STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155522	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elwood Health and Living	2300 Parkview LN Elwood, IN 46036

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49411 Based on observation, interview, and record review, the facility failed to maintain water temperatures at a comfortable level for 4 of 7 residents reviewed for comfortable water temperatures on the 300 Hall. (Residents C, D, E, F) Findings include: On 2/10/25 at 11:28 a.m., the following was observed: The hot water in room [ROOM NUMBER]'s bathroom sink reached a temperature of 96.8 degrees Fahrenheit (F) after it ran for five minutes. The hot water in room [ROOM NUMBER]'s bathroom sink reached a temperature of 100 degrees F after it ran for three minutes. During an interview, on 2/10/25 at 2:20 p.m., Resident E indicated the water from her bathroom sink was always cold, even after letting the water run for a while. It had been like that for the last 3-4 months. During an interview, on 2/11/25 at 10:32 a.m., Resident C indicated the water from her bathroom sink was cold all the time. During an observation, on 2/11/25 at 10:35 a.m., the hot water in Resident C's bathroom sink was turned on, and after letting the water run for three minutes, the water was lukewarm to touch. During an interview, on 2/11/25 at 10:59 a.m., Nurse Assistant 5 indicated some residents had complained of cold water in their bathrooms. Some rooms only had lukewarm even after running the water for a while. During an interview, on 2/11/25 at 11:03 a.m., the CNA Coordinator indicated residents had been complaining of cold water in their bathroom sinks. Further down the 300 hall you went, the colder the water was. She had to turn the water on and walk away for a while, so the water had time to warm up. She had waited over 20 minutes to get hot water in some of the resident rooms. Maintenance had been notified regarding the water being cold. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 2/11/25 at 11:07 a.m., CNA 7 indicated the bathroom sink water in room [ROOM NUMBER] only ever got lukewarm. You needed to let the water run a while before it would get warm. Maintenance had been notified regarding the cold water down the 300 hall. During an interview, on 2/12/25 at 1:22 p.m., the Maintenance Supervisor indicated residents had complained about lack of hot water toward the end of 300 hall. He had performed temperature checks and the water did get above 100 degrees F. The other day, room [ROOM NUMBER] took eight minutes to get hot water. He told staff members, in order to get hot water, they needed to let the water run a while. Weekly water temperature audit logs were obtained from the Maintenance Supervisor on 2/12/25 at 2:25 p.m. , and indicated the following: 2/11/25: room [ROOM NUMBER] was 118 degrees F room [ROOM NUMBER] was 115 degrees F room [ROOM NUMBER] was 111 degrees F room [ROOM NUMBER] was 109 degrees F The water temperature audit logs did not indicate how long the water had run to reach those temperatures. 2/4/25: room [ROOM NUMBER] was 114 degrees F room [ROOM NUMBER] was 116 degrees F room [ROOM NUMBER] was 109 degrees F The water temperature audit logs did not indicate how long the water had run to reach those temperatures. 1/23/25: room [ROOM NUMBER] was 116 degrees F room [ROOM NUMBER] was 117 degrees F room [ROOM NUMBER] was 114 degrees F The water temperature audit logs did not indicate how long the water had run to reach those temperatures. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation, on 2/13/25 beginning at 2:57 p.m. and ending at 3:28 p.m., accompanied by the Maintenance Supervisor, the following hot water temperatures were obtained: The hot water in room [ROOM NUMBER]'s bathroom sink reached 97.8 degrees F after the water ran for 15 minutes. The hot water in room [ROOM NUMBER]'s bathroom sink reached 97.7 degrees F after the water ran for 6 minutes. Upon returning to room [ROOM NUMBER], the hot water in the bathroom sink reached over 100 degrees after four minutes. Upon returning to room [ROOM NUMBER], with the water still running, the water reached 100 degrees F after running for over seven minutes. During an interview, on 2/13/25 at 2:59 p.m., the Maintenance Supervisor indicated he had a plumber in the building earlier that morning to discuss adding a recirculating pump to the end of 300 hall to help with hot water circulation. During an interview, on 2/17/25 at 2:23 p.m., the Administrator indicated they did not have a facility policy regarding environment and hot water. This citation relates to Complaints IN00449079, IN00449973, and IN00452205. 3.1-19(f)(5)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45122 Based on observation, interview, and record review, the facility failed to ensure residents with dementia did not receive anti-psychotic medications without indication and individualized interventions for behavior expressions were implemented for 2 of 5 residents reviewed for dementia care (Resident 33 and Resident 61). Findings include: 1. During an observation, on 2/10/25 at 3:50 p.m., Resident 33 walked with a shuffling gait in the activity/dining area with his hands in his pockets. He was encouraged by a staff member to participate in an activity and was assisted to sit in a chair. On 2/12/25 at 10:09 a.m., Resident 33 shuffled up and down the hall with his hands in his pockets. On 2/12/25 at 12:40 a.m., Resident 33 talked nonsensically to his tablemate while sitting at a dining table. He moved food around on his plate, then poured water on it. He put small pieces of his pie in his water glass with his fork, then he ate small bites of the pie from his water glass. On 2/14/25 at 3:39 p.m., Resident 33 was lying in bed with his eyes closed. Resident 33's clinical record was reviewed on 2/13/25 at 2:03 p.m. Diagnoses included personal history of other mental and behavioral disorders, anxiety disorder, unspecified, primary insomnia, unspecified symptoms and signs involving cognitive functions and awareness, depression, unspecified, unspecified dementia, unspecified severity, with anxiety, and unspecified dementia, unspecified severity, with psychotic disturbance. A physician's order for quetiapine fumarate 12.5 mg daily was started on 7/13/21 and was discontinued on 8/31/24. Current physician's orders included venlafaxine (antidepressant) 75 milligrams (mg) daily (started 12/17/24), melatonin (sleep aid) 3 mg daily at bedtime (started 3/25/21), and quetiapine fumarate (antipsychotic) 25 mg daily (started 9/18/24). A quarterly Minimum Data Set (MDS) assessment, dated 9/12/24, indicated the resident was severely cognitively impaired. The resident did not experience hallucinations or delusions during the assessment period. The resident did not exhibit behavioral symptoms during the assessment period. The resident did not reject care or wander during the assessment period. An annual MDS assessment, dated 1/23/25, indicated the resident was severely cognitively impaired. The resident did not experience hallucinations or delusions during the assessment period. The resident did not exhibit behavioral symptoms during the assessment period. The resident did not reject care or wander during the assessment period. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current care plan, initiated on 3/30/21 and revised on 1/19/23, indicated the resident had impaired cognitive function and/or thought processes related to diagnoses of dementia and physical behaviors related to not understanding a situation or his peers' behavior who have dementia. He believed what he saw on television. Interventions included the following: Keeping the resident's routine consistent and try to provide consistent caregivers as much as possible to decrease confusion (3/30/21) and providing a homelike environment (3/30/21). A current care plan, initiated on 4/20/21 and revised on 11/27/22, indicated the resident refused care at times. The resident picked at his food and declined to eat very much. Interventions included the following: Attempting to use a different staff member if the resident was uncomfortable with the current staff (4/20/21), educating the resident on the importance of care the staff were trying to provide (7/27/21), reapproaching the resident at a later time (4/20/21), and allowing the resident to assist with his care, by soaping up the wash cloth and handing it to him (10/15/24). A current care plan, created on 6/17/21 and revised on 5/2/24, indicated the resident may urinate/defecate in inappropriate places at times (trash can, dining room floor, dresser drawer). The resident stuck things in his pocket (i.e. butter knife) as if he is carrying a comb. He had a history of carrying a brush in his pocket. Interventions included the following: Assisting the resident with toileting before bed (11/25/24), assessing the resident for pain (initiated 6/17/21 and revised on 4/14/22), encouraging the resident to toilet frequently (initiated 6/17/21 and revised on 4/14/22), observing the resident meal tray after meals for all utensils (3/6/24), providing one on one reassurance and assistance (initiated 4/13/22 and revised on 6/28/22), and showing the resident the bathroom (initiated 6/17/21 and revised 4/14/22). A current care plan, created on 3/10/22 and revised on 1/23/23, indicated the resident may be verbally aggressive and may threaten to smack staff, cause harm to someone, talk about guns, and threaten to punch a peer. Interventions included the following: Assessing the resident for an unmet need (3/10/22), assessing the resident for pain (3/10/22), ensuring the resident is safe and ceasing interaction (3/10/22), redirecting the resident with conversation and activities he enjoys (3/10/22), and using a different caregiver if possible (3/10/22). A current care plan, created 12/26/22 and revised on 1/24/25, indicated the resident had threatened to hit staff and peers when he got agitated. He would raise his hand and shake it. He had not hit any peers. Interventions included the following: Allowing the resident to wash his own private parts assisting with putting soap on wash cloth and handing it to the resident and explaining what to do (7/3/24), allowing the resident to be up out of bed a bit before providing care when possible (1/10/25), assessing resident for a need that might be contributing to his behavior (12/26/22), redirecting the resident with activities such as listening to music he prefers like Elvis and Buddy [NAME] (11/21/24), intervening to make sure the resident and his peers are safe (12/26/22), walking away if resident is being physically aggressive with staff (11/8/23), and walking away from the resident and reapproaching after several minutes (6/10/24). (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current care plan, created and initiated on 9/17/24, indicated the resident walked up and down the hallway and hits the rails, the wall, and the nurse's cart. Interventions included the following: assess the resident for pain when he is hitting things (9/17/24), distract the resident with snack such as cookies and chocolate milk and cokes (initiated 9/17/24 and revised 1/23/25), the resident likes to listen to music and dance to the music this will redirect him at times (9/17/24), and try to distract the resident with activities of his choice when he is walking up and down the hall hitting things (9/17/24). A current care plan, created and initiated 10/1/24, indicated the resident had a diagnosis of unspecified psychosis and took an antipsychotic medication for behaviors related to this condition. Interventions included the following: Giving medication as ordered from physician (10/1/24), the resident enjoys Buddy [NAME] and Elvis Presley's music. Playing music for resident while being redirected from behaviors. (initiated 10/1/24 and revised 1/24/25), notifying the physician if the resident is having increased behaviors (10/1/24), and redirecting the resident from behaviors by engaging him in activities of his choice. He enjoys ball toss and listening and dancing to music (10/1/24). A current care plan, created 10/23/24 and revised 2/13/25, indicated the resident may take other residents' food and drinks in the dining room and will sometimes swat at staff. Interventions included the following: Moving the resident to another table (10/23/24), giving the resident's drinks to him in a clear cup (10/23/24), and offering to refill the drink if the resident drinks all of his drink (initiated 10/23/24 and revised 1/2/25). A current care plan, created and initiated on 11/26/24, indicated the resident receives psych services. Interventions included the following: Acting as a liaison between the facility, the resident, the psych personnel, and the family (11/26/24), encouraging the resident to express his feelings to the psych personnel (11/26/24), and introducing the resident to the psych personnel (11/26/24). A current care plan, created 1/23/23 and revised on 1/23/23, indicated the resident had a decline in mental status related to dementia. Interventions included the following: Allowing the resident to voice his concerns and reassure him (2/7/25), assisting the resident with tasks as needed (1/23/23), and redirecting the resident as appropriate (1/23/23). A current care plan, created 12/17/24 and revised 12/17/24, indicated the resident had depression and received an antidepressant. Interventions included the following: Allowing the resident to express his feelings and provide emotional support as needed (12/17/24), giving medications as ordered (gradual dose reduction as appropriate) (12/17/24), and notifying the physician if the depression worsened or did not get better (12/17/24). A current care plan, created 1/23/23 and revised on 5/2/24, indicated the resident walked about the unit and sometimes into other residents' rooms. He sometimes wandered and whistled because he forgot where his room was located related to his dementia. Interventions included the following: Allowing the resident to wander in a safe and unobtrusive way (1/23/23), encouraging the resident to participate or remain with the group providing him with structure (1/23/23), and engaging the resident in a functional appropriate exercise and activities. Keep the resident occupied in meaningful time pursuits (1/23/25). (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 8/17/24 at 4:01 a.m., indicated Resident 33 was assisted to the bathroom. The resident started to get agitated and started to push staff while staff were providing bowel incontinence care. A Behavior Note, dated 8/19/24 at 8:57 p.m., indicated the resident growled, cussed, hit, pushed, and grabbed during a shower. Interventions attempted included played music, talked with the resident, approached the resident by different staff, and redirected the resident. The interventions were not successful. A Social Service Note, dated 8/20/24 at 1:37 p.m., indicated the resident had several behaviors that quarter including urinating and defecating in an inappropriate place and hitting staff during care. The resident had not experienced hallucinations or delusions during that quarter. A Behavior Note, dated 8/20/24 at 7:22 p.m., indicated the resident hit, kicked, pushed, grabbed, made loud disruptive noises, threatened others, and used foul language during personal care. Interventions included talked to the resident and finished his care. A Behavior Note, dated 8/23/24 at 7:18 p.m., indicated the resident was found lying in a female resident's bed watching television. He was redirected to the dining area for breakfast. A Behavior Note, dated 8/23/24 at 7:39 a.m., indicated the resident attempted to punch the CNA twice when the CNA tried to redirect the resident from urinating in the hall. The resident was redirected and encouraged to allow care. A Behavior Note, dated 8/23/24 at 12:27 p.m., indicated the resident punched the wall, the medication carts, and the handrails. The resident was redirected. A Behavior Note, dated 8/25/24 at 10:02 a.m., indicated the resident urinated on the doors, the walls, and the bedside tables. He defecated in peers' closets, cussed, and tried to hit staff during care. The need to use the bathroom and perineal care triggered the behaviors. Interventions included talking with the resident which was unsuccessful and providing care and leaving the resident alone was successful. A Behavior Note, dated 8/25/24 at 5:00 p.m., indicated the resident paced the hall, pushed bedside tables and wheelchairs down the hallway, hit the walls as he paced the hall. He yelled and threatened staff. The resident was given snacks and toileted. The staff walked with him. The interventions were unsuccessful. A Behavior Note, dated 8/26/24 at 8:44 a.m., indicated the resident pulled back his fist towards the CNA who was providing his care. The provision of care triggered the behavior. The CNA disengaged with the resident and offered care at a later time. The resident was redirected. A Behavior Note, dated 8/26/24 at 3:53 p.m., indicated the resident was found in a female resident's bed eating candy he found in the room. The resident became agitated with attempts to redirect. The resident was redirected and offered a different snack. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Behavior Note, dated 8/26/24 at 4:30 p.m., indicated the resident was aggressive and combative with care. He hit the CNA during care. He was redirected, and staff disengaged when he became aggressive. A Nurses Note, dated 8/30/24 at 5:56 p.m., indicated the resident urinated on the floor in the hall. The resident drew his fist when the staff attempted to redirect. A Behavior Note, dated 8/31/24 at 6:26 a.m., indicated the resident threatened staff, pulled back his fist at staff, and cursed at staff. The staff talked to the resident to intervene. A Behavior Note, dated 9/1/24 at 5:14 a.m., indicated the resident went into other residents' rooms. The resident became aggressive and held his fist up when the CNA attempted to redirect him. A Behavior Note, dated 9/3/24 at 12:17 p.m., indicated the resident wandered into other residents' rooms and urinated in trash cans and on different items in peers' rooms. The resident urinated in his closet, in the office, and in the lounge. Interventions included toileted the resident before and after meals and toileted the resident when he wandered. The interventions were not successful. A Behavior Note, dated 9/3/24 at 2:49 p.m., indicated the resident pushed hard on the exit door. He shook the door and told the staff he was trying to fix it. The staff talked with the resident and gave him a snack and coke. A Behavior Note, dated 9/4/24 at 9:39 a.m., indicated the resident threatened to kill the staff and swung at the staff. The staff were cleaning urine out of his closet which triggered the behavior. The staff talked with the resident and was unsuccessful at stopping the behavior. The cease of interaction with the resident was successful. A Behavior Note, dated 9/4/24 at 9:50 a.m., indicated the resident tried to hit staff with a lotion bottle. The CNA attempted to toilet the resident, and the resident picked up a lotion bottle and attempted to hit her with it. He told her to shut up and get out of there. The resident exited the shower room. The ceasing of interaction with the resident was a successful intervention. A Behavior Note, dated 9/6/24 at 11:08 a.m., indicated the resident paced throughout the hall and into other residents' rooms. He pushed on the exit doors repeatedly. He hit his fist against the wall, the handrails, and the medication carts while he walked in the hall. He refused care. The resident was redirected and reapproached after refusals of care. He participated in an exercise activity on the unit. He was offered snacks and drinks. He was encouraged with toileting. A Behavior Note, dated 9/8/24 at 5:53 p.m., indicated the resident threatened to hit and kill staff. The resident was digging in the trash, and a staff member told him to not do that and tried to redirect the resident. The resident then tried to swing at the staff member and told her he was going to kill her. Talking with the resident was unsuccessful for changing the behavior. Redirecting the resident was somewhat successful for changing the behavior. A Behavior Note, dated 9/9/24 at 9:56 a.m., indicated the resident attempted to kick the staff member and threatened to kill the staff member when a bladder scan on the resident was attempted. The intervention was to disengage with the resident. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Behavior Note, dated 9/9/24 at 5:27 p.m., indicated the resident pulled on the handrails in the hall. The resident was redirected with ice cream, drinks of choice and meal intake encouragement. A Behavior Note, dated 9/11/24 at 6:33 p.m., indicated the resident walked around with his drink. He was about to tilt and dump his drink on another resident when the CNA attempted to help him straighten his cup, the resident pulled away from the CNA and dropped the cup on the floor. When the CNA started to pick up the cup, the resident pushed the CNA out of the way. The staff attempted to talk to the resident to explain they were trying to help, this was unsuccessful to deescalate the behavior. The resident was left alone and walked away, which was a successful intervention to deescalate the behavior. A Social Service Note, dated 9/12/24 at 8:30 a.m., indicated the resident had several behaviors since the last assessment. He had hit, cursed, and threatened staff. He urinated in inappropriate places and took other residents' belongings. He had no hallucinations or delusions. A Behavior Note, dated 9/16/24 at 12:12 p.m., indicated the resident hit the nursing staff during care. He kicked the CNA while his wet pants were changed. He threatened to kill the staff. He was redirected and reassured while care was provided. A Behavior Note, dated 9/16/24 at 6:24 p.m., indicated the resident paced in and out of rooms. He removed papers from the wall and hit carts and the handrails. When the resident was questioned, he verbalized he was in pain. The resident was redirected. Activities and meal intake was encouraged. The resident was assisted to bed. A Physician's Progress Note, dated 9/17/24 at 2:04 p.m., indicated the resident was being seen for an acute visit due to ongoing behaviors. The nursing staff had reported concerns about the safety of the staff, the resident, and the other residents. The resident was on lorazepam 0.5 mg twice a day and buspirone 10 mg twice a day. Buspirone was recently increased on 8/27/24. There had been an ongoing concern the behaviors could be due to pain. The nursing staff reported the resident occasionally admitted to lower extremity pain. The resident took scheduled acetaminophen twice a day since last year. He also had an order for acetaminophen as needed which was not taken very often. Assessment/Plan - For unspecified dementia, unspecified severity, with other behavioral disturbance the resident was having significant anxiety, agitation, and aggression. The resident had an increase in buspirone with not much changes. The resident did seem to have components of delusions and paranoia. It was difficult to assess for hallucinations. The physician suspected the changes were related to psychosis related to the progression of dementia. He started a trial of quetiapine. He also suspected a component of traumatic brain injury with apparent cognitive fluctuations and thought the quetiapine would help that component. Quetiapine 25 mg daily was ordered. A Nurses Note, dated 9/17/24 at 2:24 p.m., indicated a new order for quetiapine 25 mg daily was received. The physician requested a psychological evaluation. A Behavior Note, dated 9/18/24 at 7:39 p.m., indicated the resident grabbed the staff and squeezed their hands hard. He cursed and hit the walls. The staff redirected and talked to the resident. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Behavior Note, dated 9/22/24 at 1:44 p.m., indicated the resident raised his fist behind another resident's back. The aide intervened. The resident then tried to go into another resident's room. The aide tried to get him to come out of the room, and the resident doubled his fist and told the aide he was going to kill the aide. The resident acted like his abdomen was bothering him. Interventions included distraction and one on one. A Nurses Note, dated 9/23/24 at 9:00 a.m., indicated the recent verbalizations and nursing assessments indicated the resident was in pain. The nurse practitioner ordered tramadol 25 mg twice a day. A Behavior Note, dated 9/23/24 at 3:14 p.m., indicated the resident raised his hand toward another resident when another resident touched him to get his attention. He was redirected. A Behavior Note, dated 9/23/24 at 5:24 p.m., indicated the resident hit the walls and medication carts. He paced. He was redirected, offered food and fluids, and medication. A General Progress Note, dated 9/24/24 at 6:40 p.m., indicated the resident went into another resident's room. He had a bowel movement on the floor and stepped in it. He got feces all over the room. He urinated on the floor by the bed and the other resident's shoes by the bed. He tore the toilet paper holder off the wall. He then put his hand inside the ice chest and got a piece of ice. A Behavior Note, dated 9/25/24 at 10:42 a.m., indicated the resident tried to karate chop the staff during care when his clothes were being changed. A Behavior Note, dated 9/26/24 at 7:21 a.m., indicated the resident started to squeeze the CNAs hands, hit and kick them while they changed his brief. A Nurses Note, dated 9/30/24 at 12:20 p.m., indicated the resident's buspirone was to be gradually reduced from 10 mg bid to 5 mg bid for 7 days, then to 5 mg daily for 7 days, then to 5 mg every other day for 7 days, then discontinue. A Behavior Note, dated 10/4/24 at 12:47 p.m., indicated the resident poured chocolate milk on another resident. Then, he attempted to pour milk on other residents as the staff intervened. The resident was trying to get himself between the dining chairs and the window. Other residents were seated in those chairs, eating lunch. The resident was redirected. A General Progress Note, dated 10/4/24 at 7:30 p.m., indicated the resident urinated in the corner by the double doors and walked into other residents' rooms. When the staff attempted to redirect the resident he tried to hit them. A Behavior Note, dated 10/5/24 at 12:22 p.m., indicated the resident was physically and verbally aggressive during care. Ceasing of the interaction with the resident was successful to deescalate the behavior. A General Progress Note, dated 10/8/24 at 6:30 p.m., indicated the resident looked like he was going to urinate in the hallway, and the staff member took him to toilet him. The resident hit the staff member on the shoulder during the care (continued on next page)

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Elwood Health and Living	2300 Parkview LN Elwood, IN 46036

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Behavior Note, dated 10/9/24 at 12:36 p.m., indicated the resident wandered into other residents' rooms, destroyed the other residents' items and threw them in the trash. He banged his head on the bathroom door. He punched and hit the staff member while the staff member tried to redirect the resident out of the other residents' rooms. The staff member ceased interaction with the resident, and the resident calmed down. A Social Service Note, dated 10/9/24 at 3:40 p.m., indicated the resident was seen by the physician regarding the increased behaviors. He received a new order to increase the tramadol to three times a day. A General Progress Note, dated 10/16/24 at 6:30 p.m., indicated the resident urinated in the hall by the double doors. The aide attempted to assist him to the bathroom, and he began urinating on the floor. A General Progress Note, dated 10/18/24 at 5:53 p.m., indicated the resident tried to hit and kick the staff and called them names during toileting and changing of his clothes A Behavior Note, dated 10/18/24 at 6:19 p.m., indicated the resident got into another resident's bed. He yelled and threatened the staff when they tried to get him out of the bed. The staff talked to the resident. The behavior stopped when the staff got the resident to his own bed. A Social Service Note, dated 11/21/24 at 1:19 p.m., indicated the resident had several behaviors in the past quarter. He cursed at staff, hit staff during care, hit the walls as he walked down the wall, hit a peer when he stepped on his foot, threw milk in a peer's face, got into other residents' beds, and urinated in inappropriate places. He experienced no hallucinations or delusions during the quarter. A Social Service Note, dated 1/23/25 at 12:41 p.m., indicated the resident had multiple behaviors during the quarter. He hit the walls and medication carts, urinated in the hallways, bent the staff's fingers back, wandered in and out of other residents' rooms, and was combative with care. He had no delusions or hallucinations in the quarter. During an interview, on 2/14/25 at 9:22 a.m., QMA 11 indicated the resident had mentioned a fire the other day which was new. She did not know what he meant. Usually, he just became agitated during care. He generally just walked back and forth a lot. They met his needs the best they could. They gave him snacks and tried to redirect him. During an interview, on 2/14/25 at 2:14 p.m., CNA 16 indicated his psychosis was shown in his behaviors. Most of his aggression was with his care or also when the staff redirected him. He did not like showers. He tried to lie in other residents' beds. When assisting him with toileting, the staff did care in pairs (they use two people at least). The resident would occasionally walk by a wall and punch it. When the staff talked throughout his care telling him each step of the way, that seemed to help with his agitation. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 2/14/25 at 3:51 p.m., the Unit Manager indicated the resident's dementia had progressed significantly in the last six to eight months and had become more violent. His psychotic behaviors are throwing milk at others, mostly the staff. Everyday he changed. The staff were having him sleep in and wake up naturally and that seemed to help some. She assisted with his care, and sometimes he was fine then other times he swatted at her. When the resident was admitted he took quetiapine. The medication had been reduced then discontinued a few years ago. All of sudden recently, it seemed like his dementia had gotten worse and his agitation had gotten worse. During an interview, on 2/14/25 at 4:24 p.m., the Social Services Director (SSD) indicated the resident had started on quetiapine because he had a lot of behaviors like aggression towards staff, especially during care. He had been on quetiapine when he was admitted . The facility had tried other medications, but they were not helping control his aggressive behaviors towards others. During an interview, on 2/17/25 at 4:31 p.m., the DON indicated the medical director had ordered the quetiapine for the resident. She knew the resident had increased aggression. 2. During an observation, on 2/10/25 at 10:44 a.m., Resident 61 ambulated in the hall wearing his coat and carrying a drink. During an observation, on 2/12/25 at 8:33 a.m., Resident 61 stood in the doorway of his room. He had a pull-up brief on his right hand, wore his coat, and was looking around. His speech was nonsensical. During an observation, on 2/13/25 at 3:54 p.m., Resident 61 ambulated in the hall with his hands in his pockets. He walked by the entrance doors with no attempt to leave. During an observation, on 2/14/25 at 11:34 a.m., Resident 61 was ambulating in his room. His roommate told the resident that he was not going to see well with those glasses because they were his (the roommate's). During an observation, on 2/14/25 at 3:21 p.m., Resident 61 was standing up in his room, looking at the bed. Resident 61's clinical record was reviewed on 2/13/25 at 2:45 p.m. Diagnoses included anxiety disorder, unspecified, cerebral infarction, unspecified, dementia in other diseases classified elsewhere, unspecified severity, with anxiety, delusional disorders, unspecified psychosis not due to a substance or known physiological condition and hallucinations, unspecified. Current physician's orders included ciprofloxacin (antibiotic) 500 milligrams (mg) twice a day for urinary tract infection (UTI) for 7 days (started 2/11/25), lorazepam (antianxiety) 1 mg at bedtime daily (started 11/26/24), quetiapine fumarate (antipsychotic) 12.5 mg twice a day (started 2/4/25), and quetiapine fumarate 12.5 mg every 24 hours as needed for hallucinations, delusions, and paranoia until 2/18/25 (started 2/12/25). An admission 8/9/24 Minimum Data Set (MDS) indicated the resident was cognitively intact. He had no delusions, hallucinations, behaviors, wandering, or rejection of care during the assessment period. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A significant change 12/2/24 MDS indicated the resident was moderately cognitively impaired. He had no delusions, hallucinations, behaviors, wandering, or rejection of care during the assessment period. The resident's behavior status was the same as the prior assessment. A quarterly 12/28/24 MDS assessment indicated the resident was cognitively intact. He had no delusions, hallucinations, behaviors, wandering, or rejection of care during the assessment period. A current care plan, initiated 8/7/24, indicated the resident had impaired cognitive function or impaired thought processes related to dementia. Interventions included discussing concerns about confusion (8/7/24), disease process and nursing home placement (8/7/24), needing supervision with all decision-making (8/7/24), and keeping routine consistent with consistent caregivers as much as possible in order to decrease confusion (8/7/24). A current care plan, initiated 8/7/24 and revised on 1/21/25 indicated the resident had a diagnosis of delusional disorder, hallucinations, and psychosis. The resident took an anti-psychotic medication for those diagnoses. At home the resident would see things in the yard that weren't there. He often at the facility talked about things and saw things that did not make sense or were not present. Interventions included allowing adequate time to voice feelings and frustrations (8/7/24), never arguing with the resident about delusions/hallucinations (8/7/24), and providing psychological services as ordered (8/7/24). A current care plan, initiated 8/7/24, indicated the resident had a diagnosis of anxiety disorder and took an anti-anxiety medication for increased anxiety, pacing, fidgeting, and voicing increased anxiety/shakiness. Interventions included allowing adequate time to voice feelings and frustrations (8/7/24), reducing the medication as ordered (8/7/24), and observing and reporting increased signs and symptoms of anxiety to the physician (such as fidgety, wandering, statements of feeling anxious, shaking, shortness of breath, and change in appetite/sleep) (8/7/24). A current care plan, initiated 1/8/25, indicated the resident used psychotropic medications related to hallucinations and delusions. The goals were to remain free of drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through the review date and to reduce the use of psychoactive medications through the review date (both initiated 1/8/25). Interventions included consulting with pharmacy, considering by physician of dosage reduction when clinically appropriate and observing and recording of target behavior symptoms (pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others) and document per facility protocol (1/8/25). A current care plan, initiated 1/21/25, indicated the resident frequently packed his belongings and asked when/where he was supposed to be going to. He rummaged through his roommate's belongings at times. Interventions included offering the resident the activity of conversation to redirect him from behavior (he enjoys talking about his past work as a policeman/mayor, he enjoys going outside when the weather is nice) (1/21/25), offering the resident a snack or drink (he likes suckers) (1/21/25), and offering the resident to call his son (1/21/25). A current care plan, initiated 1/21/25, indicated the resident wandered in the hallways with no concrete destination. Interventions included assessing the resident for basic needs, assessing the resident for pain, offering the resident an activity to occupy time, and offering to call the resident's son (1/21/25). (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurses Note, dated 11/23/24 at 4:14 p.m., indicated the resident was in his room packing his bags and packing his roommate's items with his belongings. The resident was agreeable to putting the roommate's belonging back after the staff talked with the resident. A Behavior Not[TRUNCATED]

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48384 Based on observation, interview, and record review, the facility failed to ensure an antipsychotic medication was not initiated without indication for 1 of 5 residents reviewed for unnecessary medications. (Resident 15) Findings include: Resident 15's clinical record was reviewed on 2/17/25 at 9:32 a.m. Diagnoses included generalized anxiety disorder, alcohol dependence (in remission), hypertension, sedative, hypnotic, or anxiolytic dependence (uncomplicated), cognitive communication deficit, and unspecified dementia (unspecified severity - with other behavioral disturbance). A quarterly MDS, dated [DATE], indicated the resident had active diagnoses of anxiety, depression, and a psychotic disorder (other than schizophrenia). Current orders included buspirone (anti-anxiety) 5 mg tablet give 1 tablet by mouth three times a day, tramadol (opiate pain reliever) 50 mg tablet give 1 tablet by mouth every 8 hours as needed, quetiapine fumarate (anti-psychotic) 25 mg give 1 tablet by mouth at bedtime, and behavior assessment to be performed every shift due to psychotropic medications. A current, 3/20/22, care plan indicated the resident had a diagnosis of insomnia. She had daytime tiredness, irritability, depression and/or anxiety. Interventions included gradual dose reductions (GDRs) as ordered, medications as ordered, observe for signs and symptoms of adverse reactions to medications and notify they physician of any concerns, provide a relaxing environment for the resident, and psych services as ordered. A current, 3/30/22, care plan indicated a diagnosis of generalized anxiety disorder, described as persistent worrying or anxiety about a number of areas that were out of proportion to the impact of the events, restlessness, fatigue, crying, verbal behaviors, difficulty concentrating, irritability, multiple health complaints, and tearfulness. The resident worried about her husband and daughter when unable to reach them by phone. Interventions included medications as ordered, the nurse(s) were to assess health complaints, observe and document resident for signs and symptoms of increased anxiety, offer medications for health complaints when available, provide a calm, relaxing environment for resident, and provide reflective listening and reassurance to the resident. A current, 3/30/22, care plan indicated a diagnosis of major depressive disorder, described as feelings of sadness, tearfulness, emptiness or hopelessness, fatigue, lack of energy, loss of appetite or overeating, loss of interest, and lack of concentration. Interventions included allowing the resident time to voice feelings and frustration, GDRs as ordered, medications as ordered, observe the resident for signs and symptoms of increased depression (and document), and observe for signs and symptoms of adverse reactions to medications as listed on the behavior/intervention monthly flow record. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current, 3/30/22, care plan indicated the resident had the potential for increased signs and symptoms of depression related to her diagnoses of depression, alcohol dependence, and depression assessment indicators. Interventions included allowing the resident to vent her feelings, using good listening techniques, encourage family and social interactions, encourage involvement in daily needs and concerns, monitor for signs and symptoms of depression, provide a caring and structured environment and routine, and use supportive words and reassurance during contact with the resident. A current, 3/30/22, care plan indicated the resident had a history of making negative statements, i.e., stating she wished to disappear, wanted to harm herself (but then stated she just wanted God to kill her), wished she were dead, and wanted to die because her stomach hurt. She indicated she was Catholic and would never harm herself. She often had those ideations during times of pain or when requesting more pain medications. Interventions included assessing the resident for pain, assisting the resident to call her family members, medications as ordered for depression, observe any changes in mood, appetite, change in sleep patterns, or any increased verbalizations of being depressed or blue, and provide reflective listening and reassurance to the resident. A current, 3/30/22, care plan indicated the resident exhibited anxious verbalizations, i.e., yelling out continuously, even with redirection, and crying out loudly that she was dying. Interventions included introducing the resident to peers with similar interests, offer a small conversation to help calm and reassure the resident, and offer a back rub or repositioning. A current, 9/28/22, care plan indicated the resident had impaired cognitive function or impaired thought processes related to a dementia diagnosis. The resident needed supervision with all decision making. Interventions included keeping her routine consistent and provide consistent care givers as much as possible, in order to decrease confusion. A current, 9/28/22, care plan indicated the resident had a diagnosis of alcohol and sedative/hypnotic/anxiolytic dependence. Interventions included offering validation, empathy, and listening techniques, identifying triggers that led to urges of alcohol use, observe and report to the physician any changes in mood (withdrawal) or urges to use alcohol. A current, 7/17/23, care plan indicated the resident had a diagnosis of psychosis. She took antipsychotic medications related to the following behaviors - pain, constipation, multiple health conditions, money, yelling out, statements that she was dying because her stomach hurt, uncontrollable sobbing, calling 911 frequently, and verbal aggression towards the staff and her roommate. Interventions included GDRs as ordered, medications as ordered, observe for signs and symptoms of adverse reactions to medications as listed on the behavior/intervention monthly flow record, observe for side effects of medications and notify physician of any concerns, and psych services as ordered. A behavior note, dated 4/13/24 at 5:24 p.m., indicated the resident had been walking around the building with her roommate. During resident care, she told the nurse she needed her pain pill. The nurse explained it was not yet time for the pill. The nurse offered acetaminophen instead. The resident argued that it was time for her pain pill. The nurse tried to explain why the pain pill could not be given but the resident continued to argue with the nurse. The behavior assessment indicated the resident was irritated. A behavior note, dated 5/10/24 at 10:21 a.m., indicated the resident refused to get out of bed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note, dated 12/1/24 at 11:49 a.m., indicated the resident requested pain medication. She wanted to go to the emergency room to get some good meds. The resident yelled that she wanted to die. She had no plans to hurt herself. She was placed on 15 minute checks at that time. A social service progress note, dated 1/14/25 at 9:11 a.m., indicated the resident was on buspirone two times and day for anxiety and quetiapine 25 mg once daily at bedtime for depression. The resident had no behaviors since 5/10/24. A physician's progress note, dated 1/29/25 at 2:36 p.m., indicated the resident was seen to follow up on hip pain. The resident had complained of pain in her right hip and threatened to call 911. She wanted to go to the hospital. The pain radiated from her right hip into her leg. The pain medication was not helping. The resident was repositioned at that time. A nursing progress note, dated 2/5/25 at 2:36 p.m., indicated the resident was upset because her pain medication was not helping her pain. The nurse practitioner discontinued her narcotic pain medication at that time and started the resident on acetaminophen (Tylenol) 1000 mg, three times a day and tramadol 50 mg, three times a day as needed. A behavior progress note, dated 2/11/25 at 9:40 a.m., indicated the resident refused to go to a doctor's appointment. She had been sick all night and did not want to go to the appointment. Her behavior was described as upset and anxious. A physician's progress note, dated 2/11/25 at 3:43 p.m., indicated the resident was not feeling well and stated she was a ball of nerves. She denied having concerns about anything in particular. She refused to go to an outside doctor's appointment that day and denied having any pain. The resident's buspirone was increased to three times a day. During an interview with CNA 14, on 2/17/25 at 11:19 a.m., she indicated Resident 15 would often have her call light going off every few minutes, complaining of pain. Even when told she was not due for a medication, she would continue to ask the nurse for pain medication. She would follow the nurse around, sometimes into other resident's rooms. During an interview with the Activities Assistant (AA), on 2/17/25 at 11:22 a.m., she indicated the resident cried sometimes because she was lonely or did not feel well. No hallucinations or delusions were observed by the AA. The resident often complained of pain. During an interview with QMA 15, on 2/17/25 at 11:24 a.m., she indicated the resident had good and bad days. Interventions were implemented but did not always work. When interventions were unsuccessful, the staff would document the behavior. Most often, the behavior was related to pain. The resident had never said anything about hearing voices or seeing things that were not there. During an interview with the Director of Nursing (DON), on 2/17/25 at 4:42 p.m., she indicated most of Resident 15's behaviors were complaints of pain. She would sometimes say she felt like she was losing her mind. The resident had a long history of addiction. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A summary of the black box warning for quetiapine, retrieved from https://www.nami.org/about-mental-illness/treatments/mental-health-medications/types-of-medication/quetiapine-seroquel/ on 2/18/25 at 12:08 p.m., indicated the following: .Increased Mortality in Elderly Patients with Dementia Related Psychosis - When used for dementia related psychosis in elderly patients, both first generation (typical) and second generation (atypical) antipsychotics are associated with an increased risk of mortality A current facility policy, with a revision date of 10/2022, and titled Psychotropic Medication Policy, was provided by the Administrator on 2/17/25 at 1:30 p.m. The policy indicated the following: .Behavioral interventions are individualized, non-pharmacological approaches to care that are provided as part of a supportive physical and psychosocial environment, directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities, as well as maintaining or improving a resident's mental, physical or psychosocial well-being .Expressions or indications of distress refers to a person's attempt to communicate unmet needs, discomfort, or thoughts that he or she may not be able to articulate. The expressions may present as crying, apathy, or withdrawal, or as verbal or physical actions such as pacing, cursing, hitting, kicking, pushing, scratching, tearing things, or grabbing others .Medication Management: .The facility will ensure to the extent possible that the following are met regarding medication management .Selection of medications(s) based on assessing relative benefits and risks to the individual resident .Evaluation of a resident's physical, behavioral, mental, and psychosocial signs and symptoms, to identify the underlying cause(s), including adverse consequences of medications .The facility will ensure each resident's clinical record contains the following: 1) Indication and clinical need for medication . Additionally, the facility will ensure when administering psychotropic medication, the following is met: Giving psychotropic medications only when necessary to treat a specific diagnosed and documented condition . Residents must not receive any medications which are not clinically indicated to treat a specific condition. The medical record must show documentation of the diagnosed condition for which a psychotropic medication is prescribed .Facility shall not use these types of brain altering medications .unless there is documented clinical indication for the use .The facility will use extreme caution in utilizing antipsychotic medications in the elderly. The following will be considered prior to initiation of antipsychotic medication: Behavioral symptoms present a danger to the resident or others 3.1-48(a)(4)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48384 Based on observation, interview, and record review, the facility failed to ensure staff implemented transmission based precautions for 2 of 8 residents reviewed for infection control. (Residents D and Resident 62) Findings include: Resident 62's clinical record was reviewed on 2/10/25 at 1:38 p.m. Diagnoses included osteomyelitis of vertebra, thoracic region, cerebral infarction, COVID-19, depression, and cognitive communication deficit. Physician orders, dated 2/5/25 at 2:00 p.m., indicated transmission based (droplet) precautions were to be observed for 9 days for COVID-19. All services were to be received in his room. On 2/10/25 at 10:47 a.m., a sign on Resident 62's door indicated the resident was on droplet precautions. The Certified Occupational Therapy Assistant (COTA) exited the room wearing a surgical mask and glasses. The COTA indicated she would remove personal protective equipment (PPE) when exiting a room. She would replace the N-95 mask with a surgical mask. Her personal glasses were not covered by protective eyewear because she was not able to see well with goggles over her glasses. Resident D's clinical record was reviewed on 2/10/25 at 2:18 p.m. Diagnoses included hypothyroidism, anxiety, chronic combined systolic and diastolic heart failure, and bipolar disorder. Physician orders, dated 2/3/25 at 10:00 p.m., indicated droplet precautions were to observed for 10 days. The resident tested positive for COVID-19. All services were to be received in her room. On 2/11/25 at 10:40 a.m., an Activities Assistant was observed entering Resident D's room. A sign on the door indicated the resident was on droplet precautions. The Activities Assistant donned a gown and a surgical mask. She did not don gloves or protective eyewear. During an interview, at the time of the observation, the Activities Assistant indicated staff should don gloves, a gown, an N-95 mask, and protective eyewear. She forgot to wear the goggles. During an interview with Nurse Assistant 5, on 2/11/25 at 10:59 a.m., she indicated staff should wear a gown, mask, and protective eyewear when entering the room of a resident diagnosed with COVID-19. During an interview with the Certified Nursing Assistant Coordinator, on 2/11/25 at 11:03 a.m., she indicated staff should wear protective eyewear, a mask, an N-95 mask, gloves, and gown when entering the room of a resident diagnosed with COVID-19. Even if staff wore glasses, they should put protective eyewear over the glasses. During an interview with CNA 7, on 2/11/25 at 11:07 a.m., she indicated staff should wear gloves, a gown, an N-95 mask, and protective eyewear when entering the room of a resident diagnosed with COVID-19. Staff wearing glasses should also don protective eyewear over them. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155522	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elwood Health and Living	2300 Parkview LN Elwood, IN 46036

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LPN 10 on 2/11/25 at 1:34 p.m., she indicated staff should wear a gown, an N-95 mask, protective eyewear, and gloves when entering the room of a resident diagnosed with COVID-19. Goggles should be worn over eyeglasses. A current 7/5/21 facility policy, titled Transmission Based Precautions Infection Control, provided by the Administrator on 2/17/25 at 4:35 p.m., indicated the following: .It is the policy of (the facility) to take appropriate precautions to prevent transmission of infectious agents. Transmission based precautions are for resident's who are known or suspected to be infected or colonized with infectious agents, including certain epidemiologically important pathogens, which require additional control measures to effectively prevent transmission. These precautions are to be used in adjunct with standard precautions .Droplet Precautions .a) Intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions (respiratory droplets that are generated by a resident who is coughing, sneezing, talking, or singing) .d) Healthcare personnel must wear a mask (surgical, N-95, approved KN95, or respirator when appropriate) 3.1-18(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49411 Based on observation and interview, the facility failed to provide a safe and comfortable environment for 3 of 4 residents reviewed for homelike environment. (Resident C, Resident D and Resident 42) Findings include: Resident D's clinical record was reviewed on 2/12/25 at 10:38 a.m. Diagnoses included type 2 diabetes mellitus, chronic kidney disease, muscle weakness, and abnormality of gait and mobility. During an interview, on 2/12/25 at 12:09 p.m., Resident D indicated maintenance would be replacing her countertop. She used the countertop to help herself balance during transfers. They had not fixed the countertop at that time, as they had to order a new one. During a room observation, on 2/12/25 at 12:17 p.m., room [ROOM NUMBER]'s bathroom countertop was pulling away from the wall. It had a small gap between the backsplash and the wall. The countertop moved downward when pressure was placed on top of it. During an interview, on 2/12/25 at 1:17 p.m., Resident D indicated she went to get up from the toilet, twisted her knee wrong and was able to lower herself down to the floor. She used the loose countertop to get herself off the floor. She always transferred on her own. An Interdisciplinary Team (IDT) progress note, dated 2/10/24 at 1:29 p.m., indicated Resident D reported she attempted a self-transfer from the toilet to her wheelchair, lost her balance, and fell to one knee. The resident reported she was able to get herself back into her wheelchair and was not injured. Her bathroom was assessed and non-skid strips were in front of the toilet, there was a grab bar on the right-hand side of toilet, and a toilet seat riser. Her countertop was beginning to deteriorate and was loose when pressure was applied to the top of the counter. Resident D reported that she used the countertop to balance herself during transfers and felt that movement may have contributed to her fall. A maintenance request was put in for her countertop to be replaced. During an interview, on 2/12/25 at 1:22 p.m., the Maintenance Supervisor indicated he had Resident D's bathroom countertop in his office since Monday, it was just a matter of getting the time to install it. The countertop needed the hole cut out for the sink to drop in. He felt it was late last week when he was notified that her bathroom countertop was loose. He was unable to restructure/brace the existing countertop due to ADA guidelines. 2. During an interview, on 2/11/25 at 10:32 a.m., Resident C indicated she had paint missing from her walls where she and her roommate's bed were rubbing up against the wall, causing it to scrape into the drywall. She had complained to the maintenance department regarding wanting her room fixed and repainted. It had been like that for the last four months. During an observation, at the time as the interview, Resident C's room had numerous areas just above the bed, where the bed frame had scrapped into the drywall causing small holes and paint to be missing. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 2/12/25 at 1:22 p.m., the Maintenance Supervisor indicated Resident C had asked previously when her walls would be fixed. He spoke with Resident C weekly regarding painting her walls. He wasn't able to put a timeframe on when it would be fixed, as he has other issue that need fixed with a higher level of severity. A random observation of the 300 hall, on 2/12/25 at 11:09 a.m., indicated the following: room [ROOM NUMBER] had missing paint and gouges of missing drywall, above the resident's bed. A large area, approximately the size of an index cared, of missing paint and the top layer of drywall was missing around the door frame of the soiled utility room. 3. During an observation, on 2/17/25 at 1:56 p.m., Resident 42's window sill behind her bed's headboard had a hole approximately the size of an index card and approximately one inch deep. It was covered with plastic and paper tape that was peeling off. During an interview, on 2/17/25 at 1:58 p.m., QMA 11 indicated the area had been there since January 2025. She had not reported it to maintenance, and she was unsure if anyone else had reported it. During an interview, on 2/17/25 at 1:59 p.m., LPN 12 indicated the area in Resident 42's window sill had been there for at least a month. She was uncertain if it had been reported to maintenance. During an interview, on 2/17/25 at 2:04 p.m., the Maintenance Supervisor indicated he was just notified on Friday regarding the residents window sill. He thought he had a board to fix it but needed to get a bigger board. During an interview, on 2/17/25 at 2:23 p.m., the Administrator indicated they did not have a facility policy regarding environment. This citation relates to Complaints IN00449079, IN00449973, and IN00452205. 3.1-19(e)