STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195501	A. Building B. Wing	07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harvest Manor Healthcare and Rehabilitation Center	839 North Range Avenue Denham Springs, LA 70726

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to ensure each resident remained free from physical and psychosocial abuse for 7 (#R1, #1, #3, #5, #6, Unknown Resident #1, and Unknown Resident #2) of 9 (#R1, #1, #3, #4, #5, #6, #7, Unknown Resident #1, and Unknown Resident #2) residents reviewed for abuse. This deficient practice resulted in an Immediate Jeopardy situation on 02/22/2025, when Resident #4, a cognitively impaired resident, hit Resident #R1 on the back. The facility failed to ensure effective interventions were put into place to protect the resident's from abuse after the 02/22/2025 incident. Resident #4 exhibited continued aggressive and abusive behaviors, and was transferred to the facility's locked dementia care unit on 03/25/2025. On 03/25/2025, Resident #4 was observed grabbing Unknown Resident #1 by the feet and attempting to pull the resident out of their wheelchair. The resident was observed by a former employee to be fearful, displaying physical and verbal signs of stress. Unknown Resident #1 was scared, crying, and kept doing a swatting motion with her hands. The IJ continued on 04/17/2025, when Resident #4 interlocked her arms around Resident #3's throat then began pulling back, choking her. The IJ continued on 05/20/2025, when Resident #4 pushed Resident #5, causing Resident #5 to fall to the floor. Resident #4 then hit Resident #5 in her face. Resident #5 complained of hip pain after the incident. Resident #5's family requested Resident #5 be moved out of the locked dementia care unit for safety, which resulted in Resident #5 crying for days. The IJ continued on 05/26/2025, when Resident #4 grabbed Unknown Resident #2's hair, pulled it, and would not let go. On 05/26/2025, Resident #4 was placed on 1:1 supervision then removed from 1:1 supervision on 06/09/2025. On 06/09/2025, Resident #4 pushed Resident #6 into the wall, causing Resident #6 to hit her head against the wall. Resident #6 complained of a headache after the incident and required administration of Tylenol for pain management. Resident #4 was placed back on continuous 1:1 supervision on 06/09/2025. On 06/16/2025, Resident #1 was found in a resident's room lying on her left side in a fetal position. Resident #4 was observed standing on the right side of Resident #1's wheelchair with Resident #1's wheelchair pad in her hand, and no staff present with Resident #4. Resident #1 was noted to have swelling to the left side of her face and right knee. Resident #1 was transferred to the hospital where it was determined she had a right femur fracture and a left facial hematoma. Due to Resident #1's age, she was unable to undergo surgery and was ultimately transferred to an inpatient hospice facility where she passed away on 06/25/2025. On 07/09/2025 at 5:30 a.m., an observation was made of Resident #4. She was lying in her bed with no staff present at bedside. As a result of the investigation, despite there not being a significant decline in mental or physical functioning for Residents #R1, #3, #6, Unknown Resident #1, and Unknown Resident #2, it could be determined a reasonable person would have experienced psychosocial harm as a result of Resident #4's abusive behaviors since a reasonable person would not expect to be treated in this manner in their own home or a health care facility. S1ADM was notified of the Immediate Jeopardy situation on 07/09/2025 at 4:58 p.m. Findings:Review of the facility's policy dated 03/25/2023 and titled, Abuse-Prevention and Prohibition Policy and Procedure, revealed the following, in part:Purpose:Each resident has the right to be free from abuse.3. Physical Abuse may include hitting, slapping, pinching, biting, shoving, and kicking.4. Mental Abuse includes, but is not limited to, harassment.There may be some situations in which the resident is unable to express him/herself due to a medical condition and/or impairment, cannot relate what has occurred, or may not express outward signs of physical harm, pain, or mental anguish. A lack of response by the resident does not mean that mental abuse did not occur. Resident #R1Review of Resident #R1's clinical record revealed he was admitted to the facility on [DATE]. Review of Resident #R1's Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 07/02/2025 revealed a Brief Interview for Mental Status (BIMS) of 5, which indicated Resident #R1 was severely cognitively impaired. Resident #4Review of Resident #4's clinical record revealed she was admitted to the facility on [DATE] with diagnoses which included, Dementia with Agitation, Major Depressive Disorder, and Anxiety. Review of Resident #4's Quarterly MDS with an ARD of 05/14/2025 revealed a BIMS of 2, which indicated she had severe cognitive impairment. Further review revealed Resident #4 was ambulatory and required supervision with ADL's. Review of Resident #4's Nurse's Notes revealed the following, in part:02/22/2025 at 4:42 p.m.-While doing medication pass, Resident #4 was in another residents room and Resident #R1 (Resident #4's husband) was standing at doorway. I asked Resident #4 to follow me to her room and she exited with the other

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all alleged allegations involving physical and psychological abuse were reported immediately, but not later than 2 hours after the allegation was made, to the State Survey Agency, for 7 (#R1, #1, #3, #5, #6, Unknown Resident #1, and Unknown Resident #2) of 9 (#R1, #1, #3, #4, #5, #6, #7, Unknown Resident #1, and Unknown Resident #2) residents reviewed for abuse. This deficient practice resulted in an Immediate Jeopardy situation on 02/22/2025, when the facility failed to report allegations of abuse to the State Agency. On 02/22/2025, Resident #4 hit Resident #R1. On 03/25/2025, Resident #4 attempted to pull Unknown Resident #1 out of her wheelchair by her feet. On 04/17/2025, Resident #4 hit Resident #3. On 5/20/2025, Resident #4 pushed Resident #5, causing her to fall then Resident #4 hit Resident #5 in the face. On 05/25/2025, Resident #4 grabbed Unknown Resident #2's hair and pulled it and wouldn't let go. On 06/09/2025, Resident #4 told Resident #6 to shut up and pushed Resident #6 backwards causing her to stumble and hit her head against the wall and fall to the floor. On 06/16/2025, the nurse heard a scream and a wheelchair alarm go off and a second scream and she observed Resident #1 lying on her left side on the floor by the bed in a fetal position, and observed Resident #4 standing at the end of the bed next to Resident #1's wheelchair with the seat pad in her hands. Record review revealed none of the above incidents were reported to the State Agency. Interview with S1ADM revealed he was aware of the incidents above and none were reported to the State Agency. As a result of the investigation, despite there not being a significant decline in mental or physical functioning for Residents #R1, #3, #5, #6, Unknown Resident #1, and Unknown Resident #2, it could be determined a reasonable person would have experienced psychosocial harm as a result of Resident #4's abusive behaviors since a reasonable person would not expect to be treated in this manner in their own home or a health care facility. S1ADM was notified of the Immediate Jeopardy situation on 07/11/2025 at 11:10 a.m. This deficient practice continued at a potential for more than minimal harm for the other 166 residents residing in the facility. Findings:Cross Reference F600 and F835 Review of the facility's policy dated 03/25/2023 and titled, Abuse-Prevention and Prohibition Policy and Procedure, revealed the following, in part: II. Procedures:7. Reporting/Response: The facility employee or covered individual who becomes aware of abuse or neglect, including injuries of unknown source or alleged misappropriation of resident property, shall immediately report the matter to the facility administrator. The Administrator shall immediately initiate a self-reported incident report to the State Survey Agency and the facility's local law enforcement agency, but not less than 2 hours after forming the suspicion of a crime if the alleged violation involves abuse (physical, sexual, verbal, or mental) or results in serious bodily injury. On 07/10/2025 at 9:20 a.m., review of the facility's self-reported incidents dated January 2025 through July 2025 revealed no incidents of resident to resident abuse reported to State Agency. Resident #R1Review of Resident #R1's clinical record revealed he was admitted to the facility on [DATE]. Review of Resident #4's Nurse's Notes revealed the following, in part:02/22/2025 at 4:42 p.m.-While doing medication pass Resident #4 was in another residents room and Resident #R1 (Resident #4's husband) was standing at doorway. I asked Resident #4 to follow me to her room and she exited with the other residents blanket rolled up in her arms. Resident #R1 attempted to take it from her and give it back to the other resident, and when she followed him out she hit him in his back. Signed, S4EMP. On 07/10/2025 at 9:55 a.m., an interview was conducted with S4EMP. She stated she observed the incident between Resident #4 and #R1 on 02/22/2025. She stated she would consider this incident resident to resident physical abuse. She stated she reported the incident but did not recall who she reported it to. She stated the facility's protocol was to notify the direct supervisor immediately after a witnessed incident. Unknown Resident #1Review of Resident #4's Nurse's Notes revealed the following, in part: On 03/25/2025 at 7:10 p.m.-Resident #4 noted attempting to take residents from the community area against their will. Unable to redirect, she is becoming verbally aggressive. Resident #4 noted tearing padding off a residents wheelchair, when redirection attempted she grabbed Unknown Resident #1 by both feet and began trying to pull her out of her chair by her feet. Unknown Resident #1 is fearful and showing physical as well as expressing verbal signs of stress. Resident #4 then walked away and took a facility chair making attempts to leave with the chair but while sitting in it. Signed by S30FEMP. On 07/10/2025 at 9:38 a.m., a telephone interview was conducted with S30FEMP. She stated she observed the incident above between Resident #4 and Unknown Resident #1 on 03/25/2025. She stated she informed S1ADM of the incident after it happened. Resident

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews, the facility failed to ensure a resident received adequate supervision to prevent incidents for 1 (#4) of 10 (#1, #2, #3, #4, #5, #6, #7, #R1, Unknown Resident #1, and Unknown Resident #2) residents review for incidents. This deficient practice resulted in an Immediate Jeopardy situation on 05/26/2025, when Resident #4, a cognitively impaired resident with a history of aggressive behaviors and was assessed to need 1:1 supervision, was left unattended by staff. Resident #4 was placed on 1:1 supervision from 05/26/2025 through 06/09/2025. On 05/26/2025, Resident #4 was observed grabbing and pulling Unknown Resident #2's hair. On 06/02/2025, Resident #4 grabbed Resident #1's wheelchair, spun her around forcefully and began telling her she was bothering her. Interviews with staff revealed Resident #4 was not receiving 1:1 supervision at that time. On 06/09/2025, 1:1 supervision was removed and later that day, Resident #4 was involved in another incident where she pushed Resident #6 into the wall, causing her to hit her head. Resident #4 was placed back on 1:1 close monitoring following the incident on 06/09/2025. On 06/11/2025, Resident #4 was found in an empty resident's room at 12:21 a.m., attempting to get in bed. Interviews with staff revealed Resident #4 did not have 1:1 supervision during the 10:00 p.m. to 6:00 a.m. shifts. On 06/16/2025, Resident #1 had an incident where she was found lying on the floor in front of her wheelchair, on her left side. Resident #4 was found standing beside Resident #1's wheelchair, with no staff present with Resident #4. Resident #1 acquired a right femur fracture and facial soft tissue hematoma which extended into left frontal scalp. Due to Resident #1's age, she was unable to undergo surgery, and she was transferred to an inpatient hospice facility, where she passed away on 06/25/2025. Staff interviews revealed Resident #4 did not have 1:1 supervision at the time of the incident on 06/16/2025. Staff interviews revealed Resident #4 was not provided with consistent 1:1 supervision during the day until after Resident #1's incident on 06/16/2025. On 07/09/2025 at 5:30 a.m., an observation was made of Resident #4. She was lying in her bed with her eyes closed. There was no staff present providing 1:1 supervision. S1ADM was notified of the Immediate Jeopardy situation on 07/11/2025 at 11:10 a.m. This deficient practice continued at a potential for more than minimal harm for the other 24 residents residing in the locked dementia unit and any resident who would require 1:1 supervision. Findings: Cross Reference F600 and F835 Review of Resident #4's clinical record revealed she was admitted to the facility on [DATE] with diagnoses which included, Dementia with Agitation, Major Depressive Disorder, and Anxiety. Review of Resident #4's Quarterly MDS with an ARD of 05/14/2025 revealed a BIMS of 2, which indicated Resident #4 had severe cognitive impairment. Further review revealed Resident #4 was ambulatory and required supervision with ADL's. Review of Resident #4's current Physician Orders revealed the following, in part:03/19/2025-Admit to memory care; secure unit monitoring Review of Resident #4's current Care Plan revealed the following, in part:Problem: Resident #4 went into another resident's room and urinated on the floor, turning on/off others lights. 03/26/25- Resident #4 has been taking other residents food, throwing food at staff, hitting staff members, yelling at other residents, and pushing furniture while other residents are on it. Resident #4 can be difficult to redirect. 03/27/25- Resident #4 has been taking family members belongings and refusing to give them back. Resident #4 attacked a CNA when the resident could not open window. Intervention: Every 30 minute checks for behavior x 24 hours, initiated 05/20/2025. Redirect as needed. Resident #4 separated on 05/20/2025. 1 on 1 observation 05/26/2025-06/09/2025. Sent to ER for evaluation/treatment dated 06/09/2025. 1:1 close monitoring initiated on 06/09/2025. Review of Resident #4's Nurse's Notes revealed the following, in part:On 05/26/2025 at 7:47 p.m. - 4:30 p.m.-Resident #4 agitated at another resident continuously calling staff lil N***** girls. Resident #4 jumped up out of chair and rushed over to another resident yelling, Ok you are being obnoxious and I've had enough! Resident #4 abruptly grabbed Unknown Resident #2's wheelchair and started pushing Unknown Resident #2 quickly down the hall and then spun Unknown Resident #2 around and started pushing Unknown Resident #2 quickly back to dining room. Unknown Resident #2 asked, What are you gonna do, push me into somebody? Resident #4 stepped around wheelchair, facing Unknown Resident #2 and attempted to grab Unknown Resident #2. Staff stepped in between both residents and attempted to redirect them. Unknown Resident #2 stated, I'm gonna kill her. Resident #4 left staff and rushed back to Unknown Resident #2 and grabbed a hand full of hair from the top of Unknown Resident #2's head and continued to pull it. Resident #4 would not let it go. RN supervisor entered unit a few minutes later and was informed of incident. Signed by S10EMP

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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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, and interviews, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 7 (#R1, #1, #3, #5, #6, Unknown Resident #1, and Unknown Resident #2) of 9 (#R1, #1, #3, #4, #5, #6, #7, Unknown Resident #1, and Unknown Resident #2) sampled residents. The facility failed to:1. Protect Resident's #R1, #1, #3, #5, #6, Unknown Resident #1, and Unknown Resident #2 from physical and psychosocial abuse by Resident #4;2. Report allegations of physical and psychosocial abuse by Resident #4 to the State Agency in the required timeframe; and3. Ensure Resident #4 received consistent adequate staff supervision to manage the resident's known verbally and physically abusive behaviors.This deficient practice resulted in an Immediate Jeopardy situation on 02/22/2025, when Resident #4, a cognitively impaired resident, hit Resident #R1. Resident #4 exhibited continued aggressive and abusive behaviors, and was transferred to the facility's locked dementia care unit on 03/25/2025. On 03/25/2025, Resident #4 was observed grabbing Unknown Resident #1 by the feet and attempting to pull the resident out of their wheelchair. Unknown Resident #1 was observed by a former employee to be fearful, displaying physical and verbal signs of stress, including crying and repeatedly making a swatting motion with her hands. The IJ continued on 04/17/2025, when Resident #4 interlocked her arms around Resident #3's throat then began pulling back, choking her. The IJ continued on 05/20/2025, when Resident #4 pushed Resident #5, causing Resident #5 to fall to the floor. Resident #4 then hit Resident #5 in her face. Resident #5 complained of hip pain after the incident. Resident #5's family requested Resident #5 be moved out of the locked dementia care unit for safety, which resulted in Resident #5 crying for days. The IJ continued on 05/26/2025, when Resident #4 grabbed Unknown Resident #2's hair, pulled it, and would not let go. On 05/26/2025, Resident #4 was placed on 1:1 supervision until 06/09/2025. However, staff interviews revealed during that time Resident #4 received inconsistent 1:1 supervision. On 06/09/2025 after 1:1 supervision was removed, Resident #4 pushed Resident #6 into the wall, causing Resident #6 to hit her head against the wall. Resident #6 complained of a headache after the incident and required administration of Tylenol for pain management. Resident #4 was placed back on continuous 1:1 supervision on 06/09/2025. On 06/16/2025, Resident #1 was found in a resident's room lying on her left side in a fetal position. Resident #4 was observed standing on the right side of Resident #1's wheelchair with Resident #1's wheelchair pad in her hand, and no staff present with Resident #4. Resident #1 was noted to have swelling to the left side of her face and right knee. Resident #1 was transferred to the hospital where it was determined she had a right femur fracture and a left facial hematoma. Due to Resident #1's age, she was unable to undergo surgery and was ultimately transferred to an inpatient hospice facility where she passed away on 06/25/2025. Staff interviews revealed Resident #4 did not have 1:1 monitoring during the 10:00 p.m. to 6:00 a.m. shifts, and Resident #4 was not provided with consistent 1:1 monitoring during the day until after Resident #1's incident on 06/16/2025. On 07/09/2025 at 5:30 a.m., an observation was made of Resident #4. She was lying in her bed with no staff present at bedside. Record review and interview with S1ADM revealed S1ADM was aware of each of the above incidents with Resident #4, but none of the above incidents were reported to State Agency. As a result of the investigation, despite there not being a significant decline in mental or physical functioning for Residents #R1, #3, #5, #6, Unknown Resident #1, and Unknown Resident #2, it could be determined a reasonable person would have experienced psychosocial harm as a result of Resident #4's abusive behaviors since a reasonable person would not expect to be treated in this manner in their own home or a health care facility. S1ADM was notified of the Immediate Jeopardy situation on 07/11/2025 at 11:10 a.m. This deficient practice continued at a potential for more than minimal harm for the other 167 residents residing in the facility. Findings:Cross reference F600, F609, and F689 Review of the facility's policy dated 03/25/2023 and titled, Abuse-Prevention and ProhibitionPolicy and Procedure, revealed the following, in part:Purpose:Each resident has the right to be free from abuse. 3. Physical Abuse may include hitting, slapping, pinching, biting, shoving, and kicking. 4. Mental Abuse includes, but is not limited to, harassment.There may be some situations in which the resident is unable to express him/herself due to a medical condition and/or impairment, cannot relate what has occurred, or may not express outward signs of physical harm, pain, or mental anguish. A lack of response by the resident does not mean that mental abuse did not occur. II. Procedures:7. Reporting/Response: The facility employee or covered individual who

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the Quality Assurance and Performance Improvement (QAPI) committee failed to provide sufficient evidence that ongoing monitoring was implemented to ensure corrective actions were put in place after identifying issues with inadequate supervision related to resident-to-resident incidents. This deficient practice had the potential to affect a census of 167 residents. Findings: Review of the facility's policy dated 04/28/2025 and titled, Quality Assurance and Performance Improvement (QAPI) Plan, revealed the following, in part:Our QAPI plan addresses:i. Clinical Care-monitor Quality Measures, internal tracking tools for falls, medication errors, pressure ulcers, incident reports and infection reports. Areas identified will be addressed via Performance Improvement Projects. II. Governance and LeadershipThe Administrator is responsible and accountable for developing, leading and closely monitoring the QAPI program. Review of the facility's Quality Improvement Corrective Action Plan dated 05/20/2025, revealed the following, in part:Identifiable Problem:Facility failed to ensure that each resident received adequate supervision to prevent alleged resident-to-resident incidents. Recommended Plan of Action: Corrective action taken by: e. Facility sent out Resident #4 for evaluation and treatment. f. Facility increased supervision of Resident #4 upon return. 2. All residents have the potential to be affected by the alleged deficient practice. 5. Corrective action will be completed by 07/04/2025.Recurring Problems: Resident had another occurrence on 05/26/2025 therefore placed resident on 1: 1 monitoring. Review of the facility's Follow-up Form dated 05/21/2025-07/04/2025, and completed by S1ADM, revealed the following: 05/21/2025-No behaviors related to wandering. 05/22/2025-No behaviors related to wandering. 05/23/2025-No behaviors related to wandering. 05/26/2025-Resident #4, Resident noted with behavior-resident placed on 1:1. 05/27/2025-Resident #4, 1:1 in place. Currently sitting with staff no issues. 05/28/2025-Resident #4, No new concerns noted. 06/03/2025-Resident #4 noted pushing another resident in chair. 06/06/2025-Resident #4, Minimal concerns noted since 1:1. Consider removing 1:1 effective on 06/09/2025 if no concerns over weekend. 06/09/2025-Resident #4. No concerns noted over weekend. Discontinue 1:1. Will continue to monitor. 06/10/2025-following discontinuance of 1:1, Resident #4 had incident with another resident. Sent out for evaluation. 1:1 reinstated upon return-sent out referral for alternative placement. No other wandering issues noted/observed. QA to be extended to ensure continued compliance. 06/12/2025-No wandering behaviors06/16/2025-Resident #1 had a fall. Resident not previously classified as wandering due to only being ambulatory by wheelchair. 06/17/2025-No issues/concerns noted. 06/18/2025-No concerns. 06/20/2025-Resident #4. Negative behavior noted. Referred physician to review medications. Increase activities in resident room. Additional education provided to staff. Physician increased medication and referred to psychiatric physician for additional thoughts. Spoke with NFA at another local facility about transferring to facility possibly Monday. Attempting to send to behavioral hospital. 06/25/2025-Resident #4 out of facility. NFA virtually observed common areas no concerns noted. 06/26/2025-Resident #4 returning. NFA virtually observed common areas. No concerns noted. Resident #4 noted to be 1:1 upon return. 06/27/2025-Resident #4 Behavior. Resident eating breakfast quietly at table. CNA assigned 1:1 was seated beside her and was attentive. 07/02/2025-No issues. 07/03/2025-No issues. 07/04/2025-No issues. Continue 1:1 until alternative placement achieved. Staff will continue to document 1:1 on designated forms. Review of Resident #4's clinical record revealed she was admitted to the facility on [DATE] with diagnoses which included, Dementia with Agitation, Major Depressive Disorder, and Anxiety. Review of Resident #4's current Care Plan revealed the following, in part:Intervention: 1:1 observation 05/26/2025-06/09/2025. Sent to ER for evaluation/treatment dated 06/09/2025. 1:1 close monitoring initiated on 06/09/2025. Review of Resident #4's 1:1 monitoring tools revealed documentation of 1:1 monitoring by staff began on 06/20/2025. Review of Resident #4's Nurse's Notes revealed the following, in part:On 06/02/2025 at 3:23 p.m. -Resident approached Resident #1, who she saw was wheeling herself in her wheelchair down the hallway and grabbed the handles of the wheelchair swinging Resident #1 around with force and trying to push her down the hallway. Staff immediately redirected Resident #4 away from Resident #1 and encouraged Resident #4 to not worry about the other resident, Resident #4 stated she just makes me so angry Staff was able to redirect resident out of situation. Will continue to monitor. Signed by S11EMP. On 06/11/2025 at 12:21 a.m. -Resident #4 found up and in another room attempting to get in bed. Brought back to her room and assisted into her room without incident. Will continue to monitor. Signed by S8EMP. On 6/16/2025 at 2:50 p.m. -When