STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155691	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morristown Manor	868 S Washington St Morristown, IN 46161

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41129 Based on interview and record review, the facility failed to protect a resident's right to be free from physical abuse by another resident for 1 of 4 residents reviewed for abuse. (Resident D) Findings include: The clinical record for Resident D was reviewed on 3/22/24 at 10:40 a.m. Resident D's diagnoses included, but not limited to, dementia and mood (affective) disorder (marked disruption in emotions; extreme highs/severe lows). An interview with Resident D conducted on 3/22/24 at 10:40 a.m. indicated she was going to be discharged from the facility on April 1, 2024. When asked why she was going to be discharged , she indicated she had been abusive to another resident. An interview with SSD (Social Services Director) conducted on 3/26/24 at 3:55 p.m. indicated Resident D was being discharged to another facility once her granddaughter had chosen one that is closer to her. When asked if Resident D's discharge was related to abuse, SSD indicated yes and Resident D had body slammed another resident to the floor then tried to deny that she knew anything about how the other resident came to be resting on the floor. An Indiana State Department of Health reportable incident report was received on 3/27/24 at 1:56 p.m. The report indicated, Resident D and Resident P, who both resided on the memory care unit, had a resident-to-resident altercation on 11/7/23. The Brief Description of Incident indicated, 11/7/23 [Resident P's first name] claimed [Resident D's first name] pushed her but there were no witnesses. It was in a common area, so we were able to access a camera and verify the incident. The type of injury added indicated, [Resident P's first name] has a knot to the back of her head and a skin tear. The immediate actions included: separation of the two residents; Resident D was placed on one-on-one supervision; pain and skin assessments were completed; social services was to provide 72 hours of psychosocial support; and families, doctors and the administrator were notified. Resident D was sent to a psychiatric facility for evaluation and treatment. The follow-up dated 11/13/23 indicated, no signs/symptoms of distress were noted for Resident P and Resident D had gone to a psychiatric facility. (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

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation file for the resident-to-resident altercation between Resident D and P was received on 3/27/24 10:10 a.m. from CS (Clinical Specialist). Within the file, was a typed statement which indicated, There was not witness to the actual incident. The resident [sic, Resident P's full name] was found on the floor and she stated she was pushed. The camera footage was pulled and the entire incident was viewed. [sic, name of Resident P] was attempting to sit at the empty seat at the dining room table. [sic, Resident D's name] grabbed the chair not allowing [sic, Resident P's name] to sit down. Then [sic, Resident D's name] stood up, threw a metal drinking cut at [sic, Resident P] hitting her in the abdomen area. Then [sic, Resident D's name] came around the side of the table and forcefully shoved [sic, Resident P] onto the floor. [sic, Resident D] picked up her cup and quickly sat back down in her spot at the table. The staff within approx.[sic, approximately] 30 seconds who were in the pantry of the dining area came to [sic, Resident P] who was on the floor to assess and care for her. The video footage was viewed by the DON [sic, Director of Nursing], SSD [sic, Social Services Director], and the clinical specialist. 11/7/23 A nursing note in Resident D's clinical record dated 11/7/23 at 12:27 p.m. indicated Resident was seen on the video footage shoving another resident. Resident P indicated she was shoved onto the floor by Resident D. Resident D stated, she didn't do anything. A nursing note in Resident P's clinical record dated 11/7/23 at 2:34 p.m. indicated Resident P was shoved down in the dining room and sustained a skin tear to her right hand and a hematoma to the back of her head. A Social Services note dated, 11/7/2023 at 3:17 p.m. indicated social services had spoken to Resident D who indicated, she had pushed Resident P because she did not want that lady to sit with her at the table. When Resident D was told she would be going to a psychiatric facility, she replied, I don't give a f***, send me the f*** anywhere. A nursing note dated, 11/8/2023 at 10:01 a.m. indicated, IDT [sic, Interdisciplinary Team] met and reviewed recent aggressive behaviors from 11/07/2023. resident [sic, Resident D] was not triggered or instigated by any other residents. behaviors[sic] were very aggressive that resulted in injuries to other resident. Resident[sic, Resident D] was removed from situation and immediately placed on 1 on 1 supervision until resident left for [sic, name of psychiatric facility] for in patient psych stay. no [sic] further behaviors once 1 on 1 initiated. resident [sic] did leave this am [sic, a.m.] for hospital. A Social Services note dated, 1/29/2024 at 12:08 p.m. in Resident D's clinical record indicated, a care plan meeting with Resident D, Resident D's family, SSD (Social Services Director), IP (Infection Preventionist) and ED (Executive Director) had occurred, and they discussed Resident D's behaviors and stated, we are not able met her needs here at this facility. [sic, Resident D] is physically and verbally aggressive towards others, hiding knifes [sic] and scissors in her bra and under her bed. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Abuse, Neglect, and Misappropriation Prohibition and Prevention policy was received on 3/22/24 at 3:38 p.m. from ED. The policy indicated, it is the policy of the facility to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse .Reporting to the Administrator .Our facility will not condone resident abuse by anyone, including .other residents .Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish Physical abuse is defined as hitting, slapping, pinching, kicking, etc . 3.1-27(a)(1)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34850 Based on interview and record review, the facility failed to timely report a reportable incident for 2 of 4 residents reviewed for abuse. (Resident 94 and Resident E) Findings include: 1. The clinical record for Resident 94 was reviewed on 3/25/24 at 10:30 a.m. The diagnoses for the resident included, but were not limited to, dementia with psychotic disturbance and hallucinations. The resident was admitted on [DATE]. The 2/9/24 Admission Minimum Data Set (MDS) Assessment for Resident 94 indicated she was severely impaired. 2. The clinical record for Resident E was reviewed on 3/22/24 at 3:11 p.m. The diagnoses for the resident included, but were not limited to, dementia with psychotic disturbance and hallucinations. The 1/8/24 Quarterly Minimum Data Set (MDS) Assessment for Resident E indicated he was severely impaired. A reportable incident that was reported to the Indiana Department of Health was provided by the Clinical Specialist on 3/25/24 at 9:00 a.m. It indicated .Incident date: 2/27/24 Incident Time: 3:01 p.m Brief Description of Incident .[Resident 94] touched [Resident E] on the outside of his pants in his lap area . An event for Resident 94 dated 2/26/24 indicated the resident on 2/26/24 at 10:00 a.m., had touched male resident in private area. A Social Services note for Resident E dated 2/26/24 at 2:41 p.m., indicated Visited with [Resident E] and asked if anything happened this morning. He said he couldn't remember. I asked if a female resident touched his private area. [Resident E] stated [NAME] (sic). I asked if that bothered him, he said no it was fine with me. A Social Services note dated 2/26/24 at 2:54 p.m., indicated spoke with [Resident 94] today regarding this morning incident. [Resident 94] did not recall doing that. I explained to her that she cannot go up to another resident and touch them. She replied okay. An interview was conducted with the Executive Director on 3/26/24 at 3:46 p.m. He indicated when the incident between Resident E and Resident 94 was first reported to him; it was not presented to him as something he thought at that time needed to be reported. After realizing the incident did need to be reported; he reported on 2/27/24. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An abuse policy was provided by the Executive Director on 3/22/24 at 3:38 p.m. It indicated .It is the policy of [NAME] & Associates, Inc. and its member Communities to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion and misappropriation of their property .Policy Interpretation and Implementation .C. Reporting to State Agencies . 1. Allegations of abuse and any neglect, mistreatment or injury of unknown source that results in serious injury will be reported immediately to the State licensing/certification agency through that agency's approved method of incident reporting .2. Allegations of mistreatment, neglect, or injury of unknown source that do not result in serious injury will be reported within a reasonable amount of time not to exceed 24 hours to the State licensing/certification agency through the approved method of reporting . 3.1-28(c)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34850 Based on interview and record review, the facility failed to thoroughly investigate a reportable incident for 2 of 4 residents reviewed for abuse. (Resident E and Resident 94) Findings include: 1. The clinical record for Resident 94 was reviewed on 3/25/24 at 10:30 a.m. The diagnoses for the resident included, but were not limited to, dementia with psychotic disturbance and hallucinations. The resident was admitted on [DATE]. The 2/9/24 Admission Minimum Data Set (MDS) Assessment for Resident 94 indicated she was severely impaired. 2. The clinical record for Resident E was reviewed on 3/22/24 at 3:11 p.m. The diagnoses for the resident included, but were not limited to, dementia with psychotic disturbance and hallucinations. The 1/8/24 Quarterly Minimum Data Set (MDS) Assessment for Resident E indicated he was severely impaired. A reportable incident that was reported to the Indiana Department of Health was provided by the Clinical Specialist on 3/25/24 at 9:00 a.m. It indicated .Incident date: 2/27/24 Incident Time: 3:01 p.m Brief Description of Incident .[Resident 94] touched [Resident E] on the outside of his pants in his lap area . An investigation involving Resident 94 and Resident E was provided by the Clinical Specialist on 3/27/24 at 10:30 a.m. The investigation included but was not limited to: a written statement by Certified Nursing Assistant (CNA) 5. It indicated the following: To Whom This May Concern: I walked out of a Resident's room, and there was [Resident 94], in the hallway in front of the nurse's station holding another resident's private area. I quickly asked her to stop, saying you can not do that, and I asked the nurse to help because she's (sic) wouldn't let go so the nurse grabbed her, and I grabbed him, and took him to his room immediately!!! . The investigation did not include any additional statements from the staff that were present during the incident between Resident 94 and Resident E. An interview was conducted with CNA 5 on 3/27/24 at 11:55 a.m. She indicated Resident E was clothed and standing in the hallway. Resident 94 had ambulated up to Resident E and grabbed his genitalia through his clothing. CNA 5 had intervened to separate the residents, but Resident 94 would not let go of Resident E's private area. She hollered for assistance from Registered Nurse (RN) 10. RN 10 had assisted with separating the residents. Resident E did not voice any pain during that time. An interview was conducted with the Clinical Specialist on 3/27/24 at 1:33 p.m. She indicated the investigation between Resident 94 and Resident E provided was complete. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with RN 10 on 3/28/24 at 9:29 a.m. She indicated she was at the nurse's station and Resident 94 and Resident E were in the hallway. CNA 5 had hollered for her assistance. She had assisted CNA 5 with the separating of the two residents, but when she approached them Resident 94 was not touching Resident E's private area at that time. She had provided assistance with removing Resident E away from Resident 94 by taking him to his room. She then performed an assessment on Resident E and did not observe any injuries to him. RN 10 indicated she could not recall being asked for a written statement about the incident. She works PRN (as needed) and did not return to the facility for approximately a week after the incident. An abuse policy was provided by the Executive Director on 3/22/24 at 3:38 p.m. It indicated .It is the policy of [NAME] & Associates, Inc. and its member Communities to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion and misappropriation of their property .Policy Interpretation and Implementation .V. Abuse Investigations. 1. Should an incident or suspected incident of resident abuse, neglect, injury of an unknown source or misappropriation of resident property be reported, the Administrator or designee ensure the immediately protection and safety of the involved resident(s) and then will appoint a member of management to investigate the alleged incident while retaining ultimate responsibility for ensuring a timely and thorough investigation. 2. The Administrator or designee will provide to the person in charge of the investigation a complete copy of any supporting documents relative to the alleged incident. 3. The individual conducting the investigation will, at a minimum .g. Interview staff (on all shifts) who have had contact with the resident before, during, and immediately after the period of the alleged incident . 3.1-28(d)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 40287 Based on interview and record review, the facility failed to accurately complete the cognitive assessment portion of the MDS (Minimum Data Set) Assessment for 3 of 5 residents reviewed for Resident Assessment (Resident 28, 54, and 78). Findings include: 1a. The clinical record for Resident 28 was reviewed on 3/27/24 at 1:30 p.m. The Resident's diagnosis included, but was not limited to, dementia. A Quarterly MDS Assessment, completed 1/29/24, indicated that Resident 28 was usually able to make herself understood and was able to understand others. The BIMS (Brief Interview for Mental Status) of the MDS was not completed. 1b. The clinical record for Resident 54 was reviewed on 3/27/24 at 1:40 p.m. The Resident's diagnosis included, but was not limited to, dementia. A Quarterly MDS Assessment, completed 1/29/24, indicated that Resident 54 was usually able to make herself understood and was able to understand others. The BIMS (Brief Interview for Mental Status) of the MDS was not completed. 1c. The clinical record for Resident 78 was reviewed on 3/27/24 at 1:50 p.m. The Resident's diagnosis included, but was not limited to, dementia. A Significant Change of Status MDS Assessment, completed 2/29/24, indicated he was usually able to make himself understood and was usually able to understand others. The BIMS (Brief Interview for Mental Status) of the MDS was not completed. During an interview on 3/27/24 at 2:40 p.m., the SSD (Social Services Director) indicated that Residents 28, 54, and 78 were capable of answering questions for the BIMS Assessment, and that the assessments should have been completed for them. During an interview on 3/27/25 at 2:51 p.m., the MDSC (Minimum Data Set Coordinator) indicated the BIMS Assessment should have been completed on the MDS for Residents 28, 54, and 78. The facility used the RAI (Resident Assessment Instrument) as the policy for completing the MDS Assessments.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41129 Based on interview and record review, the facility failed to ensure a resident with an indwelling urinary catheter received appropriate treatment and services to prevent urinary tract infections and to monitor the urine characteristics of a resident being evaluated for a urinary tract infection for 2 of 3 residents reviewed for urinary catheter. (Resident H and Resident L). Findings include: 1. The clinical record for Resident H was reviewed on 3/26/24 at 10:06 a.m. Resident H's diagnoses included, but not limited to, urinary tract infection, acute pyelonephritis (infection of the kidneys), extended spectrum beta lactamase resistance (ESBL, a multi-drug resistant organism), and neuromuscular dysfunction of the bladder (lack of bladder control). A nursing note dated 1/14/2024 at 11:39 p.m. indicated Resident H had an anchored catheter for urinary drainage. The urine was very foul smelling and dark. His urine was tested in-house with a urine analyzer and had numerous abnormal values. Resident H's urine was to be sent to the lab in the morning for a urinalysis with culture and sensitivity. A physician's note dated 1/15/24 indicated, Resident H was seen in follow up rounds to review/discuss recent urinalysis with culture and sensitivity lab/diagnostic testing from 1/15/24 due to malodorous urine. The results noted the urine was positive for leukocytes, nitrites and bacteria while the culture was still pending. A new order for Keflex (an antibiotic) 500 mg (milligrams) twice a day for 7 days was to be started and possibly adjusted once the culture came back. A physician's note dated, 1/18/2024 indicated, Resident H's urine culture showed mixed flora which indicated, a contaminated sample and the lab recommended a repeat sample. The antibiotic did not meet McGreer's criteria but was continued as his urine was reported as cloudy with large sediment and a foul odor. Resident H was also noted to have had increased behaviors recently. No repeat urinalysis with culture and sensitivity labs were to be completed at that time as Resident H was currently on oral antibiotics, and this could have resulted in a false negative urine culture. A physician's order dated 9/28/23 indicated, to provide urinary catheter care every day and night shift. Resident H's care plan dated 4/3/23 and last revised on 2/17/24 indicated; he had an indwelling urinary catheter related to a neuromuscular dysfunction of bladder. Interventions included, but not limited to, provide catheter care every shift and as needed (start date 5/17/23). An interview with CS (Clinical Specialist) conducted on 3/26/24 at 4:14 p.m. indicated, a review of Resident H's MAR (medication administration report) and TAR (treatment administration report) for January and February 2024 did not contain verification documentation that indwelling urinary catheter care had been performed every shift from 1/15/24 to 2/5/24. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Bed Bath/Perineal procedure was provided by CS on 3/27/24 at 10:19 a.m. CS indicated, the facility does not have an indwelling urinary catheter care policy. The Bed Bath/Perineal care procedure indicated, Catheter care: 22. If resident has catheter, check for leakage, secretions or irritation. Gently wipe four inches of catheter from meatus out .Perineal Care .For Males .Pull back foreskin if male is uncircumcised. Wash and rinse the tip of penis using circular motion beginning with urethra. Continue washing down the penis to the scrotum and inner thighs. Rinse off soap and dry. Return foreskin over the tip of the penis. 40287 2. The clinical record for Resident L was reviewed on 3/22/24 at 10:52 a.m. The Resident's diagnosis included, but were not limited to, cerebral infarct (stroke) and dysuria (painful urination). She was admitted to the facility on [DATE]. An Admission Assessment, dated 3/11/24, indicated Resident L was occasionally incontinent at night and had no symptoms of burning, frequency, pain with urination, or urgency. She wore incontinent pads or briefs to assist with controlling incontinence. A care plan, initiated 3/12/24, indicated Resident L had urinary incontinence. She required staff to assist with toileting and toilet hygiene. The goal was for her not to develop skin breakdown related to incontinence. The interventions included, but were not limited to, assist with toileting and personal hygiene as needed, provide incontinent care after each episode, and weekly skin assessments. A BIMS (Brief Interview for Mental Status) Assessment, completed 3/19/24, indicated she was cognitively intact. A Nurse Practitioner Progress Note, dated 3/20/24, indicated that Resident L had complaints of dysuria on exam. A UA C&S (Urinary Analysis with Culture and Sensitivity) was ordered. During an interview on 3/22/24 at 10:52 a.m., Resident L indicated she thought she was getting a urinary tract infection. She had told the facility, and they were testing her. It took a long time for the staff to take her to the bathroom and she was having urinary accidents. A Nursing Progress Note, dated 3/22/2024, indicated urine was collected for UA C&S and sent to the lab. A Nursing Progress Note, dated 3/25/2024, indicated that the urine sample previously sent to the lab was reported as possibly contaminated. The Nurse Practitioner had been made aware. During an interview on 3/26/24 at 3:19 p.m., Resident L indicated she was beginning to have burning with urination and that it seems to run every 15 minutes. During an interview on 3/26/24 at 3:57 p.m., the Director of Nursing indicated the Nurse Practitioner had been informed of possible contamination of the previous urine sample and had ordered to repeat the UA. A Nursing Progress Note, dated 3/27/2024, indicated that urine had been obtained and sent to the lab that morning. A urine culture was pending at that time and the nurse practitioner was aware. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/27/24 at 11:11 a.m., the Director of Nursing indicated a urine sample that had been sent to the lab that morning had been collected by using an in and out catheter. The Nursing Progress notes did not contain any assessment of Resident L's urine color, characteristics, any odor present in the urine, or how the urinary sample was obtained. On 3/28/24 at 12:16 p.m., the Clinical Specialist provided the current Catheterizing the Urinary Bladder with an In and Out Straight Catheter Skills Validation which read .Document .Document the procedure: Documentation should include a detail of the procedure, the resident's tolerance of the procedure, the color, character and amount of the urine noted in the drainage bag . This citation relates to Complaint IN00425957. 3.1-41(a)(2)

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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** 34850 Based on observation, interview and record review, the facility failed to provide adequate supervision for an ambulatory cognitively impaired resident that resided on the memory care unit for 3 of 4 residents reviewed for abuse. (Resident 15 and Resident 94, and Resident E) Findings include: 1a. The clinical record for Resident E was reviewed on 3/22/24 at 3:11 p.m. The diagnoses for the resident included, but were not limited to, dementia with psychotic disturbance and hallucinations. The 1/8/24 Quarterly Minimum Data Set (MDS) Assessment for Resident E indicated he was severely cognitively impaired. 1b. The clinical record for Resident 94 was reviewed on 3/25/24 at 10:30 a.m. The diagnoses for the resident included, but were not limited to, dementia with psychotic disturbance and hallucinations. The resident was admitted on [DATE]. The 2/9/24 Admission Minimum Data Set (MDS) Assessment for Resident 94 indicated she was severely cognitively impaired. A care plan for Resident 94 dated 2/7/24 indicated .[Resident 94] has a diagnosis of dementia with behaviors and at times exhibits the following signs and symptoms attempting to hit staff, yelling out. [Resident 94] also has a current dx [diagnosis] of hallucinations and is at risk of experiencing certain behaviors regarding . Approach .New or worsening behaviors will be monitored and new interventions will be considered in order to promote the highest level of quality of life for this resident .Allow for hoarding or wandering in a controlled environment with acceptable limits . A care plan dated 2/27/24 indicated .Resident touching another resident inappropriately. Increased interest in touching self, masturbation .Approach .Give resident privacy in own room when desires to masturbate or touch self .Resident on 15 min [minutes] check until deemed necessary to remove per IDT [Interdisciplinary Team.] . A care plan dated 3/6/24 indicated Entering another residents room and taking their belongings .Approach . Goal. Resident will not go into other residents rooms and take their belongings .Approach. Encourage resident to join in scheduled activities to keep her busy .See [Psych Provider] as needed .Stop sign placed on other residents door, 15 min checks to continue until deemed appropriate to remove by IDT .Try self directed activities to help keep resident busy, walk with resident in hallway . A care plan dated 3/6/24 indicated .Resident is at risk for psychosocial distress from physical contact from another resident .Approach .Monitor for any signs of distress, withdraw, change in mood (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan for Resident 94 dated 3/14/24 indicated Behavioral symptoms. Resident is at risk wandering, exit seeking, history of elopement from home, expresses the need to go home or leave, , and/or expresses anger or frustration about being in the community. wander guard to L [left] ankle. Resident cuts off wanderguard at times .Approach .3/14/24 Increase staff monitoring as needed .Redirect resident if wandering in unsupervised areas .When resident begins to wander, provide comfort measures for basic needs . A physician order dated 2/6/24 indicated Resident 94 was to receive 10 milligrams of memantine daily for a diagnosis of dementia with psychotic disturbances that included hallucinations. A physician order dated 2/6/24 indicated the resident was to receive 2 milligrams of diazepam in the morning daily for combative behavior. The medication was discontinued on 2/7/24. A physician order dated 2/6/24 indicated the resident was to receive 2 milligrams of diazepam at bedtime daily for combative behavior. A nursing progress note for Resident 94 dated 2/6/24 indicated Unable to complete admission PPD [Purified Protein Derivative] testing at this time. Patient is being extremely combative, yelling, swinging arms/attempting to strike nursing staff, screaming and unable to redirect. Will continue w/ [with] plan of care. A Social Services note for Resident 94 dated 2/7/24 indicated Nursing staff did report that on the evening of 2/6/24, resident was combative with nursing staff during admission process/care; attempting to hit nursing staff, verbal aggression. Staff also report that on the morning of 2/7/24, resident was yelling out/screaming at others during care. Staff will continue to reassure resident of her safety during care, and will continue to cue and assist resident as necessary. A physician note dated 2/7/24 indicated .behaviors in hospital requiring prn [as needed] zyprexa. Consult psych if needed. Cont [continue] memantine, diazepam reports of anxiety and behaviors. Add hydroxyzine 25 mg [milligrams] bid [twice a day] prn x 14 days. May need to increase diazepam dosage . A physician order dated 2/8/24 indicated the resident was to receive 25 milligrams of hydroxyzine twice a day as needed. A physician note dated 2/9/24 indicated Resident 94 was confused, but mood was stable. A nursing progress note for Resident 94 dated 2/23/24 indicated Resident wandering throughout the entire morning. She had to be redirected from 3 other resident rooms. In the last room she was found unclothed in another residents bed and had ripped her brief off. She does not take direction well and is not able to understand what you're asking d/t [due to] dementia. Will continue to redirect. An event for Resident 94 dated 2/26/24 indicated the resident on 2/26/24 at 10:00 a.m., had touched male resident in private area. Interventions that were put in place after the incident was one on one interaction, reassurance from staff, 15-minute monitor checks, and psych provider was notified. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A reportable incident that was reported to the Indiana Department of Health was provided by the Clinical Specialist on 3/25/24 at 9:00 a.m. It indicated .Incident date: 2/27/24 Incident Time: 3:01 p.m Brief Description of Incident .[Resident 94] touched [Resident E] on the outside of his pants in his lap area .Follow up: 3/5/24 [Resident 94] was seen by psych and new med [medication] added to help with behavior. 15-minute checks continue for [Resident 94]. Interdisciplinary team will evaluate circumstances to decide when they can be discontinued. Neither resident is showing any s/s [signs and symptoms] of psychosocial distress from incident. An investigation involving Resident 94 and Resident E was provided by the Clinical Specialist on 3/27/24 at 10:30 a.m. The investigation included but was not limited to: a written statement by Certified Nursing Assistant (CNA) 5. It indicated the following: To Whom This May Concern: I walked out of a Resident's room, and there was [Resident 94], in the hallway in front of the nurse's station holding another resident's private area. I quickly asked her to stop, saying you cannot do that, and I asked the nurse to help because she's (sic) wouldn't let go so the nurse grabbed her, and I grabbed him, and took him to his room immediately!!! . An interview was conducted with CNA 5 on 3/27/24 at 11:55 a.m. She indicated she was the staff present during the incident on 2/26/24 between Resident E and Resident 94. Resident E was clothed and standing in the hallway. Resident 94 had ambulated up to Resident E and grabbed his genitalia through his clothing. CNA 5 had intervened to separate the residents, but Resident 94 would not let go of Resident E's private area. She hollered for assistance from Registered Nurse (RN) 10. RN 10 had assisted with separating the residents. Resident E did not voice any pain during that time. Resident 94 was then placed on every 15-minute checks. An interview was conducted with RN 10 on 3/28/24 at 9:29 a.m. She indicated she was at the nurse's station and Resident 94 and Resident E were in the hallway. CNA 5 had hollered for her assistance. She had assisted CNA 5 with the separating of the two residents, but when she approached them Resident 94 was not touching Resident E's private area at that time. She had provided assistance with removing Resident E away from Resident 94 by taking him to his room. She then performed an assessment on Resident E and did not observe any injuries to him. A Post Behavioral/Emotional IDT Form dated 2/26/24 indicated .resident went to common area and touch a male resident in his private area .New interventions that will be added to prevent a reoccurrence; make sure resident does not sit next to male resident in common area . A 2/28/24 Behavior IDT follow up for Resident 94 indicated resident was on 15-minute monitoring checks and psych provider ordered 10 milligrams of Paxil (antidepressant) daily. A physician order dated 2/28/24 indicated the resident was to receive 10 milligrams of Paxil daily. A Social Services note dated 3/6/24 at 7:49 a.m., indicated On 3-5-24 at 11:12 p.m., [Resident 94] was having trouble sleeping, up walking and going in/out of other residents rooms taking their personal belongings. Staff did try the following redirection, one-on-one, toileted, provided a calm environment, given food/fluids, was not effective. IDT team reviewed behaviors. Staff will continue to redirect resident as needed. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1c. The clinical record for Resident 15 was reviewed on 3/25/24 at 1:11 p.m. The diagnosis for the resident included, but was not limited to, dementia. The 1/29/24 Admissions Minimum Data Set (MDS) Assessment for Resident 15 indicated she was severely cognitively impaired. A nursing progress note dated 3/6/24 at 8:13 a.m., indicated Res [resident] 94 in [Resident 15]'s room trying to take res in room belongings. Res [94] was struck in the back with a closed fist before staff could intervene. Res was not injured by this contact. Res skin was assessed and found to have no redness or bruising to area Res does not seem to have any memory of this incident and continues to try and go into others rooms and take things out of rooms that are not hers. Res redirected several times without effectiveness. A reportable incident that was reported to the Indiana Department of Health was provided by the Clinical Specialist on 3/25/24 at 9:01 a.m. It indicated .Incident date: 3/6/24 Incident Time: 9:01 a.m Brief Description of Incident .[Resident 94] wandered into [Resident 15]'s room and before staff could reach [Resident 94] and redirect her [Resident 15] touched her back with her hand .Immediate Action taken .Residents were immediately separated. Skin and pain assessment has been initiated .Stop sign was placed at [Resident 15]'s door .Follow up .[Resident 94] was seen by psych [provider] and new order added to care. 15 - minute checks continue with [Resident 94] IDT team met and reviewed behaviors. Staff will continue to redirect as needed. They will try and engage her in self-directed activities along with scheduled activities. An investigation involving Resident 94 and Resident 15 was provided by the Clinical Specialist on 3/27/24 at 10:30 a.m. The investigation included but was not limited to: a written statement by License Practical Nurse (LPN) 2. It indicated, 3/6/24 at 8:05 a.m. Res [94] was in [Resident 15's room] and had taken some belongings from res [15]. Res in [Resident 15's room] was distressed about [Resident 94] in her room. Res [94] had belongings in her hand. Retrieved res belongings and got her to head to the door. As were coming through the door [Resident 15] hit her in the back. Removed res [94] from [Resident 15's room] & assessed for injury. Res in [Resident 15's room] went back to her chair and was upset about her being in her room . A Social Services progress note dated 3/7/24 at 7:37 a.m., indicated On 3-6-24 at 8:00 a.m., [Resident 94] was rummaging through other residents's belongings. Staff did try the following redirection, one-on-one, offered food/fluids was not effective. On 3-6-24 at 9:47 p.m., [Resident 94] was having trouble sleeping, wondering into other residents rooms, taking their belongings, waking them up and yelling at them about her husband. Staff did try the following redirection, one-on-one, food/fluids, toileted, returned to her room, position change, was not effective. On 3-7-24 at 2:56 a.m., [Resident 94] was having trouble sleeping and wandering. Staff did try the following redirection, one-on-one, toileted, returned to her room, position change, was not effective. IDT team met and reviewed behaviors. Staff will continue to redirect resident as needed. Resident just had a recent increase in her Paxil. A physician order dated 3/6/24 indicated Resident 94 was to be increased to 20 milligrams of Paxil daily. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation behavior note for Resident 94 dated 3/8/24 indicated .follow up behavior and resident altercation/contact .Root cause: Resident with altercation with other female resident and also previously touched male resident in hallway in his lap area on outside of his pants/increased pleasing self-masturbation. Current status: resident conts [continues] to wander however no aggression or physical contact with others. Resident has had no psychosocial distress from physical contact to back when she roamed into other residents room to take her items. Intervention(s): Paxil was increased by psych earlier this week, and it does seem to be helping. Psych evaluated resident this week. This resident is on 15 min checks, and a stop sign is on the door for the female resident whos room she entered and that is effective at this time. Staff gives redirection as needed and engages in appropriate activities . A psych visit note dated 3/8/24 indicated .The patient reports no difficulty with sleeping at night. Staff notes she is having trouble with some difficulty with being up wandering at times. If she continues to have difficulty we will add melatonin She denies difficulty with anxiety and no symptoms are observed. She is more restless than anxious, probably due to her confusion .She is having difficulty with behaviors, including stealing belongings from peers and going in their room. She also has had some sexual behaviors. She was started on Paxil for these, and her dose was increased recently .Staff are obtaining UA on her today. Her recent one was negative for UTI [Urinary Tract Infection]. The patient's cognition is significantly declined. She is currently receiving memantine for cognition decline, which we will probably discontinue once her behavior issues are stabilized Follow up 1 month . An observation behavior note for Resident 94 dated 3/15/24 indicated follow up behaviors .Root cause: resident with behaviors, wandering into others rooms, taking belongings, recently having hypersexual behaviors, such as masturbating. Current status: residents sexual behaviors have decreased, no touching others, conts to roam in to others rooms, and is taking down stop signs. They are not effective. Intervention(s): psych is following resident, and [Medical Provider]. U/A [Urinalysis] ordered. Paxil was started and also increased which has helped resident some . A Social Services note for Resident 94 dated 3/18/24 indicated On 3/15/24 at 9:16 p.m., [Resident 94] was repetitive asking questions. Staff did try to redirect, was not effective. On 3/16/24 at 1:00 a.m., [Resident 94] was having trouble sleeping and going into other residents rooms while they were sleeping. She would uncover them and tell them it was time to get up. She also pulled their clothing out of the closet and put them on top of them. Staff did try the following redirection, offered food/fluids, toileted and returned to her room, was not effective. On 3/17/24 at 7:31 p.m., [Resident 94] was wondering about the unit. Staff did try the following redirection, backrub and provided calm environment, was not effective. IDT team met and reviewed behaviors. Staff will continue to redirect resident as needed through out her daily routine. They will also try to have her do self directed activities and join in scheduled activities. A medical provider note dated 3/19/24 indicated .Resident with pacing and restlessness at night .Start low dose melatonin 3 mg q hs [every night. A physician order dated 3/20/24 indicated the resident was to receive 3 milligrams of melatonin daily at bedtime. (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 follow up note dated 3/22/24 indicated Root cause: resident with ongoing behaviors. sexual behaviors have decreased some, not touching others. Conts to wander into other areas. Current status: stable. Conts to wander into others space, non pharm [nonpharmacological] interventions attempted. Staff attempting to engage in activities and keep resident busy. Staff reported to NP [Nurse Practitioner] resident not sleeping well. Intervention(s): Melatonin started, cont ss [social services] follow up, psych, and NP to follow .no further IDT monitoring needed at this time . Resident's 94 staff monitoring documents were provided by the Clinical Specialist on 3/26/24 at 12:55 p.m. The monitoring documents indicated Resident 94 was on staff 15-minute monitoring checks on 2/26/24, 2/27/24, 2/28/24, 2/29/24, 3/1/24, 3/2/24, 3/3/24, 3/5/24, 3/6/24, 3/7/24, 3/8/24, 3/9/24 and 3/10/24. An observation was made of Resident 94 on 3/25/24 at 10:55 a.m. During a scheduled activity on the memory care unit, Resident 94 was observed wandering. The resident had wandered into Residents' 68 and 79's room. The residents that reside in the room were not present in the room at that time. Resident 94 was observed going to one of the resident's bed and messing up blankets; rummaging through the closet, and the bathroom. There was no observation of staff redirecting the resident at that time. The resident then left the room and ambulated to the nurse's station. Resident 94 indicated at that time; she needed her, dirty white clothes. During an interview with CNA 5 on 3/27/24 at 11:55 a.m., she indicated Resident 94 wanders in and out of residents' rooms, and it upsets other residents. A stop sign was placed on Resident 15's door after the incident occurred on 3/6/24, with Resident 15. Resident 15 gets upset when Resident 94 takes her belongings. Resident 94 goes into other residents' rooms; messes up their covers and belongings. The stop signs do not help. The resident removes the stops signs. The resident does like her room to be set at a warmer temperature. She will occupy her time in her room at times if the temperature in her room was set to her liking. During an interview with RN 10 on 3/28/24 at 9:29 a.m., she indicated Resident 94 does wander in and out of other residents' rooms. They utilize stop signs on the doors to detour her from entering. An interview was conducted with LPN 2 on 3/28/24 at 11:06 a.m. She indicated she was the staff person present during the incident on 3/6/24 with Resident 94 and Resident 15. She was assisting a resident; assuring that resident was not going to fall and had observed Resident 15 getting aggravated with Resident 94 in her room taking her belongings. She heard Resident 15 yelling get out! Then, LPN 2 entered the room to intervene and redirect. LPN 2 was able to get Resident 94 to head to the doorway of the room. During that time, Resident 15 hit Resident 94 in the back prior to getting Resident 94 to exit the room. LPN 2 indicated stops signs do not stop Resident 94 from entering other residents' rooms. She removes them. Does not help at all; nothing works. She wanders everywhere. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Behavioral Health Management Program was provided by the Director of Nursing on 3/28/24 at 11:50 a.m. It indicated, Behavior policy .[NAME] communities provide services to our residents with specific diseases and disorders. Some of our residents have medical disabilities that can lead to disruptive behaviors and these behaviors have the potential to create a negative effect on the resident, other residents, visitors, and the staff. It is [NAME]'s policy that each community will have a behavior program that: identifies, monitors, manages, and disseminates (whenever possible) all behavioral events by utilizing the least invasive approach based on the individual resident affected. Our goal is to provide the highest level of functioning and well being for each resident we serve. [NAME] believes in a person-centered care approach and tailors all considerations for the individual affected, including physical and psychosocial aspects of well being when it comes to managing maladies that manifest behavioral disturbances . 3.1-37(a)

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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. 36942 Based on interview and record review, the facility failed to ensure transmission-based precautions (TBP) were initiated timely for a resident with COVID-19 for 1 of 3 residents reviewed for TBP. (Resident 255) Findings include: The clinical record for Resident 255 was reviewed on 3/25/24 at 1:55 p.m. The diagnoses included, but were not limited to, COVID-19, cough, and hypertension. A progress note, dated 3/16/24 at 12:54 p.m., indicated Resident 255 admitted to the facility from the hospital and admitted with COVID-19. A physician order, dated 3/18/24, indicated the following, .droplet/contact isolation, with no roommate. All meals, activities, therapy and services must be provided in room with isolation precautions followed There was no indication in the progress notes or the physician orders that the resident was in TBP until 3/18/24. A policy titled COVID-19 Policy and Procedure, dated 8/6/23, was provided by Clinical Specialist on 3/26/24 at 12:55 p.m. The policy indicated the following, .Additional PPE [personal protective equipment] and Other Precautions .A. Face Shield/Goggles, N95 Respirator, and a Gown must be worn by healthcare personnel (HCP) who provide essential direct care within 6 feet of the resident when .1. Caring for a Resident in a Red Zone 3.1-18(b)(2)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 36942 Based on interview and record review, the facility failed to ensure annual influenza immunization was administered per physician orders for 1 of 5 residents reviewed for immunizations. (Resident 82) Findings include: The clinical record for Resident 82 was reviewed on 3/25/24 at 1:50 p.m. The diagnoses included, but were not limited to, heart failure, diabetes mellitus, and weakness. An immunization consent form, undated, indicated consent was given to administer the influenza vaccine. A physician order, dated 11/3/23, was noted for Fluzone Quad 2023-2024 (flu vaccine) intramuscular injection. The electronic medication administration record (EMAR), dated November of 2023, indicated the dose of Fluzone Quad was not signed off, as administered, on 11/3/23. An interview conducted with the Infection Preventionist (IP), on 3/26/24 at 4:50 p.m., indicated she reached out to the physician and obtained an order to administer the influenza vaccine since it was still within the window to receive the annual influenza vaccine. A policy titled Influenza Immunization Policy - Residents, revised 9/23/20, was provided by the Executive Director on 3/22/24 at 1:30 p.m. The policy indicated the following, .All residents will be offered an influenza vaccination as appropriate when residing in a [name of Corporation] Community. Annually [name of Corporation] will offer the influenza vaccination beginning on October 1 unless the vaccinations have not yet been received in stock by [name of pharmacy] and continue through the influenza season .This policy is created with the intention to follow current CDC [Centers for Disease Control and Prevention] recommendations for influenza vaccination A document from the Centers for Disease Control and Prevention (CDC) titled Key Facts About Flu Vaccines, last reviewed March 22, 2024, indicated the following, .When should I get vaccinated .For most people who need only one dose of influenza vaccine for the season, September and October are generally good times to be vaccinated against influenza. Ideally, everyone should be vaccinated by the end of October