing the entrance to her room. Resident E proceeded to approach her from behind and placed both of his hands around her neck. Resident F indicated it was "very tight" and made it "difficult to breathe". She was anxious and fearful after the incident and ended up relocating to another nursing facility after the incident involving Resident E. The clinical record for Resident F was reviewed on 5/1/24 at 12:30 p.m. The diagnoses included, but were not limited to, cerebral infarction (damage to tissues in the brain due to loss of oxygen), hemiplegia (paralysis that affects only one side of the body), anemia, and hypertension. An admission MDS assessment, dated 1/17/24, indicated she was cognitively intact. An interview conducted with the Administrator in Training (AIT), on 5/1/24 at 1:25 p.m., indicated the incidents to where Resident E made physical contact with other residents on 12/12/23 and 12/13/23 did not appear to be reported to the Indiana Department of Health. AIT was not working at the facility during that time period. An interview conducted with Social Services Director (SSD), on 5/1/24 at 1:50 p.m., indicated the previous mental health provider went out of business. So, the mental health provider continued to see the residents, but it was "pro bono" from January to March of 2024, and the provider did not leave any notes during that time period. We were going to switch to another			

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	provider, but we did not receive consents for Resident E to be seen by the new provider. We will be obtaining consent to Resident E can be seen by the current mental health provider. 1b. An observation conducted of Resident E, on 4/30/24 at 10:37 a.m., of him laying in bed with the television on. An interview conducted with Licensed Practical Nurse (LPN) 2, on 4/30/24 at 11:04 a.m., indicated she gets worried about Resident E. He had made contact with other residents in the past. His behaviors come in "spurts" but it's not an everyday thing. Resident E's behaviors are random, and you never know why he's doing it. It's very difficult to communicate with Resident E due to the difficulty in understanding him. An observation conducted of Resident E, on 4/30/24 at 3:00 p.m., of him up in his wheelchair propelling himself going into the dining room. At 3:05 p.m., he proceeded to propel himself out of the main dining room. There was a female resident sitting in the dining room looking outside. There were no nursing staff within a close distance to Resident E during the observations in the dining room. An observation conducted of Resident E, on 5/1/24 at 1:00 p.m., of him up in his wheelchair sitting in the doorway looking outside of his room. His television was on. There was activities going on in the activity room down the hallway. An observation conducted of Resident E, on 5/1/24 at 1:30 p.m., of him propelling himself in the wheelchair by the common area just outside of the nurses' station. There was activities going on in the activity room down the hallway.			

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	An observation conducted of Resident E, on 5/1/24 at 4:30 p.m., of him sitting up in his wheelchair in the common area just outside of the nurses' station. There were no activities going on at that time. Resident E's room was observed with a gaming system located beside his television. A policy titled "Behavior Management Policy", dated 11/28/19, was provided by the AIT on 4/30/24 at 2:15 p.m. The policy indicated the following, "...It is the policy of this facility that Residents with a need to address Behavioral Health will receive services, receive trauma related care and services from a clinician who has expertise and knowledge of this type of service and referrals will be made...PROCEDURE...3. For Residents who have been identified as having on-going behaviors/mood alterations, a Behavior Tracking should be utilized for all observed issues...4. Social Services Director will use Behavior Documentation to guide in IDT discussion regarding Residents with symptoms and the effectiveness of interventions...5. If behavior/mood interventions were not effective, the IDT will review and determine if new interventions should be initiated...6. Social Services Director will communicate recommended interventions to all staff via the Care Plan...10. At least quarterly interdisciplinary meetings will be held to discuss all Residents on the behavior management program as well as those Residents receiving psychoactive medication who may be due for reduction. During the meeting Behavior Tracking and care plans will be reviewed. Interventions will be discussed and changed if necessary...." A policy titled "Reportable Incidents and Unusual Occurrence, Abuse Prevention, Reporting, and			

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	Investigation Policy", revised 8/28/23, was provided by the AIT on 4/30/24 at 2:15 p.m. The policy indicated the following, "...3. Physical Abuse...a. Resident to resident. May be considered abuse and an investigation should occur...." This citation relates to Complaints IN00432416 and IN00432418. 3.1-37(a) 3.1-43(a)(1)			
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 interview and record review, the facility failed to ensure a resident with dementia had a care plan with resident-specific interventions in regards to making inappropriate comments towards staff, monitoring of behaviors and documentation of such behaviors in the clinical record; document interventions in response to such behaviors, and ensure the safety of other residents to where a resident (Resident H) was found to have touched another resident's (Resident G's) breast for 3 out of 5 residents reviewed for behavioral health. (Resident G and Resident H and Resident J) Findings include: 1. The clinical record for Resident G was reviewed on 4/30/24 at 3:00 p.m. The resident's diagnoses included, but were not limited to, dementia,	F 0744	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident H continues to reside at the facility and has not had any further sexually inappropriate behaviors. 2. Resident H was sent to inpatient psych for treatment and returned to the facility following stay with medication adjustments. 3. Resident H will continue to receive psychiatric services at the facility and the facility will follow recommendations in collaboration with the MD/NP. 4. Resident G continues to reside at the facility and has not	05/20/2024

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	155022	A. BUILDING 00 B. WING	05/02/2024

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WILLOWS OF SHELBYVILLE	2309 S MILLER ST SHELBYVILLE, IN 46176

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	psychotic disturbance, mood disturbance, and neurocognitive disorder with Lewy bodies. The 4/23/24 Quarterly MDS (Minimum Data Set) assessment indicated Resident G was severely cognitively impaired. 2. The clinical record for Resident H was reviewed on 4/30/24 at 2:45 p.m. The resident's diagnoses included, but were not limited to, disorientation, dementia, psychotic disturbance, mood disturbance and anxiety. The 4/10/24 Quarterly MDS (Minimum Data Set) assessment indicated Resident H was moderately cognitively impaired. A care plan date initiated 12/1/22 indicated Resident H "has a hx [history] of being sexually inappropriate towards others r/t [related to] dementia and impulse control deficits....interventions...Will have no evidence of behavior problems such as sexual comments and grabbing staff in a sexual manner by." Resident H's behavioral care plan developed for sexually inappropriate behaviors did not include interventions to address those behaviors. A care plan dated 10/9/22 indicated "Doctor has determined resident needs long term stay d/t [due to] safety awareness...Interventions...Provide resident's services according to care plans in an effort to enhance optimum well-being..." A care plan dated 12/13/22 indicated "Resident has impaired cognitive function and impaired communication r/t Dementia...Interventions: Administer meds as ordered...Ask simple		experienced any negative psychosocial effects. 5. Resident J continues to reside at the facility and has not experienced any negative psychosocial effects. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. 1. All residents have the potential to be affected. 2. SSD/MCF completed facility wide audit for all residents displaying or having a history of sexual behavior. Behavioral task added to the point of care documentation for all residents identified. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur. 1. DNS/designee educated nursing staff on Dementia Care on/by 5/20/24. 2. SSD will review behavioral documentation 5x/week in daily clinical meetings to identify new/worsening sexual behaviors and ensure appropriate interventions and documentation. How the corrective actions will be monitored to ensure the deficient practice will not recur. 1. All results and audits will be	

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	questions...Present only 1 thought, idea or question at a time...Report changes to MD/NP [medical doctor/Nurse Practitioner]...Try to keep routine consistent when possible." The residents care plan addressing his dementia diagnosis did not include person center interventions to address the resident's dementia. A physician order dated 8/2/23 indicated Resident H was to receive 150 milligrams of Depo-Provera every 14 days for sexual behavior. A behavioral note written by social services for Resident H dated 8/9/23 indicated "Resident with 2 episodes of refusing showers and making sexually inappropriate statements to staff. Staff with attempts to talk with and reproach ineffective as behaviors continued." A behavioral note written by social services for Resident H dated 1/10/24 indicated "Resident with 2 episodes of making sexually inappropriate comments to staff. Staff with attempts to talk with, redirect and offer space ineffective as behaviors continued." The resident's clinical record did not include behavior monitoring and/or implementation of new interventions to address the resident's sexually inappropriate behaviors. A behavior note written by social services dated 4/18/24 indicated Resident H "was witnessed to be touching another resident [G] inappropriately on 4/18/2024. Residents were immediately separated and [Resident H] was put on 1-1 supervision w/ [with] 15 minute checks starting at 6:00 p.m. on 4/18/2024... [Resident H] was moved off the unit on		reviewed by the QA committee monthly x6 months for substantial compliance and ongoing until 100% compliance is achieved.	

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	4/19/2024...Once moved [Resident H] settled into his new room and went to lunch in the main dining room...." A reportable incident dated 4/18/24 indicated "...brief description of incident...Male resident [Resident H] was witnessed to be inappropriately touching female resident [Resident G]...Action Taken...Male resident was put on 1:1...Follow up: 4/23/24 [Resident H] remained 1:1 following incident and then placed on 15-minute checks. Care conference held with [Resident H's Representative] and resident and both parties agreeable to move [Resident H] to an alternative room in the facility, as resident will be able to socialize more with peers. Social services followed up with both residents x [times] 72 hours with no concerns. [Resident G] is unable to recall incident and is participating in normal routine. No adverse psychosocial effects noted. [Resident H] is participating in normal routine and continues to deny that the incident ever occurred...." The investigation file for the reportable incident between Resident G and Resident H was provided by the Administrator in Training (AIT) on 5/2/24 at 8:41 a.m. The file included the following: An incident physical assessment for Resident H indicated "Staff responded to resident [H] inappropriately touching resident [G] once reported by [Resident G Representative]...Resident [H] stated 'He never touched anyone's boobs." An incident physical assessment for Resident G indicated "[Resident G's Representative] reported to license nurse that he witnessed resident [H] inappropriately touching [Resident G]..." Resident G was unable to provide statement.			

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A 15-minute safety check document indicated Resident H was placed on 15-minute checks. They were started on 4/18/24 at 6:00 p.m. and discontinued on 4/19/24 at 10:45 a.m.

A room change document indicated Resident H was moved to a different room in the facility off the memory care unit.

Resident H's care plan for sexually inappropriate behaviors was revised on 4/19/24 indicated "...interventions...1:1 initiated, and then room move 4/19/24,...administer medications as ordered date initiated 4/10/24, redirect [Resident G] if he is being inappropriate as needed...Redirect w/ [with] games, bible books, phone calls to friends,...refer to psych as needed,...Remove [Resident G] from the situation if he is a harm to himself or others."

3. The clinical record for Resident J was reviewed on 5/1/24 at 1:00 p.m. The resident's diagnoses included, but were not limited to, dementia, psychotic disturbance, mood disturbance, and neurocognitive disorder with Lewy bodies.

The 3/19/24 Quarterly MDS (Minimum Data Set) assessment indicated Resident J was severely cognitively impaired.

A behavior note written by social services on 4/24/24 indicated "...Resident J reported to nursing that [Resident H] touched her inappropriately in the common area. She stated he had attempted to do the same yesterday but was not able. Residents have been separated. [Resident H] is on one-one observation. [Resident H] has a hx [history] of this type of bx [behavior]. He has recently been moved off another unit for touching another female resident [G]. referral has

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	been sent to [name of psych hospital] for placement." A behavior note written by social services on 4/24/24 at 3:47 p.m., indicated Resident H had been transferred to psych hospital. An investigation file regarding the incident between Resident H and Resident J was provided by the AIT on 5/2/24 at 8:41 a.m. The file included the following: A written statement by Activities Director on 4/24/24 indicated "Resident [J] came to my office very upset stating that her and a guy where (sic) sitting in the common area on the couch when he tried to touch her boob. I ask her to tell me what the guy looked like and she told me a homeless looking man with a cap on." A statement by Administrator on 4/24/24 indicated "Writer interviewed Resident [J]. Writer asked [Resident J] if she had any problems with anyone today. Resident [J] stated yeah 'that homily looking man wanted to touch my boobs.' I asked her if he touched her boobs. She said 'oh no, he brushed my shoulders and I told him to go on and he did.' Writer went and got Director of nursing...to come with and talk to resident again to have resident repeat the conversation. Resident again stated that, 'he did NOT touch her breasts..." An interview was conducted with License Practical Nurse (LPN) 3 on 4/30/24 at 11:35 a.m. She indicated Resident H was very complimentary to the staff's appearance. He liked the attractive female staff to care for him. An interview was conducted with the Social			

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	Services Director on 4/30/24 at 3:15 p.m. He indicated Resident H had a history of sexually inappropriate behavior toward staff. The intervention implemented after the incident with Resident G on 4/18/24, was to move Resident H out of the memory care unit and place him in a room outside of the unit. Resident H's 15-minute checks had been discontinued prior to the incident that occurred on 4/24/24, but the staff was closely monitoring the resident. After the incident with Resident J on 4/24/24, SSD had made arrangements for Resident H to be transferred to a psych hospital due to his behaviors. Resident H will return on Friday. He has had medication adjustments. An interview was conducted with AIT on 4/30/24 at 2:47 p.m. She indicated the staff should be monitoring and documenting the residents' behaviors. She had witnessed the incident between Resident H and Resident J on 4/24/24. The two residents were in the common area, and the two residents had rubbed shoulders. Resident H had not touched her breasts. A "Dementia Care" policy was provided by the AIT on 5/2/24 at 8:41 a.m. It indicated "...Policy: It is the policy of this facility to provide the appropriate treatment and services to every resident who displays signs of or is diagnosed with dementia, to meet his or her practicable physical, mental, and psychosocial well-being...Policy Explanation and Compliance Guidelines: 1. The facility will assess, develop, and implement care plans through an interdisciplinary team (IDT) approach that includes the resident, their family, and/or resident representative, to the extent possible...3. The care plan interventions will be related to each resident's individual symptomology and rate of			

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	dementia (or related disease) progression with the end result being noted improvement or maintained of the expected stable rate of decline associated with dementia and dementia-like illnesses. 4. Care and services will be person-centered and reflect each resident's goals while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety...7. The care plan goals and interventions will be monitored on an ongoing basis for effectiveness, and will be reviewed/revised as necessary. 8. Appropriate referrals will be made if current interventions are ineffective or resident shows a decline in psychosocial, mood, or behavioral status (i.e. physician, mental health provider, licensed counselor, pharmacist, social worker)..." This citation relates to Complaints IN00433278 and IN00432991. 3.1-37(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.			

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	§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed to ensure narcotic medication was administered per physician orders for 2 of 3 residents reviewed for medication administration. (Resident E and Resident D) Findings include: 1. The clinical record for Resident E was reviewed on 5/1/24 at 11:00 a.m. The diagnoses included, but were not limited to, Huntington's disease, extrapyramidal and movement disorder, psychosis, anxiety disorder, major depressive disorder, schizophrenia, and insomnia. A quarterly minimum data set (MDS) assessment, dated 3/19/24, indicated severe cognitive impairment and physical behavior directed towards others that occurred in 1-3 days. A physician order, dated 12/28/23, was noted for	F 0755	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident E continues to reside at the facility and has not experienced any adverse side effects related to the alleged deficient practice. 2. Resident D no longer resides at the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. 1. All residents receiving routine-controlled substance medication have the potential to be affected. 2. DNS/designee completed	05/20/2024

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	diazepam 10 milligrams (mg) twice daily for hyperkinesia due to Huntington's disease. The narcotic log sheets for Resident E's diazepam tablets was reviewed and indicated the following date(s)/time(s) were noted without documentation of the medication administration: 3/4/24 for both doses, 3/5/24 for both doses, 3/14/24 at 8:00 p.m., 3/15/24 at 8:00 p.m., 3/17/24 at 8:00 p.m., 4/13/24 at 8:00 a.m., 4/21/24 for both doses, 4/22/24 for both doses, 4/25/24 at 8:00 p.m., 4/26/24 at 8:00 a.m., & 4/27/24 at 8:00 a.m. 2. The clinical record for Resident D was reviewed on 4/30/24 at 3:15 p.m. The diagnoses included, but were not limited to, heart failure, fibromyalgia, anxiety disorder, and low back pain. A quarterly minimum data set (MDS) assessment, dated 4/9/24, indicated Resident D was cognitively intact. An interview conducted with Resident D, on 4/30/24 at 10:47 a.m., indicated there have been issues with receiving her scheduled pain medication. A physician order, dated 2/3/24 and discontinued on 4/8/24, indicated the use of Norco 5-325 milligrams; give one tablet three times a day at 6:00 a.m., 2:00 p.m., and 10:00 p.m. A physician order, dated 4/8/24, indicated the use		facility wide audit to identify all residents receiving routine-controlled substances. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur. 1. DNS/designee educated nursing staff on Medication Administration on/by 5/20/24. 2. DNS/designee will audit MAR/TAR for accurate controlled substance administration 5x/week in daily clinical meeting. 3. DNS/designee will audit controlled substance accountability sheets 5x/week x4 weeks then monthly x6 months to ensure documentation matches medication administration records. How the corrective actions will be monitored to ensure the deficient practice will not recur. 1. All results and audits will be reviewed by the QA committee monthly x6 months for substantial compliance and ongoing until 100% compliance is achieved.	

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	of Norco (hydrocodone-acetaminophen) 5-325 milligrams: one tablet three times a day at 8:00 a.m., 2:00 p.m., and 10:00 p.m. The narcotic log sheets were reviewed for Resident D's Norco tablets. The following date(s)/time(s) were noted without the documentation of the medication administration: 4/12/24 at 10:00 p.m., 3/29/24 at 6:00 a.m., 3/11/24 at 10pm 3/9/24 all scheduled doses, 3/8/24 all scheduled doses, 3/7/24 all scheduled doses, 3/6/24 all scheduled doses, & 3/5/24 10:00 p.m. dose. A policy titled "Controlled Substance Storage", dated 02/20, was provided by the Administrator in Training (AIT) on 5/2/24 at 2:16 p.m. The policy indicated the following, "...F. A controlled substance accountability record is prepared by the pharmacy/facility...I. Current controlled substance accountability records are kept in the MAR [medication administration record], or designated book. Completed accountability records are submitted to the director of nursing and kept on file...." A policy titled "Medication Administration", undated, was provided by the AIT on 5/2/24 at 12:28 p.m. The policy indicated the following, "...Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection...."			

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	This citation relates to Complaint IN00429302. 3.1-25(b) 3.1-25(e)(2)			